HEALTH REIMBURSEMENT ARRANGEMENT

PLAN DOCUMENT

City of Colorado Springs

Established January 1, 2011
Restated January 1, 2014
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HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

The City of Colorado Springs hereby adopts this Health Reimbursement Arrangement (the “Plan”) for the purpose of allowing certain former employees to obtain reimbursement of eligible medical expenses incurred by such former employees and their family members. The City of Colorado Springs intends the Plan to qualify as a “health reimbursement arrangement” as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended, and the Plan will be interpreted at all times in a manner consistent with such intent.

ARTICLE I
ADOPTION AGREEMENT

1.1 Name of Plan:
City of Colorado Springs Health Reimbursement Plan

1.2 Plan Sponsor:
City of Colorado Springs
Contact Name: Human Resources Director
Address: 30 South Nevada Avenue, Suite 702
          Colorado Springs, CO 80901
Telephone Number: 719-385-5904
Tax Identification Number: 84-6000573

1.3 Plan Administrator:
Human Resources Director
City of Colorado Springs
30 South Nevada Avenue, Suite 702
P.O. Box 1575, Mail Code 720
Colorado Springs, CO 80901-1575
719-385-5125

1.4 Effective Date:
January 1, 2014

1.5 Eligible Retiree:
Sworn retiree who is Medicare eligible and enrolled in Medicare Part A and Part B, who is eligible for a City medical subsidy, and was enrolled in the City’s medical plan or in the Waiver Program immediately prior to electing a plan through Extend Health.
1.6 **Benefit Credit:**

i. The following monthly amount will be credited on behalf of Participants who are Eligible Retirees:

   a. Partial Paid Subsidy – shall receive $91.40 per month

   b. Fully Paid Subsidy – shall receive an amount equivalent to the cost per month of the medical and prescription drug plan in which they have enrolled through Extend Health, in addition, eligible to receive the cost per month of the Medicare Part B premium.

ii. The following amount will be credited on behalf of Participants who are Eligible Spouse or Surviving Spouse:

   a. (Specify formula): Spouse or Surviving Spouse of Fully Paid retiree will receive monies equivalent to the cost of the medical and prescription drug plan in which they have enrolled through Extend Health, in addition, eligible to receive the cost of the Medicare Part B premium.

   b. Surviving Spouse of Partial Paid retiree will be eligible to receive the same partial subsidy amount of $91.40 per month.

1.7 **Account:**

One HRA Account will be established per Participant.

1.8 **Timing of Credit:**

Benefit Credit specified in Section 1.6 will be credited to HRA Accounts on the first day of each calendar month.

1.9 **Carryover of Accounts:**

Credits remaining in an HRA Account (after the expiration of the claims run-out period) at the end of a Plan Year shall be carried over to the following Plan Year to reimburse Participants for Health Care Expenses incurred during subsequent Plan Years.

1.10 **Death:**

Surviving Spouse of retiree will continue to receive the credit until his/her death.

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**ARTICLE II**

**DEFINITION OF TERMS**

2.1 **Definitions:**

Whenever used in this Plan, the following terms shall have the meanings set forth below.
i. “HRA Account” means the hypothetical account established for a Participant to hold his or her Benefit Credits.

ii. “Benefit Credit” means the amount credited to a Participant’s HRA Account for the provision of benefits under the Plan.

iii. “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.


v. “City” means the City of Colorado Springs


vii. “Health Care Expense” means an expense incurred by a Participant or by a Participant’s Spouse for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations, including premiums for health care insurance coverage and premiums for long-term care insurance coverage. Health Care Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant or the Participant’s Spouse. Health Care Expenses are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses.

viii. “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

ix. “Participant” a person who participates in this Plan as specified under Section 3.1

x. “Plan” means this plan, The City of Colorado Springs Health Reimbursement Plan named in Section 1.1 and set forth herein, as may be amended from time to time.

xi. “Plan Year” means, with respect to the initial Plan Year, the period from the Effective Date through the next following December 31. Thereafter, “Plan Year” means the twelve (12)-month period commencing on each January 1.

xii. “PHI” means protected health information as described in 45 C.F.R. § 164.103, and generally includes individually identifiable health information held by or on behalf of the Plan.

xiii. “Spouse” means the husband or wife of an Eligible Retiree from the City.

