Riverbend
Water Resources District

RIVERBEND RESOLUTION NO. 20200422-03

AUTHORIZING THE EXECUTIVE DIRECTOR/CEO TO EXECUTE AN INTERLOCAL AGREEMENT WITH TML HEALTH BENEFITS POOL TO PROVIDE EMPLOYEE HEALTH AND LIFE INSURANCE BENEFITS

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; and

WHEREAS, Riverbend Water Resources District currently has an interlocal agreement with TML Health Benefits Pool for a health benefits plan including health insurance, life insurance, health reimbursement accounts and retirement reimbursement accounts for district employees; and

WHEREAS, Riverbend Water Resources District has a continued need for health and life insurance benefits to support the operation and management of its wet utilities and TML Health Benefits Pool is fully qualified to provide and perform these needed services; and

NOW, THEREFORE, BE IT RESOLVED that the Executive Director/CEO shall be and is hereby authorized to execute an interlocal agreement(s) with TML Health Benefits Pool to continue to provide health and life insurance benefit services for Riverbend Water Resources District.

PASSED and APPROVED this 22nd day of April 2020

Sonja Hubbard, President

ATTEST:

Marshall Wood, Secretary

Attached: TML Health Benefits Pool Agreement

TML Health Benefits Pool

Health Reimbursement Arrangement

Riverbend Water Resources District

Service Agreement for Plan Supervisor

This SERVICE AGREEMENT between the Riverbend Water Resources District, (Plan Sponsor) and TML MultiState Intergovernmental Employee Benefits Pool doing business as TML Health Benefits Pool (TML Health), (Plan Supervisor) will be effective on 5/1/20.

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 a Health Reimbursement Arrangement (HRA) under the Internal Revenue Service Code (the "Code"). 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 HRA 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.

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. The Plan Document is attached hereto as Attachment 1 and fully incorporated by reference.

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 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 in accordance with the Schedule of Fees attached hereto as Attachment 2, and fully incorporated by reference. The fees 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.

4.2 Spenddown period administration shall be available from the Plan Supervisor for a period of up to twelve (12) months following cessation of contributions to the Plan by the Plan Sponsor provided the Plan Sponsor continues to pay the Monthly Service Fee stated above.

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 (1^{st}) 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. The Additional Contract Documents referenced in Section 8.8 may be amended by Notice of Renewal for each renewal Plan Year or by Notice of Mid-Year Plan Amendments. In the event any such Additional Contract Document is amended, said amended document will be attached to this Agreement and incorporated by reference to said document. 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 Health 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):

☐ Monthly

☒ Annually

8.8 Additional Contract Documents

The following attachments are additional contract documents:

1. Attachment 1 – HRA Plan Document
2. Attachment 2 – Schedule of Fees
3. Attachment 3 – Retirement Reimbursement Arrangement Addendum
4. Attachment 4 – Not Applicable
5. Attachment 5 – Not Applicable
6. Attachment 6 – HRA Forms
7. *[Add Attachment Documents for Optional Services Selected]*

IN WITNESS THEREOF, the Plan Sponsor and the Plan Supervisor have executed this Agreement this day of _____, 20___.

The HRA Plan Year is 5/1/2020 to 9/30/2020.

TML Health	Riverbend Water Resources District
Jennifer Hoff	
Print name	Print Name
Signature	Signature
Executive Director	
Title	Title
Date	Date

APPROVED AS TO FORM:

_____

Leah Simon, General Counsel

Attachment 1
HRA Plan Document

Article I - Introduction

1.1 Establishment of Plan

The undersigned Riverbend Water Resources District hereby adopts the TML MultiState Intergovernmental Employee Benefits Pool doing business as TML Health Benefits Pool (TML Health) Health Reimbursement Arrangement (HRA) Plan (the "Plan") effective 5/1/20 (the "Effective Date") as established by the TML Health 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 the Code and implementing rules and regulations, 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 the Code.

Article II - Definitions

2.1 Definitions

"Administrator" means TML Health.

"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 Coverage" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, coverage which is a continuation of Plan coverage when it would otherwise end because of a life event called a "qualifying event".

