Riverbend
Water Resources District

# RIVERBEND RESOLUTION NO. 20160413-04

## AUTHORIZING THE EXECUTIVE DIRECTOR/CEO TO EXECUTE INTERLOCAL AGREEMENT(S) FOR HEALTH REIMBURSEMENT ARRANGEMENT AND RETIREMENT REIMBURSEMENT ARRANGEMENT SERVICES WITH TML MULTISTATE IEBP

**WHEREAS,** Riverbend Water Resources District is a conservation and reclamation district created under and essential to accomplish the purposes of Section 59 Article XVI, Texas Constitution, existing pursuant to and having the powers set forth in Chapter 9601 of the Special District Local Laws Code of the State of Texas;

**WHEREAS,** Riverbend Water Resources District currently has an interlocal agreement with TML MultiState IEBP for a health benefits plan for district employees;

**WHEREAS,** Riverbend Water Resources District has a need for health reimbursement arrangement and retirement reimbursement arrangement services to support the operation and management of its wet utilities; and

**WHEREAS,** TML MultiState IEP provides said needed health reimbursement arrangement and retirement reimbursement arrangement services and is fully qualified and certified to perform these services;

**NOW, THEREFORE, BE IT RESOLVED** that the Executive Director/CEO shall be and is hereby authorized to enter into interlocal agreement(s) with TML MultiState IEP to provide health reimbursement arrangement and retirement reimbursement arrangement services for Riverbend Water Resources District.

**PASSED and APPROVED this 13th day of April, 2016**

Sean Rommel, President

Riverbend
Water Resources District

ATTEST:

Fred Milton, Secretary

Attached: Health Reimbursement Arrangement Plan
Health Reimbursement Service Agreement for Plan Supervisor
Retirement Reimbursement Arrangement Addendum


## PLAN YEAR 2015-2016

# HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

## Riverbend Water Resources District

| Resource | Contact Information | Accessible Hours |
|---|---|---|
| TML MultiState Intergovernmental Employee Benefits Pool (IEBP) | 1821 Rutherford Lane, Suite 300 \| Austin, Texas 78754<br>PO Box 149190 \| Austin, Texas 78714-9190 | |
| Customer Care Helpline: | (800) 282-5385 | 8:30 AM - 5:00 PM Central |
| Provider Benefit Information Portal: Provider information can be found under the Provider Services menu. Member specific information such as Eligibility, Claims, Summary of Benefits and Coverage, Provider Coding Guidelines, Medication Therapy Management Guide, Member Rights and Responsibilities, Provider/Member Appeal Rights and IEBP Quality Improvement Plan information is also available. | Visit www.iebp.org \| to register, click on the "Sign Up" link under the provider section \| to login, click on the "Login" button at the top right hand side of the screen | |
| Secured Customer Care E-mail: | Visit www.iebp.org \| click on the "Login" button \| click on "Online Customer Care" under the "My Tools" menu \| click on "Send a Secure Email" | 8:30 AM - 5:00 PM Central |
| TML MultiState IEBP Internet Website: | www.iebp.org | Twenty-four (24) hrs |
| *My*IEBP Mobile Access: | iPhone–App Store, Droid–Google Play, All other Phones–www.iebp.org | Twenty-four (24) hrs |
| Medical Authorizations: | (800) 847-1213 | 8:30 AM - 5:00 PM Central |
| Professional Health Coaches: | (888) 818-2822 | 8:30 AM - 6:00 PM Central or Scheduled Appt. |
| Spanish Line: | (800) 385-9952 | |
| Where to Mail Paper Medical Claims: | TML MultiState IEBP<br>PO Box 149190 \| Austin, Texas 78714-9190 | |
| After Hours and/or Weekend Medical and Mental Healthcare Emergencies: | Call 911 or immediately go to the emergency department. | |

# Article I

## Introduction

### 1.1 Establishment of Plan

The Riverbend Water Resources District hereby adopts the TML MultiState Intergovernmental Employee Benefits Pool Health Reimbursement Arrangement (HRA) Plan (the "Plan") effective May 1, 2016 (the "Effective Date") as established by the TML MultiState Intergovernmental Employee Benefits Pool for adoption by Member political subdivisions of the Risk and Non-Risk members of the Pool. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is intended to permit an Eligible Employee to obtain reimbursement of Eligible Medical Care Expenses on a nontaxable basis from the HRA Account.

### 1.2 Legal Status

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating employees' gross incomes under Code § 105(b).

# Article II

## Definitions

### 2.1 Definitions

**"Administrator"** means TML MultiState Intergovernmental Employee Benefits Pool.

**"Adopting Employer"** means a political subdivision thereof that adopts this Plan by completing and executing an Adoption Agreement.

**"Adoption Agreement"** means the separate agreement, or portions thereof, completed and executed by an Adopting Employer setting forth the Adopting Employer's selection of options under the plan.

**"Benefits"** means the reimbursement benefits for Medical Care Expenses described under Article VI.

**"Claims Administrator"** means the entity designated by and under contract with the Plan Administrator to perform certain administrative functions with respect to the Plan, including, but not limited to, claims administration and recordkeeping. If no such entity is designated by the Plan Administrator, the Plan Administrator shall serve as the Claims Administrator.

**"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**"Code"** means the Internal Revenue Code of 1986, as amended.

**"Compensation"** means the wages or salary paid to an Employee by the Employer.

**"Covered Individual"** means a Participant, Spouse or Dependent.

**"Dependent"** means any individual who is enrolled on the Health Benefits Plan and is also a tax dependent of the Participant as defined in Code § 152, with the following exception: any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents.