ARTICLE III
PARTICIPATION

3.1 Agreement to Participation:
An Eligible Retiree and Eligible Retiree’s Spouse who:
   i. become eligible for coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare);
   ii. obtained an individual health insurance policy facilitated through Extend Health, Inc. or any affiliate or, if elected by the Plan Sponsor
   iii. completed any enrollment form (which may be electronic) or any enrollment procedures

3.2 Cessation of Participation:
An Eligible Retiree shall cease to be a Participant on the earliest of the following to apply to the Eligible Retiree, and an Eligible Retiree’s Spouse shall cease to be a Participant on the earliest of the following to apply to the Spouse:
   i. Death
   ii. As to the Spouse, termination of the marriage
   iii. With respect to an Eligible Dependent, the date he or she ceases to be eligible for coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare):
   iv. Termination of this Plan with respect to an Eligible Dependent Spouse, the date he or she divorces the Eligible Retiree;
   v. with respect to an Eligible Retiree, the date he or she is rehired as an active benefit eligible employee of the City;
   vi. the effective date of any Plan amendment that renders him or her ineligible to participate;
   vii. the effective date of request for opt-out by the Eligible Retiree or Eligible Dependent Spouse; or
   viii. the termination of the Plan.

Reimbursement from the Participant’s HRA Account after termination of participation shall be governed by Section 5.2.
ARTICLE IV
FUNDING

4.1 Funding:
   i. In no event may any benefits under the Plan be funded with Participant contributions.
   ii. The HRA Account balance does not accrue interest at any time.

ARTICLE V
BENEFITS

5.1 Provision of Benefits:
The Plan will reimburse Participants for Health Care Expenses, up to the balance in the Participant’s HRA Account. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses incurred after he or she becomes a Participant in the Plan and before his or her participation has ceased. In no event shall any benefits under this Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Health Care Expenses.

5.2 Amount of Reimbursement:
At all times during the Plan Year, a Participant shall be entitled to benefits under this Plan for payment of Health Care Expenses in an amount that does not exceed the balance of his or her HRA Account. Each reimbursement hereunder shall be a charge to such HRA Account available to pay Health Care Expenses under the Plan.

5.3 Expense Reimbursement Procedure:
Reimbursement for Health Care Expenses shall be made in accordance with this Section 5.2.

   i. Timing: Reimbursement shall only be permitted by written application to the Third Party Administrator for eligible Health Care Expense incurred during Participation. The Participant may submit claims for reimbursement for Health Care Expenses incurred prior to his or her loss of eligibility, provided the Participant files such claims within one hundred eighty (180) days of such loss of eligibility.

   ii. Claims Substantiation: The Plan Administrator shall require the Participant to furnish a bill, receipt, cancelled check, or other written evidence or certification of payment or of obligation to pay Health Care Expenses. The Plan Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior
to reimbursement. Unless otherwise permitted by the Third Party Administrator, each request for reimbursement shall include the following information:

c. The amount of the Health Care Expense for which reimbursement is requested;

d. The date the Health Care Expense was incurred;

e. A brief description and the purpose of the Health Care Expense;

f. The name of the person for whom the Health Care Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant;

g. The name of the person, organization or other provider to whom the Health Care Expense was or is to be paid;

h. A statement that the Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Health Care Expense under Code Section 213; AND

i. A written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Expenses eligible for coverage under any medical, HMO, prescription, dental, or vision care plans in which the Participant is enrolled must be submitted first to all appropriate claims administrators for such plans before submitting the expenses to the Provider for reimbursement under the Plan. A Participant who is entitled to payment or reimbursement under a health care reimbursement account in a cafeteria plan under Code Section 125 must receive his or her maximum annual reimbursement under the health care reimbursement account in the cafeteria plan before he or she is entitled to any reimbursement under this Plan.

iii. **Decision by Plan Administrator.** The Third Party Administrator shall review such claim and respond within thirty (30) days after receiving the claim. If the Third Party Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Provider will notify the claimant within the initial
thirty (30)-day period that the Provider needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Provider. The claimant will have no less than forty-five (45) days from the date he or she receives the notice to provide the requested information. The Provider shall provide to every claimant who is denied a claim for benefits (in whole or in part) written or electronic notice setting forth in a manner calculated to be understood by the claimant:

a. The specific reason or reasons for the denial;

b. Specific reference to pertinent plan provisions on which denial is based;

c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

d. A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and

e. A description of the Plan's appeal procedures.

iv. **Rights to Appeal:** Claims that are partially or wholly denied may be appealed to the Plan Administrator as provided in Section 6.4.

5.4 **Carryover of Accounts:**
To the extent a Participant has a balance in his or her HRA Account at the end of a Plan Year, the balance shall be carried over to following Plan Years to the extent elected by the Plan Sponsor in Section 1.9.