"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 Employer's Health Benefits Plan and is also a qualifying child or qualifying relative under the Code.

"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 at lease twenty (20) hours per week. An elected official while holding office is considered an Eligible Employee for purposes of this Plan.

"Employer" means TML Health or any related Member Employer that adopts this Plan with administrative approval of TML Health.

"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.

"Flexible Spending Arrangement" means an arrangement that allows employees to be reimbursed for medical expenses and are usually funded through voluntary salary reduction agreements with your employer but the employer may also contribute. Benefits include: contributions made by your employer can be excluded from your gross income; no employment or federal income taxes are deducted from the contributions; reimbursements may be taxed free if you pay qualified medical expenses; and you can use an FSA to pay qualified medical expenses even if you haven't yet placed the funds in the account.

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

"Health FSA" means a Health Flexible Spending Arrangement that is an employer-established benefit plan that allows an enrolled employee to be reimbursed for medical expenses.

"Health FSA – grace period" means that coverage during a grace period by a general purpose health FSA that is allowed if the balance in the health FSA at the end of its prior year plan is zero.

"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 Expenses" or "Medical Expenses" are the costs an employee paid for diagnosis, cure, mitigation, treatment, or prevention of disease, and for the purpose of affecting any part or function of the body, including the costs of equipment, supplies, and diagnostic devices needed for these purposes. Expenses may also include the premiums an employee paid for the plan that covers the expenses of medical care, and the amounts paid for transportation to get medical care. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, which affects group health plan coverage by: providing individuals special enrollment rights in group health coverage when specific events occur; prohibiting discrimination in group health plan eligibility, benefits, and premiums based on specific health factors; and prohibiting preexisting condition exclusions in plan years.

"HRA" means a Health Reimbursement Arrangement that is an employer-funded plan that reimburses employees for medical expenses, up to a maximum dollar amount for a coverage period, that aren't included in the employee's income.

"HRA Account" means a tax-exempt custodial account solely funded by employer contributions from which the enrolled employee may withdraw funds to pay for certain medical expenses.

"HSA" means a Health Savings Account that is a tax-exempt custodial account the Administrator establishes to pay or reimburse certain medical expenses an enrolled employee incurs.

"Limited-purpose Health FSA or HRA" means the types of arrangements that can pay or reimburse the items allowed under other health coverage if you have other insurance that provide benefits for the following items: liabilities incurred under workers' compensation laws, tort liabilities, or liabilities related to ownership or use of property; a specific disease or illness; or a fixed amount per day (or other period) of hospitalization. Also allowed under coverage (whether provided through insurance or otherwise) for the following items: accidents; disability; dental care; vision care; or long-term care. These arrangements can also pay or reimburse preventative care expenses because they can be paid without having to satisfy the deductible.

"Medical Care Expenses" or "Health Care Expenses" are the costs an employee paid for diagnosis, cure, mitigation, treatment, or prevention of disease, and for the purpose of affecting any part or function of the body, including the costs of equipment, supplies, and diagnostic devices needed for these purposes. Expenses may also include the premiums an employee paid for the plan that covers the expenses of medical care, and the amounts paid for transportation to get medical care. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation..

"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.

"Other Health Coverage" with respect to a "Limited-purpose" health FSA or HRA means other insurance that provide benefits for the following items: liabilities incurred under workers' compensation laws, tort liabilities, or liabilities related to ownership or use of property; a specific disease or illness; or a fixed amount per day (or other period) of hospitalization. Also allowed under coverage (whether provided through insurance or otherwise) for the following items: accidents; disability; dental care; vision care; or long-term care.

"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 Health 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.

"Post-deductible health FSA or HRA" means arrangements that do not pay or reimburse any medical expenses incurred before the minimum annual deductible amount is met. The deductible for these arrangements doesn't have to be the same as the deductible for the HDHP, but benefits may not be provided before the minimum annual deductible amount is met.

"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).

"Retirement HRA" means an arrangement that pays or reimburses only those medical expenses incurred after retirement. After retirement you are no longer eligible to make contributions to an HSA.