Notwithstanding the foregoing, the HRA Account will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

**"Effective Date"** of this Plan has the meaning described in Section 1.1.

**"Eligible Employee"** means an Employee who works for the Employer on a regular basis in the usual course of the Employer's business. To be considered an Eligible Employee, the person must work at least twenty (20) hours per week, and must receive all benefits of an Employee, including but not limited to vacation, sick leave and pension. An Eligible Employee who is on paid or unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) will be considered an active Eligible Employee for the purposes of this Plan. An elected official while holding office is considered an Eligible Employee for purposes of this Plan.

**"Employer"** means TML MultiState Intergovernmental Employee Benefits Pool or any related Member Employer that adopts this Plan with administrative approval of TML MultiState Intergovernmental Employee Benefits Pool.

**"Employment Commencement Date"** means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

**"Employer Contribution"** means a non-elective contribution in an amount not less than $25.00 per employee per month made by the Adopting Employer on behalf of each Participant in the Plan. The Employer contribution is an amount that has not been actually or constructively received by the Participant, and it is made available to the Participant exclusively for reimbursement under the Plan.

**"Enrollment Form"** means any form that may be provided by the Administrator for the purpose of allowing an eligible Employee to participate in this Plan.

**"FMLA"** means the Family and Medical Leave Act of 1993, as amended.

**"Health FSA"** means a Health Flexible Spending Arrangement as defined in Prop. Treas. Reg. § 1.125-2, Q/A-7(a).

**"Health Benefits Plan"** means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group or partially self-funded health plan(s).

**"Health Care Expense"** shall not include any expense not described as an eligible HRA expense in IRS Revenue Ruling 2002-41 and IRS Notice 2002-45. If Health Care Expense is defined to include health insurance premiums and the adopting Employer sponsors a cafeteria plan, Health Care Expense shall not include premiums that may be paid on a pre-tax basis in accordance with the terms of such cafeteria plan, which may include premiums for major medical coverage provided by the Employer and premiums for coverage under an insurance contract, health maintenance organization agreement, or other benefit agreement providing coverage issued on a non-group, individual basis.

**"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**"HRA"** means a Health Reimbursement Arrangement as defined in IRS Notice 2002-45.

**"HRA Account"** means the HRA Account described in Section 6.4.

**"HSA"** means a Health Savings Account held in conjunction with a High Deductible Health Plan as described in 26 U.S.C §223.

**"Medical Care Expenses"** has the meaning defined in Section 6.2.

**"Open Enrollment Period"** with respect to a Plan Year means a period of time at some point preceding the Plan Year, or such other period as may be prescribed by the Administrator.

**"Participant"** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

**"Period of Coverage"** means the plan year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the plan year following the date participation commences; and (b) for Employees who terminate participation, it shall mean the portion of the plan year prior to the date participation terminates, as described in Section 3.2. A different Period of Coverage (e.g., monthly) may be established by the Administrator and communicated to Participants.

**"Plan"** means the TML MultiState Intergovernmental Employee Benefits Pool HRA Plan as set forth herein and as amended from time-to-time.

**"Plan Year"** means the twelve (12) month period beginning and ending as indicated in the Adoption Agreement. The initial Plan Year may be a "short" Plan Year beginning and ending as indicated in the Adoption Agreement.

**"Protected Health Information"** shall have the meaning described in 45 C.F.R. § 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

**"QMCSO"** means a qualified medical child support order, as defined in ERISA § 609(a).

**"Spouse"** means an individual who is enrolled on the Health Benefits Plan and is also legally married to a Participant under the laws of any state, who is the opposite gender from the Participant.

**"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

# Article III

## Eligibility and Participation

### 3.1 Enrollment Requirements

The names, social security numbers, genders, and birth dates of all persons in a family enrolling in the Plan will be provided to the Administrator on an enrollment form or a change form signed and dated by the Participant and Employer and received by the Administrator.

**a. Employees**

To receive coverage, TML MultiState IEBP must receive enrollment information within thirty-one (31) days of the commencement of employment with the Employer regardless if the employer has a waiting period, or within thirty-one (31) days of the date the Employer first offers coverage. Upon timely enrollment, an Eligible Employee's coverage will begin the later of:

1. the date the Eligible Employee became an Active Employee of the Employer working at least twenty (20) hours per week; or
2. the date the Eligible Employee completes any waiting period established by the Employer.

Eligible Employees must enroll within the initial enrollment period, a qualifying event or wait until the next Open Enrollment period.

**b. Dependents**

To cover Dependents under the Health Reimbursement Arrangement, at the time of initial enrollment or during an Open Enrollment period, a Participant must furnish to the Administrator, in writing, the names of his or her Dependents eligible to receive benefits under the HRA Plan. Coverage for Dependents enrolled at the time of initial enrollment will be effective on the same date that the Participant's coverage is effective. Coverage for Dependents enrolled during an open enrollment period will be effective on the first day of the Plan Year following the open enrollment period.

During the Plan Year, certain qualifying events will permit a Participant to add a Dependent(s) other than during an Open Enrollment period. The Participant must add a Dependent(s) within thirty-one (31) days of the qualifying event and must submit documentation of the qualifying event to the Administrator, when requested or wait until the next Open Enrollment period. Coverage for Dependents enrolled within thirty-one (31) days of a qualifying event will be effective the first day of the month following the Administrator's receipt of an approved enrollment form and any required documentation. Except, in the case of a newborn child, the Participant has sixty (60) days from the child's date of birth to add the child, and, when enrolled within sixty (60) days, coverage for the newborn child will be effective on the child's date of birth.