"Spenddown Period" means the period of time (1) following termination of employment and before election of and payment for COBRA coverage during which the Participant may continue to access the HRA benefits for expenses incurred during the HRA benefit period and/or during the Spenddown Period; (2) following the death of the Participant and before election of and payment for COBRA coverage during which the Spouse or Dependent may continue to access the HRA benefits for expenses incurred during the HRA benefit period and/or during the Spenddown Period; or (3) following termination of the HRA plan by the Employer during which the Participant may continue to access the HRA benefits for expenses incurred during the HRA benefit period and/or during the spend down period.

"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.

"Suspended HRA" means the election to suspend the HRA before the beginning of an HRA coverage period. The HRA doesn't pay or reimburse, at any time, the medical expenses incurred during the suspension period except preventive care and items listed under "other health coverage". When suspension period ends, you are no longer eligible to make contributions to an HSA.

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

"You" means a Participant.

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 must 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. Appropriate documentation may be required.

a. Participants

Participants will receive coverage when TML Health Benefits Pool receives complete 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, following a qualifying event or wait until the next Open Enrollment period.

b. Dependents

Dependents will be covered under the Health Reimbursement Arrangement at the time of initial enrollment or during an Open Enrollment period when, a Participant furnishes 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 first enroll the Dependent in the Employer's Health Benefits Plan. 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. losing eligibility under Medicaid or SCHIP;
4. loss of coverage due to termination of a Spouse's or Dependent's employment;
5. loss of coverage due to change from full-time to part-time of the Spouse's or Dependent's employment;
6. loss of coverage due to an unpaid leave of absence from the Spouse's or Dependent's employment;
7. a significant increase (i.e., an increase of at least 10%) in the cost of health coverage under the Spouse's or Dependent's Employer-sponsored health plan; and
8. any other qualifying change in status event described by federal regulation.

c. Mentally or Physically Disabled Children

1. 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 disabled and for whom the Participant may claim a personal exemption tax deduction, coverage may be continued. You must submit satisfactory proof of the child's disability 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 disability continues, subject to payment of the required contribution and all other terms of the Plan.
2. The Group Benefits Administrator may require satisfactory proof of the continued 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 disability, 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

1. 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.
2. In administering this coverage, TML Health 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 Health Benefits Pool that a Participant has been called to active duty and submit a copy of the Employer's Active Reservist Policy.
3. 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.
4. 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 Health Benefits Pool of the qualifying event and submit a copy of the employee's written order for call to duty.
5. If TML Health Benefits Pool administers COBRA Continuation of Coverage, Employer must notify TML Health 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 Health 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.
6. Texas law 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.

   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.
7. 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 Continuation of Coverage is in the section of this Plan on 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 Participant voluntarily drops coverage.
2. If the Employee terms with the Employer, the Participant is allowed a Spenddown Period of N/A days.
3. 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. If elected, the COBRA benefit coverage period shall commence immediately following the final day of the Spenddown Period.
4. Upon expiration of the Spenddown Period or if elected, the COBRA benefit coverage, any remaining HRA funds held for that Participant revert to the Employer.

5. 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.
6. 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.
7. If the Employer stays with the Pool, but terminates providing the HRA plan, the HRA excess monies would go back to the Employer after a Spenddown Period of N/A days following the termination of that benefit.
8. The HRA can never have cash value to the Employee. It can never be cashed out.
9. Access to the HRA money as a COBRA benefit will operate under the COBRA rules. If you have any questions, please call TML Health Benefits Pool 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.

3.3 Limitations and Exceptions

a. If you (and your spouse, if you have family coverage) have HDHP coverage, you generally can't have other health coverage. However, you can still be an eligible individual even if your spouse has non-HDHP coverage provided you aren't covered by that plan.

b. An employee covered by an HDHP and a health FSA or an HRA that pays or reimburses qualified medical expenses generally can't make contributions to an HSA.

c. If the employee at any time becomes covered under a Qualified High Deductible Health Plan ("HDHP"), as prescribed by Section 223 of the Internal Revenue Code) with an accompanying health savings account ("HSA") then the carryover HRA balance will automatically convert from a general purpose HRA to a limited purpose or post-deductible HRA for any amounts incurred when the HDHP is in effect. This means that expenses for non-preventive medical costs will not be paid until the deductible for the HDHP has been met, and then only to the extent that those costs exceed the deductible.