Qualifying events are:

1. marriage;
2. within sixty (60) days of the birth, adoption or placement for adoption of a child;
3. qualifying for or losing eligibility under Medicaid or SCHIP;
4. loss of coverage due to termination of a Spouse's employment;

5. loss of coverage due to change from full-time to part-time of the Spouse's employment;
6. loss of coverage due to an unpaid leave of absence from the Spouse's employment;
7. a significant increase (i.e., an increase of at least 10%) in the cost of health coverage under the Spouses Employer-sponsored health plan; and
8. any other qualifying described by federal regulation.

**c. Mentally or Physically Handicapped Children**

If a child of a covered individual attains the age of twenty-six (26) (at which time coverage would normally terminate) but the child is mentally or physically incapable of supporting themselves and primarily dependent upon you for support, coverage may be continued. You must submit satisfactory proof of the child's incapacity to the Group Benefits Administrator within thirty-one (31) days of the date the child attains the age of twenty-six (26). Coverage may continue for such child as long as the incapacity continues, subject to payment of the required contribution and all other terms of the Plan.

The Group Benefits Administrator may require satisfactory proof of the continued incapacity documented as a disability by the Social Security Administration (SSA). The Group Benefits Administrator may have a physician examine the child or may request proof to confirm the incapacity, but not more often than once a year. If you fail to submit proof when reasonably required or refuse to allow the Group Benefits Administrator to have the child examined, then coverage for the child will terminate.

**d. Active Duty Reservists**

If covered by the Plan as an employee at the time of call to active duty, participants who are active duty reservists or guard members and their covered Dependents can maintain eligibility on the HRA Plan for up to twenty-four (24) months. The date on which the Participant's absence begins is the qualifying event for Continuation of Coverage (COBRA) to be offered to the reservist or guard member. If a fire fighter or police officer employed by a Texas municipality is called to active duty for any period, the employing municipality must continue to maintain any health, dental or life coverage received through the date the fire fighter or police officer was called to active military duty until the municipality receives written instructions from the fire fighter or police officer to change or discontinue the coverage. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, TML MultiState Intergovernmental Employee Benefits Pool will follow the time guidelines for COBRA under 42 U.S.C.A. 300bb-1 *et seq*. To qualify for this coverage, the Participant must give written notice to the Employer within 60 days of the qualifying event. The Employer must notify TML MultiState Intergovernmental Employee Benefits Pool that a Participant has been called to active duty and submit a copy of the Employer's Active Reservist Policy.

Under 38 USCA § 4316. an employee who is called for military leave may have rights to COBRA Continuation of Coverage for up to twenty-four (24) months and a right to reemployment once he/she is discharged from active military service.

If the Participant will be on active duty for thirty (31) days or less, the Employer will keep the Participant on the Plan with no change in coverage. If the Participant will be on active duty for more than thirty (31) days, the Employer will notify TML MultiState Intergovernmental Employee Benefits Pool of the qualifying event and submit a copy of the employee's written order for call to duty.

If TML MultiState Intergovernmental Employee Benefits Pool administers COBRA Continuation of Coverage, Employer must notify TML MultiState Intergovernmental Employee Benefits Pool by sending a Qualifying Event Notice and mark the qualifying event "Called to Active Duty" and attach a copy of the employee's written order for the call to duty. If the Employer administers its own COBRA Continuation of Coverage, the Employer must notify TML MultiState Intergovernmental Employee Benefits Pool of the termination if call to active duty is more than thirty-one (31) days. The Employer is responsible for all required notices.

Section 143.072, Texas Local Government Code may require an employer to "continue to maintain" coverage on a police officer or fire fighter while he/she is on military leave if the employer has adopted civil service requirements and the leave has been approved by the Fire Fighters' and Police Officers' Civil Service Commission. This section only applies if the employer meets the requirements of Chapter 143 of that Code, including having a population of 10,000 or more and voted to adopt the applicable provisions of the law.

For the Participant to return to the HRA Plan and continue his or her benefits with no waiting period, the Participant must return to work within the time periods required by state and federal law for such return.

The additional 2% contribution for Continuation of Coverage is not charged for (1) a Participant called to active duty or (2) a surviving spouse or dependent who continues coverage pursuant to Chapter 615, Texas Government Code.

## 3.2 Termination Date of Coverage

Information concerning rights to COBRA Continuation of Coverage is in the section of this Plan on COBRA Continuation of Coverage.

**a. Participant Coverage**

Coverage will terminate on the earliest of:

1. the date the Plan terminates coverage with the Employer;
2. the date the Employer is no longer participating under the Plan; or
3. upon Employee termination, the terminated Employee has continued access to the HRA as specified in c. below, and in compliance with regulatory guidelines.

**b. Dependent Coverage**

Coverage will terminate on the earliest of:

1. the end of the month the covered individual's employment terminates, if contributions are paid, or the date the covered individual ceases to be an active Employee;
2. the end of the month in which a Dependent no longer meets the definition of Dependent under the Plan;
3. the date the Plan terminates coverage with the Employer;
4. the date the Dependent becomes enrolled in Medicaid;
5. the end of the month in which a Dependent child attains age twenty-six (26);
6. the date the Employer is no longer participating under the Plan; or
7. the end of the month the Participant voluntarily drops Dependent coverage.