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.* Participant contributions for Benefits under the Plan are prohibited.

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.

5.3 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Covered Individual, and no Covered Individual or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

Article VI - Health Reimbursement Benefits

6.1 Benefits

The Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's HRA Account, as set forth and adjusted under Section 6.4.

6.2 Eligible Medical Care Expenses

Under the HRA Account, a Participant may receive reimbursement for Eligible Medical Care Expenses incurred during an HRA Period of Coverage.

a. *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for or pays for the medical care. Medical Care Expenses incurred before a Covered Individual first becomes covered by the Plan are not eligible.

b. *Medical Care Expenses Generally.* "Medical Care Expenses" means expenses incurred by a Participant or by his or her Spouse or Dependents for medical care, as defined in Code § 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs). Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents shall be charged against the Participant's HRA Account. Reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

c. *Cannot Be Reimbursed or Reimbursable From Another Source.* Medical Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Benefits Plan, other health coverage or any other accident or health plan (but see Section 6.8 if the other health plan is a Health FSA Account). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Benefits Plan imposes copayment or deductible limitations), the HRA Account can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VI.

d. The Plan does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are payable under any worker's compensation law or other employer, union or association.

e. The Plan does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are received by the Participant under any health and accident insurance policy or program, whether or not premiums are paid by the Adopting Employer or by the Participant, the Participant's Spouse or the Participant's Dependent Child.

6.3 Maximum Benefits

a. *Maximum Benefits.* The maximum dollar amount that may be credited to an HRA Account for an Employee who participates for an entire twelve (12) month Period of Coverage shall be determined by the Employer. Unused amounts may be carried over to the next Period of Coverage, as provided in Section 6.5.

b. *Changes.* For subsequent plan years, the maximum dollar limit may be changed by the Employer and shall be communicated to Employees through the Enrollment Form, the Schedule of Medical Expense Benefits or Plan document.

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 in accordance with the Code.

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 Medical Care Expenses incurred during a subsequent Period of Coverage.

6.6 Reimbursement Procedure

a. Timing. In cases where a Participant pays for a medical expenses by means other than a debit card tied to the HRA Account, the Participant must submit a reimbursement claim to the Administrator. Within thirty (30) days of a reimbursement claim from a Participant; 1) the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Administrator approves the claim); or 2) 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

COBRA Continuation of Coverage can become available to the Participant and other members of the Participant's family when the Participant's group health coverage would otherwise end. For more information about the Participant's rights and obligations under the Plan and under federal law, the Participant should review the Plan booklet or contact TML Health Benefits Pool, 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." The Participant, the Participant's spouse and the Participant's 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 the Participant's Employer.

If the Participant was an employee, the Participant will become a qualified beneficiary if the Participant loses coverage under the Plan because of either one of the following qualifying events:

1. The Participant's hours of employment are reduced; or
2. The Participant's employment ends for any reason other than your gross misconduct.

The spouse of the Participant, becomes a qualified beneficiary if the Participant's spouse loses coverage under the Plan because of any of the following qualifying events:

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

The Participant's dependent children will become qualified beneficiaries if the Participant's dependent children 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 (45^{th}) 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 the Participant's 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 the Participant had voluntary life coverage, the Participant may convert it to an individual policy within thirty-one (31) days of the Participant's qualifying event. Contact the Participant's 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 TML Health Benefits Pool has been notified that a qualifying event has occurred. The Employer must notify TML Health Benefits Pool 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), the Participant must notify TML Health Benefits Pool within sixty (60) days after the qualifying event occurs. The Participant must provide notice to: TML Health Benefits Pool, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

e. How is COBRA Continuation of Coverage Provided?
Once TML Health Benefits Pool 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. Participants 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 Participant, the Participant's becoming entitled to Medicare benefits (Part A, Part B and/or Part C), divorce or legal separation of the Participant from his or her Spouse or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation of Coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the Participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA Continuation of Coverage for qualified beneficiaries other than the Participant lasts until 36 months after the date of Medicare entitlement. For example, if a Participant becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA Continuation of Coverage for the Participant's Spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Participant's hours of employment, COBRA Continuation of Coverage generally lasts for only up to a total of 18 months. There are three (3) ways in which this 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 Participant 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 Participant'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 Health Benefits Pool 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 Participant must give written notice to the Employer within sixty (60) days of the qualifying event. The Employer member must notify TML Health Benefits Pool that an employee has been called to active duty and submit a copy of the Employer member's active reservist policy to TML Health Benefits Pool.

g. Disability extension of COBRA Continuation of Coverage
If the Participant or anyone in the Participant's family covered under the Plan is determined by Social Security to be disabled and the Participant notifies TML Health Benefits Pool within sixty (60) days of that determination, the Participant and the Participant's entire family may be entitled to receive up to an additional 11 months of COBRA Continuation of Coverage for a total maximum of 29 months. The disability must start at some time before the 60th 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. The Participant may contact TML Health Benefits Pool about a disability determination at 1821 Rutherford Lane, Suite #300, Austin, Texas 78754 or by telephone at (800) 282-5385.

h. Second Qualifying Event extension of COBRA Continuation of Coverage
If the Participant's 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 the Participant's family can get up to eighteen (18) additional months of COBRA Continuation of Coverage, for a maximum of thirty-six (36) months, if TML Health Benefits Pool 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 Participant or former Participant 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 the Participant and the Participant's 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.

The Participant can learn more about many of these options at http://www.healthcare.gov.

j. Adding Dependents

If the Participant is a COBRA Continuation of Coverage participant, the Participant has the same rights to add dependents to the Participant's COBRA Continuation of Coverage as an active employee Participant. For example, the Participant may add dependents to the Participant's COBRA Continuation of Coverage within thirty-one (31) days of marriage or sixty (60) days of the birth, adoption or placement for adoption of a child. Also, the Participant may add dependents to the Participant's COBRA Continuation of Coverage during the Employer's Open Enrollment. However, these dependents who were not covered under the Plan before the Participant's qualifying event occurred are not qualified beneficiaries and do not have individual COBRA Continuation of Coverage rights, except for children added within sixty (60) days of birth, adoption or placement for adoption. Children added to your COBRA Continuation of Coverage within sixty (60) days of birth, adoption or placement for adoption are qualified beneficiaries and have their own COBRA Continuation of Coverage rights.

k. If the Participant has Questions

Questions concerning the Participant's COBRA Continuation of Coverage rights should be addressed to the contact or contacts identified below. State and local government employees seeking more information about their rights under COBRA Continuation of Coverage, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, can contact the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services at:

- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html; or
- https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html#COBRA

l. Keep the Plan Informed of Address Changes

In order to protect the Participant's and the Participant's family's rights, the Participant should keep TML Health Benefits Pool informed of any changes in addresses of family members. The Participant should also keep a copy, for the Participant's records, of any notices the Participant sends to the Participant's Employer and TML Health Benefits Pool.

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 Qualified 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 twelve (12) months 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 Health HRA Plan, Employer has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 20____.

Riverbend Water Resources District

By: _____

Attachment 2
Schedule of HRA Plan Administration Services Fees

1. Employer: Riverbend Water Resources District

2. Effective Date: 5/1/20

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.

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

☒ A pro-rated amount (mark one):

- ☒ Annual rate divisible by twelve (12) months (not to exceed 102% of active rate) $ 500.00
- ☐ Only the administrative fee of $_____
- ☐ Other $_____

If Employer funds annually and TML Health 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) $ 500.00

☐ Only the administrative fee of $_____

☐ Other (not to exceed 102% of active rate) $_____

Attachment 3
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
   - ☒ Retiree is responsible for the administration fee of $3.70.
   - ☐ Employer will be responsible for the administration fee.