Coverage for a Dependent cannot extend beyond the date coverage for the active Employee ends, unless required by Section 615.071 of Chapter 615 of the Government Code for survivors of certain employees described in Section 615.003 of the Chapter who are killed in the line of duty. Section 615.075(c) requires that the survivor must give the Employer notice of election to purchase coverage within one hundred eighty (180) days of the decedent's death.

**c. Termination of Coverage**

Coverage may terminate as follows:

1. The end of the month in which the Covered Individual voluntarily drops coverage.
2. If an Employee terms with the Employer the HRA funds may be accessed as a COBRA benefit. To access the HRA funds under the COBRA benefit, the COBRA participant will have to make an HRA deposit monthly per the HRA funding requirements that the Employer has implemented. If the Employer charges a 2% administrative fee on the COBRA services the COBRA participant will have to pay the HRA monthly deposit requirement plus 2%. At this time the HRA COBRA benefit can be accessed without accessing COBRA on the Medical Plan.
3. Upon expiration any COBRA benefit coverage, any remaining HRA funds held for that Participant revert to the Employer.
4. If the Employee elects to draw pension benefits through the retirement plan of the Employer, following a rollover of HRA funds to a Retiree Reimbursement Arrangement (RRA) if such an RRA program has been established by the Employer.

5. If the Employer terminates with the Pool, the HRA funds will be submitted to the Employer and the Employer will need to find a new HRA administrator and an administrator that will administer the HRA COBRA benefit.
6. If the Employer stays with the Pool, but terminates providing the HRA plan, the HRA excess monies would go back to the Employer following the termination of that benefit.
7. The HRA can never have cash value to the Employee. It can never be cashed out.
8. Access to the HRA money as a COBRA benefit will operate under the COBRA rules. If you have any questions, please call TML MultiState IEBP customer care at 800-348-7879.

**d. Coordination with Cafeteria Plan**

To the extent the Adopting Employer also sponsors a medical reimbursement program as part of its cafeteria plan within the meaning of Section 125 of the Code, a Participant participates in the medical reimbursement program, and the Participant or a Covered Individual covered through such a Participant incurs an eligible Health Care Expense that is also eligible for reimbursement under the medical reimbursement program, which program pays first is described in the Adoption Agreement.

# Article IV

## Method and Timing of Enrollment

### 4.1 Enrollment When First Eligible

An Employee who first becomes eligible to participate in this Plan will commence participation on the first day of the month after the eligibility requirements have been satisfied, provided that an Enrollment Form, if such is necessary, is submitted to the Administrator before the first day of the month in which participation will commence. Once enrolled, the Eligible Employee's participation will continue from month-to-month and year-to-year until the Eligible Employee's participation ceases pursuant to Article III. The Enrollment Form shall identify the Spouse and Dependents whose medical expenses may be submitted to the HRA. The Participant must promptly notify the Administrator if this information changes.

# Article V

## Benefits Offered and Method of Funding

### 5.1 Benefits Offered

When an Eligible Employee becomes a Participant in accordance with Articles III and IV, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Eligible Medical Care Expenses, as described in Article VI. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

### 5.2 Employer and Participant Contributions

a. *Employer Contributions.* The Employer funds the full amount of the HRA Accounts in an amount established by the Employer. Nothing in this plan shall be interpreted to restrict the Employer from changing prospective contributions on a month-to-month basis.

b. *Participant Contributions.* There are no Participant contributions for Benefits under the Plan.

c. *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, Employer contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or Employer contributions be treated as Employer contributions to the Plan.

c. *Nondiscrimination.* Reimbursements to highly compensated Individuals may be limited or treated as taxable compensation to comply with Code § 105(h), as may be determined by the Administrator in its sole discretion.

### 6.4 Establishment of Account

The Administrator will establish and maintain an HRA Account. The HRA Account so established will reimburse eligible medical expenses per Section 213.

a. *Crediting of Accounts.* A Participant's HRA Account will be credited at the beginning of each month with an amount equal to the applicable maximum dollar limit for the Period of Coverage divided by the number of months in that Period of Coverage (e.g., divided by twelve (12) in a twelve (12) month Plan Year), increased by any carryover of unused HRA Account balance from a prior Period(s) of Coverage.

b. *Debiting of Accounts.* A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

c. *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

### 6.5 Carryover of Accounts

If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to the next HRA Plan Year to reimburse the Participant for eligible Medical Care Expenses incurred during a subsequent Period of Coverage.

### 6.6 Reimbursement Procedure

a. *Timing.* In cases where a debit card tied to the HRA Account is not used, within thirty (30) days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied (see Section 8.1 regarding procedures for claim denials and appeals procedures). This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant forty-five (45) days in which to complete an incomplete reimbursement claim.

b. *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe, by no later than the last day of the third (3rd) month following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

- the person or persons on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Medical Care Expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA Account coverage, if any, for such Medical Care Expenses has been exhausted.

The application shall be accompanied by bills, invoices or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Administrator may request.

c. *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article VIII.

d. *Claim filing Deadline.* A claim for reimbursement of expenses under the HRA must be submitted to the Administrator within three hundred sixty (360) days of the incurred date within the HRA plan year.

## 6.7 COBRA Continuation of Coverage

### a. Introduction

The right to COBRA Continuation of Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation of Coverage can become available to you and other members of your family when your group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan booklet or contact TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

### b. What is COBRA Continuation of Coverage?

COBRA Continuation of Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA Continuation of Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation of Coverage may be required to pay for coverage depending on the policy of your Employer.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you're the spouse of the employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B and/or Part C); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of any of the following qualifying events:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (Part A, Part B and/or Part C);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

Any decision of whether an Employee was terminated because of gross misconduct will be made by the Employer. The Employer may not change its decision on whether or not a termination was for gross misconduct later than the forty-fifth (45th) day after the date employment terminated or the date a COBRA Continuation of Coverage election notice was mailed to the employee, whichever is earlier. Any determination of gross misconduct shall be based on events that occurred prior to the termination of employment.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage for any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Please note that COBRA Continuation of Coverage does not include any life benefits. If you had voluntary life coverage, you may convert it to an individual policy within thirty-one (31) days of your qualifying event. Contact your Employer's human resources office for more information and conversion forms.

c. **When is COBRA Continuation of Coverage Available?**

The Plan will offer COBRA Continuation of Coverage to qualified beneficiaries only after IEBP has been notified that a qualifying event has occurred. The Employer must notify IEBP of the following qualifying events:

1. The end of employment or reduction of hours of employment;
2. Death of the employee;
3. Commencement of a proceeding in bankruptcy with respect to the employer; or
4. The employee's becoming entitled to Medicare benefits (under Part A. Part B and/or Part C).

d. **Participant Must Give Notice of Some Qualifying Events**

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify IEBP within sixty (60) days after the qualifying event occurs. You must provide notice to: TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

e. **How is COBRA Continuation of Coverage Provided?**

Once IEBP receives notice that a qualifying event has occurred, COBRA Continuation of Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Continuation of Coverage. Covered employees may elect COBRA Continuation of Coverage on behalf of their spouses, and parents may elect COBRA Continuation of Coverage on behalf of their children.

COBRA Continuation of Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (Part A, Part B and/or Part C), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA Continuation of Coverage lasts for up to a total of thirty-six (36) months. When the qualifying event is the end of the employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA Continuation of Coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA Continuation of Coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA Continuation of Coverage generally lasts for only up to a total of eighteen (18) months. There are three (3) ways in which this eighteen (18) month period of COBRA Continuation of Coverage can be extended.

f. **Active Duty Reservists extension of COBRA Continuation of Coverage**

If covered by the Plan as an employee at the time of call to active duty, active duty reservists or guard members and their covered dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which the person's absence begins is the qualifying event for COBRA Continuation of Coverage (COC) to be offered to the reservist or guard member.

If a fire fighter or police officer is called to active duty for any period, the Employer must continue to maintain any health, dental, or life coverage received on the date the fire fighter or police officer was called to active military duty until the Employer receives written instructions from the fire fighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COBRA Continuation of Coverage purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, TML MultiState IEBP will follow the time guidelines of COBRA Continuation of Coverage under 42 U.S.C.A.300bb-1 *et seq*. To qualify for this coverage, the employee must give written notice to the Employer within sixty (60) days of the qualifying event. The Employer member must notify TML MultiState IEBP that an employee has been called to active duty and submit a copy of the Employer member's active reservist policy to TML MultiState IEBP.

g. **Disability extension of COBRA Continuation of Coverage**
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify IEBP within sixty (60) days of that determination, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA Continuation of Coverage for a total maximum of twenty-nine (29) months. The disability must start at some time before the sixtieth ($60^{th}$) day of COBRA Continuation of Coverage and must last at least until the end of the eighteen (18) or twenty-four (24) month period of COBRA Continuation of Coverage. You may contact TML MultiState IEBP about a disability determination at 1820 Rutherford Lane, Suite #300, Austin, Texas 78754 or by telephone (800) 282-5385.

h. **Second Qualifying Event extension of COBRA Continuation of Coverage**
If your family experiences another qualifying event while receiving eighteen (18) or twenty-four (24) months of COBRA Continuation of Coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA Continuation of Coverage, for a maximum of thirty-six (36) months, if IEBP is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA Continuation of Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B and/or Part C) gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is available only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

i. **Are there other coverage options besides COBRA Continuation of Coverage?**
Yes. Instead of enrolling in COBRA Continuation of Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation of Coverage. You can learn more about many of these options at www.healthcare.gov.

### 6.8 Coordination of Benefits: Health FSA to Reimburse First

Benefits under this Plan are intended to reimburse Participants solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's Medical Care Expenses are covered by both this Plan and by a Health FSA, then this Plan is not available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the Health FSA Account have been exhausted. If the Participant's Medical Care Expenses are covered by both this Plan and by a Health Savings Account, then this Plan is not available for reimbursement (except for preventive care) of such Medical Care Expenses until the deductible on the accompanying High Deductible Health Plan has been met.

# Article VII

## HIPAA Privacy and Security

### 7.1 Permitted Disclosure of Enrollment/Non-enrollment Information

The Plan may disclose to the Employer information on whether an individual is participating in the Plan.

### 7.2 Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending or terminating the Plan. "Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

# Article VIII

## Appeals Procedure

**8.1 Procedure If Benefits Are Denied Under This Plan**

If a claim for reimbursement under this Plan is wholly or partially denied, appeals shall be reviewed in accordance with the appeal provision in the Benefit Plan. Appeals must be made in writing and submitted within one hundred eighty (180) days of the denial of benefits.