2. Employer Retiree Reimbursement contribution
   - ☒ 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 _____

Title _____

Address _____

Attachment 6
HRA Forms

HRA Employee Enrollment Agreement Form

TML Health Benefits Pool

Employer Name	Employer Group #

Social Security #	Last Name	First Name	MI	Date of Birth

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced Date Employed _____

Employee and Dependent Alternate Mailing Address

Employee Mailing Address _____ Street _____ City _____ State _____ Zip Code

☐ **Check here if new**

_____ Preferred Contact Phone # _____ E-mail

Dependent Alternate Address _____ Street _____ City _____ State _____ Zip Code

Dependent/Spouse Coverage Information

Spouse Name (First, M.I.)	Date of Birth	Dependent Name (First, M.I.)	Date of Birth	Dependent Name (First, M.I.)	Date of Birth
Dependent Name (First, M.I.)	Date of Birth	Dependent Name (First, M.I.)	Date of Birth	Dependent Name (First, M.I.)	Date of Birth

	Annually	**Monthly**
Employer Contribution for Health Reimbursement Arrangement	$	$

Employee Declination/Waiver of Participation

The benefits of the plan have been thoroughly explained to me and I **decline** to participate.

_____ Employee Signature _____ Date

Employee Acceptance

I certify the above information to be correct and true to the best of my knowledge and that any child(ren) listed are dependents under Section 152 of the Internal Revenue Code.

_____ Employee Signature _____ Date

Employer Accepted

_____ By

_____ Date

Please return this form to your employer.

HRA Employee
Request for Change Form

TML Health Benefits Pool

Employer Name	Employer Group #

Social Security #	Last Name	First Name	MI	Change Effective Date

Please Mark Change Desired

☐ Address Change ☐ Name Change _____ *(former name)*

☐ Retired Date of Retirement _____ Medicare Eligible ☐ Yes ☐ No If Yes, Medicare (HIC or MBI) # _____

Medicare Effective Date _____

Employee and Dependent Alternate Mailing Address

Employee Mailing Address

_____ Street _____ City _____ State _____ Zip Code

_____ Preferred Contact Phone # _____ E-mail

Dependent Alternate Address

_____ Street _____ City _____ State _____ Zip Code

Dependent/Spouse Coverage Information

- Only the dependents listed below will have the coverage selected.
- The term dependent will not include any person who is eligible for coverage as an employee. Children may be covered under only one Employ

Spouse Name (First, M.I.)	Date of Birth	Dependent Name (First, M.I.)	Date of Birth	Dependent Name (First, M.I.)	Date of Birth
Dependent Name (First, M.I.)	**Date of Birth**	**Dependent Name (First, M.I.)**	**Date of Birth**	**Dependent Name (First, M.I.)**	**Date of Birth**

	Annually	**Monthly**
Employer Contribution for Health Reimbursement Arrangement	$ _____	$ _____

Employee Acceptance	**Employer Accepted**	**Reason for Add or Change**
Employee Signature _____	By _____	**Notes**
Date _____	Date _____	

Please return this form to your employer.

Direct Deposit
Authorization Agreement

As a service of TML Health, we are offering you the opportunity to have the following claim payments deposited via electronic *'direct deposit'* into your bank account:

- **Flexible Spending Arrangement (Section 125)**
- **Health Reimbursement Arrangement (HRA)**

When you agree to allow an automatic funds transfer *(direct deposit)* into your bank account, the permission to do so will remain in effect until you notify TML Health that you are removing that permission.

If you are interested in taking advantage of this opportunity, please complete and return this form with a voided check and mail to:

TML Health
Accounting
P. O. Box 140526
Austin, TX 78714-0526

If you have any questions regarding this form, please contact Kathie Miller at (800) 348-7879.

Please Print

As a duly authorized signatory of the account number listed below I, the undersigned, authorize TML Health to initiate credit entries through Chase Bank – Austin or other transaction facilitating entities to my account, as indicated below and located at the contracted depository named below.

Bank Name: _____

Type of Account: ☐ Checking ☐ Savings

Attach a voided check for the account or provide the following:

ABA (Bank) Routing Number: _____
(9 characters, normally located on bottom of check next to Account Number)

Account Number: _____

This authority is to remain in full force and effect until TML Health has received written notification from an authorized signatory of the account in such a time and in such a manner as to afford the TML Health reasonable opportunity to act upon said notification.

_____ _____
Employee Name Employee Social Security #

_____ _____
Employer Name Employer Group Number

_____ _____
Signature Date

_____
Preferred Contact Phone #