**8.2 Submission & Consideration of Comments**

Authorized representatives will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the adverse benefit determinations will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

# Article IX

## Recordkeeping and Administration

**9.1 Administrator**

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

**9.2 Powers of the Administrator**

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters there under, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

a. To construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

b. To prescribe procedures to be followed and the forms to be used by Eligible Employees and Participants to enroll in and submit claims pursuant to this Plan;

c. To prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;

d. To request and receive from all Eligible Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

e. To furnish each Eligible Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

f To receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time-to-time to be necessary and proper;

g. To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

h. To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

i. To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

j. To maintain the books of accounts, records and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

**9.3 Reliance on Participant, Tables, etc.**

The Administrator may rely upon the information submitted by an Eligible Employee or Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by an Eligible Employee or Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys or other experts employed or engaged by the Administrator.

**9.4 Provision for Third-Party Plan Service Providers**

The Administrator may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

**9.5 Fiduciary Liability**

To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

**9.6 Health Benefits Plan Contracts**

The Employer shall have the right (a) to enter into a contract with one or more vendors for the purposes of providing any Benefits under the Plan; and (b) to replace any of such vendors or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such contract.

**9.7 Inability to Locate Payee**

If the Employer is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

**9.8 Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an individual, or the allocations made to the account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will, in its judgment, accord to such Participant or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

# Article X

## General Provisions

**10.1 Expenses**

All reasonable eligible expenses incurred in administering the Plan are currently paid by the Employer.

**10.2 No Contract of Employment**

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Eligible Employee and the Employer to the effect that such Eligible Employee will be employed for any specific period of time. All Eligible Employees are considered to be employed at the will of the Employer.

**10.3 Amendment and Termination**

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Administrator may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Administrator's Board of Trustees or by any person or persons authorized by the Board of Trustees to take such action, and any such amendment or termination will automatically apply to the Member Employers that are participating in this Plan.

**10.4 Governing Law**

This Plan shall be construed, administered and enforced according to the laws of the State of Texas to the extent not superseded by the Code or any other federal law.

**10.5 Code Compliance**

It is intended that this Plan meet all applicable requirements of the Code, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

**10.6 No Guarantee of Tax Consequences**

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

**10.7 Indemnification of Employer**

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes or other taxes from such payments or reimbursements.

**10.8 Non-Assignability of Rights**

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

**10.9 Headings**

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

**10.10 Plan Provisions Controlling**

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

**10.11 Severability**

Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder of the Plan shall be given effect to the maximum extent possible.

**10.12 Compensation and Expenses**

The Claim Administrator shall be entitled to reasonable fees for its services hereunder, which shall be described in an administrative services agreement incurred by the Claims Administrator in connection with the Plan.

**10.13 Family and Medical Leave Act of 1993 ("FMLA")**

Notwithstanding any provision of this Plan to the contrary, this Plan shall be cooperated and maintained in a manner consistent with FMLA, to the extent the Adopting Employer is subject to such law.

**IN WITNESS WHEREOF**, and as conclusive evidence of the adoption of the foregoing instrument comprising the TML MultiState Intergovernmental Employee Benefits Pool HRA Plan, Employer has caused this Plan to be executed in its name and on its behalf, on this 13th day of April, 2016.

**Riverbend Water Resources District**

**By:** _____

# Health Reimbursement Service Agreement for Plan Supervisor

This SERVICE AGREEMENT between the Riverbend Water Resources District, (Plan Sponsor) and TML MultiState Intergovernmental Employee Benefits Pool, (Plan Supervisor) will be effective on May 1, 2016.

**W I T N E S S E T H:**

## Section I

## The Plan

**1.1** The Riverbend Water Resources District, (Plan Sponsor) has adopted an Health Reimbursement Arrangement (HRA) under Internal Revenue Service Notice 2002-45. This Plan is offered to all eligible employees who are qualified by employment status.

**1.2** The Plan Participants are the employees enrolled in the Plan.

**1.3** All contributions to the Plan shall be deposited in the name of the Plan with a Bank designated by the Plan Supervisor subject to approval of the Plan Sponsor if requested by the Plan Sponsor.

**1.4** The Plan Sponsor agrees that an HRA is a health plan under Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan Sponsor agrees that it is the Plan Sponsor's, and not the Plan Supervisor's, responsibility to ensure that its HRA plan, if any, is compliant with all relevant sections of HIPAA Title II or any other law.

## Section II

## The Plan Supervisor

**2.1** The Plan Supervisor shall provide consulting services, and shall assist the Plan Sponsor in the administration of the Flexible Benefits Plan.

**2.2** The Plan Supervisor shall have the full responsibility for maintaining accounts for each eligible person electing to participate in the Plan. The Plan Supervisor shall arrange for eligible claims payments from funds deposited by the Plan Sponsor as directed by their participating employees. The claims payments shall be made by the Plan Supervisor by issuing a check or draft to the participant upon the Plan Bank Account, if such account is provided for this purpose, in an amount equal to the qualified charges from the submitted claim. The claims submitted by the Plan Participants shall be paid within ten days of receipt by the Plan Supervisor. Paper claim submissions on behalf of the Participant must equal or exceed $25.00 per submission, except in the final month of the Plan Year. ***Specifications for the HRA plan are stated in the attached HRA Information sheet.***

**2.3** To the extent that information is available to the Plan Supervisor, the Plan Supervisor shall assist the Plan Sponsor in the preparation of any report, tax return or similar papers required by state or the Federal Government pertaining to the operation or management of the HRA; however, the ultimate responsibility for filing any governmental document shall be with the Plan Sponsor.

**2.4** The Plan Supervisor shall render periodic reports to each participant, which shall include the following:

a. Receipts of the Plan Contributions;

b. Disbursement of Plan Contributions through claims payments; and

c. Statements of (a) and (b) above shall automatically be provided each Participant following the submission and payment of a qualified claim.

**2.5** The Plan Supervisor, shall prepare a Plan Document for the HRA sponsored by the Plan Sponsor. The Plan Sponsor shall assume the responsibility of obtaining legal review of the Plan Document.

**2.6** Unless otherwise provided, the Plan Supervisor is authorized to do all the things necessary or convenient to carry out the terms and purposes of the Plan.

# Section III

## Procedure for Making and Payment of Claims for Benefits from the Fund

**3.1** Any covered person may make application for benefits from the Plan as provided by the Plan upon the form or forms provided by the Plan Supervisor. The applicant shall fully and truthfully complete such application for benefits and the applicant shall supply all such pertinent information including copies of paid receipts, as may be required under the Internal Revenue Code and specified by the Plan Supervisor.

**3.2** The Plan Supervisor shall accept copies of any application for benefits made in the appropriate manner, shall duly investigate and verify the statements made on the application and determine benefit eligibility. If the facts as stated in such application entitle the covered person to receive payment of benefits from the Plan, the Plan Supervisor shall forthwith arrange for the proper payment.

**3.3** Claim filings shall be mailed/faxed to the person or department designated by the Plan Supervisor. If appropriate, claims could be submitted through the debit card transaction. Claims checks are processed each week. Only paper claims that equal or exceed twenty-five dollars ($25.00) or more shall be filed with the Plan Supervisor unless said claim is being submitted during the last Plan Month of the Plan Year. During the last month, eligible claims of any amount shall be processed by the Plan Supervisor.

**3.4** All Plan benefits processed by the Plan Supervisor shall be mailed to the qualified Plan Participant within ten (10) days of approval.

If the Plan Supervisor finds that the Plan Participant is not entitled to a claim payment under the Plan, the claim application shall be denied, all or in part, and returned to the Plan Participant with the Plan Supervisor's reason for denial. The Plan Participant may appeal a denial by the Plan Supervisor to the Plan Sponsor. The Plan Sponsor's determination is final and conclusive upon the covered person.

**3.5** The Plan Supervisor shall not be liable for any failure or refusal to pay or honor any application for benefits made pursuant to this Agreement; and the Plan Supervisor must be indemnified by the Plan Sponsor for any liability related to its duties herein, and shall be reimbursed by the Plan Sponsor for any expense, loss, damage, or legal fees incurred by the Plan Supervisor in defending any claims or demands made against the Plan Sponsor, the Plan Supervisor or the Plan. This paragraph will not apply for any loss due to the gross negligence or willful misconduct of the Plan Supervisor.

# Section IV

## Costs of Administrator

**4.1** The Plan Supervisor shall be entitled to a fee or fees for its service to the Plan and, under this Agreement, the fee shall be paid in the form of an advance start-up costs, a pass through of printing or printing preparation costs and monthly service fee.

| Item | Cost | Payable |
|---|---|---|
| Setup Fee | **$50.00**/Group | One time(1) |
| Monthly Service Fee(2) | $3.70/Participant Debit \| $5.00/Participant Paper | Monthly |
| Special Reports(3) | As agreed upon | 30 days following receipt of report |

(1) One time set up fee for each group that enrolls in the HRA Plan.

(2) Monthly Service Fee includes:
- a) processing contribution;
- b) processing claims (review and verification);
- c) paying claims (direct mail to employee);
- d) paying dependent premium (if applicable);
- e) employee fund balance statement with each reimbursement; and statement of fund balances and projected year-end balance at close of Plan Year fourth quarter.

(3) Normal Reports to the Plan Sponsor, at no additional cost are:
- a) initial enrollment verification;
- b) quarterly fund balance; and
- c) projected year-end fund balance at the close of the Plan Year fourth quarter.

# Section V

## The Plan Sponsor

**5.1** As of the effective date of this Agreement, the Plan Sponsor shall provide the Plan Supervisor with a complete list of all employees who are eligible for benefits under the Plan. The Plan Sponsor shall arrange for enrollment meetings and, with the Plan Supervisor's assistance, complete Plan enrollment.

**5.2** The Plan Sponsor shall remit contributions to the Plan Supervisor on a monthly (or pay period) basis.

**5.3** The Plan Sponsor shall forward the appropriate service fees to the Plan Supervisor on the first (1st) of each calendar month or in conjunction with the monthly plan fund collections.

**5.4** The Plan Sponsor shall assist in the enrollment of eligible employees in the Plan, notify the Plan Supervisor of any change of eligibility, cooperate with the Plan Supervisor with regard to proper claim settlement, transmit to the Plan Supervisor proper claim settlement and transmit to the Plan Supervisor all inquiries pertaining to the Plan.

**5.5** The Plan Sponsor shall be responsible for filing any documents required by the Internal Revenue Service.

# Section VI

## Termination of the Agreement

**6.1** This Agreement may be terminated by the Plan Sponsor or the Plan Supervisor by written notice of intention to terminate given to the other party, to be effective as of an annual plan anniversary date. Said written notice shall be given not less than thirty (30) days prior to such termination. The thirtieth (30th) day shall coincide with the last day of a calendar month. The Plan Supervisor may also terminate this agreement following the termination of any medical, dental, or vision coverage provided by the Plan Supervisor to the Plan Sponsor, to be effective upon ten (10) days written notice sent to the Plan Sponsor, effective on the date specified in the notice. All obligations of the Plan Supervisor related to the relevant rights of the covered Participant to payments of benefits from the Plan will be terminated and extinguished on the effective date of termination given in the notice whether or not the claim for such benefits arose prior to or following the termination of this Agreement. Absent a written notice of termination this agreement will annually renew on the effective date set forth at inception. In no case shall termination by the Plan Supervisor relieve the Plan Sponsor of its obligation to maintain the Plan.

# Section VII

## Qualifications

**7.1** To qualify the Plan Sponsor must have on file a current Interlocal Agreement with the TML MultiState Intergovernmental Employee Benefits Pool. The Plan Sponsor must have ten (10) percent of the eligible employees participate in the Plan. Should these qualifications not be met, or maintained, the Plan Supervisor may terminate this agreement pursuant to Section VI.

# Section VIII

## Miscellaneous Provisions

**8.1** In the event of resignation or inability to serve as the Plan Supervisor, the Plan Sponsor may appoint a successor.

**8.2** If during the operation of the Plan, the United States Government, the government of any state or any instrumentality or either shall assess any tax against the Plan and the Plan Supervisor is required to pay such tax, the Plan Supervisor shall report the payment to the Plan Sponsor who will reimburse the Plan Supervisor for such tax or assessment.

**8.3** The Plan Supervisor shall incur no liability to the Plan Sponsor or to an employee or dependent of the Plan Sponsor for any act or failure to act not directly connected with processing and payment of claims as provided in this Agreement, except where the liability is proximately caused solely by the gross negligence or willful misconduct of the Plan Supervisor. To the extent allowed by law, the Plan Sponsor shall hold the Plan Supervisor harmless from and indemnify it against any and all liability, claims, damages (including punitive or consequential damages), costs, expenses, or fees (legal or otherwise) incurred or paid in connection therewith which might be asserted by the Plan, the Plan Sponsor's employees or other persons for which the Plan Supervisor would not be liable to the Plan Sponsor as set forth above.

**8.4** Where the context of the Agreement requires, the singular shall include the plural and the masculine gender shall include the feminine.

**8.5** This Agreement may be amended by the Plan Sponsor and the Plan Supervisor at any time by mutual written consent of said parties.

**8.6** The Plan Sponsor hereby is designated the agent for service of legal process on behalf of the Plan, in its principal office.

**8.7** Funding for the HRA/RRA will be distributed (mark one):

- [x] Monthly
- [ ] Annually

If Employer funds Annually, any Employees hired mid-plan year will be funded as follows (mark one):

- [ ] The full Annual funded amount at date of hire
- [x] A pro-rated amount (mark one):
  - [x] Annual rate divisible by twelve (12) months (not to exceed 102% of active rate) $_____
  - [ ] Only the Administrative fee of $3.70
  - [ ] Other $_____

If Employer funds Annually and TML MultiState IEBP administers Continuation of Coverage (COC), terminated employees will be billed one of the following for monthly fee (mark one):

- [ ] Annual rate divisible by twelve (12) months (not to exceed 102% of active rate) $_____
- [ ] Only the Administrative fee of $3.70
- [ ] Other (not to exceed 102% of active rate) $_____

IN WITNESS THEREOF, the Plan Sponsor and the Plan Supervisor have executed this Agreement this 13th day of April, 2016.

**Riverbend Water Resources District**

By Elizabeth Fario Hale

Name Elizabeth Fario Hale

Title Executive Director/CEO

Address 3930 Galleria Oaks

Texarkana, TX

**TML MultiState Intergovernmental Employee Benefits Pool**

By _____

Name Susan L. Smith

Title Executive Director

The HRA Plan Year is Jan 1 to Dec 31.

# Retirement Reimbursement Arrangement Addendum

The Riverbend Water Resources District has authorized continued participation by retirees (as defined by the Employer's retirement plan) in the foregoing Health Reimbursement Arrangement (HRA) by means of a Retirement Reimbursement Arrangement (RRA). All funds in the HRA at the time of the retirement shall be transferred into the RRA. The operation of the RRA will continue on the same terms and conditions as the HRA with the following employer decisions regarding the Retiree Reimbursement account:

1. Responsibility of the $3.70 Retiree Reimbursement administration fee
   - [x] Retiree is responsible for the administration fee of $3.70.
   - [ ] Employer will be responsible for the administration fee.

2. Employer Retiree Reimbursement contribution
   - [x] Employer will not make contribution to the RRA.

3. Employer will make monthly contribution to the RRA in the amount of $_____. Monthly contributions to the RRA shall be made in an amount authorized, paid and deposited by Employer.

In the case of the death, divorce, or other qualifying event (as defined by federal law) of the retiree, any surviving, previously RRA enrolled dependents of the retiree may elect any legally required continuation of coverage (COC) of the remaining benefits from the RRA, reduced by the monthly fee described above. In no case shall the liability of the Employer for the combined RRA/COC benefits of the qualified beneficiaries exceed the balance of the RRA at the time of the retiree's death.

**ADOPTED:**

**Riverbend Water Resources District**

By _____
(Signature)

Name Elizabeth Fazio Hale

Title Executive Director / CEO

Address 3930 Galleria Oaks
Texarkana, TX 75503

Date April 13, 2016