5.5 **Death:**
In the event the Plan Sponsor elects a combined account structure in Section 1.7, and the Eligible Retiree dies without a spouse who is a Participant, his or her HRA Account shall be forfeited; provided, however, that his or her estate or representatives may submit claims for Health Care Expenses incurred by the Eligible Retiree prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death.
5.6 ERISA Legal Provisions:

i. The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

ii. To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.

ARTICLE VI
ADMINISTRATION

6.1 Plan Administrator:
The Plan Administrator is responsible for the performance of all reporting and disclosure obligations required to be performed by the plan administrator under the Code. The Plan Administrator shall be the designated agent for service of legal process with respect to the Plan.

6.2 Duties of the Plan Administrator:
The Plan Administrator shall have the sole discretion and authority to control and manage the operation and administration of the Plan.

i. The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, supply omissions, and determine the benefits payable under this Plan. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

ii. The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:
a. To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;
b. To prepare and distribute information explaining the Plan to Participants;
c. To receive from Participants such information as shall be necessary for the proper administration of the Plan;
d. To keep records of elections, claims, and disbursements for claims under the Plan, and any other information as appropriate;
e. To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents, including a Third Party Administrator as he/she deems advisable;
f. To accept, modify or reject Participant elections under the Plan;
g. To promulgate election forms and claims forms to be used by Participants, which may be electronic in nature;
h. To correct errors and make equitable adjustments for mistakes made in the administration of the Plan, specifically, and without limitation, to recover erroneous overpayments made by the Plan to a Participant or Dependent, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant or Dependent.

6.3 Allocation and Delegation of Duties:
The Plan Administrator shall not be liable for any acts or omissions of such employee, officer, member or to any others to whom duties have been delegated.

6.4 Claims Procedure:
i. Within one hundred and eighty (180) days of receipt by a claimant of a notice under Section 5.3 denying a claim in whole or in part, the claimant or his or her duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator. In connection with such review, the claimant or his or her duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits, and may submit issues and comments in writing. The
Plan Administrator shall make a decision promptly, but not later than sixty (60) days after the Plan Administrator’s receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:

a. Specific reasons for the decision;

b. Specific references to the pertinent plan provisions on which the decision is based;

c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

d. A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and

ii. The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If claimant challenges the decision of the Plan Administrator within one year after the date of the decision, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue the claim in federal court. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

6.5 Nondiscriminatory Operation:

All rules, decisions, interpretations and designations by the Plan Administrator under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.
ARTICLE VII
HIPAA

7.1 Purpose:
This Article permits the Plan to disclose PHI to the Plan Sponsor to the extent that such PHI is necessary for the Plan Sponsor to carry out its administrative functions related to the Plan. This Article reflects the requirements set forth in 45 C.F.R. § 164.504(f) of HIPAA and the related regulations promulgated by the U.S. Department of Health and Human Services. Any term used in this Article VIII shall have the meaning set forth in HIPAA and guidance issued thereunder.

7.2 HIPAA Privacy Compliance:
   i. **Disclosures to Plan Sponsor**: In accordance with HIPAA, the Plan may disclose summary health information to the Plan Sponsor as requested by the Plan Sponsor to allow it to modify, amend or terminate the Plan, or obtain premium bids from insurers to provide health insurance coverage under the Plan. The Plan may disclose to the Plan Sponsor information on whether an individual is participating or enrolled in the Plan. In addition, the Plan may disclose protected health information to the Plan Sponsor as necessary to allow the Plan Sponsor to perform plan administration functions, as used within the meaning of the HIPAA privacy regulations, including the following functions:
      a. Collection of individual premiums or contributions;
      b. Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions;
      c. Reviewing health plan performance;
      d. Activities relating to obtaining or renewing health insurance or determining premium pricing for such benefits, or placing a contract for reinsurance of risk relating to such claims;
      e. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
      f. Business planning and development of the Plan, such as conducting cost-management and planning-related analyses, including formulary development and...
administration, development or improvement of methods of payment or coverage policies;

g. Business management and general administrative activities of the Plan;

h. Determination of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;

i. Billing, claims management, collection activities, obtaining payment under a stop-loss contract, and related health care data processing;

j. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

k. Utilization review activities;

l. Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

   - Name and address;
   - Date of birth;
   - Social security number;
   - Payment history;
   - Account number;
   - Name and address of the health care provider and/or health plan; and

m. Risk adjusting amounts due to enrollee health status and demographic characteristics.

ii. Access to Medical Information: The following employees or individuals under the control of the Plan Sponsor shall have access to the Plan’s protected health information to be used solely for the purposes described above:

   a. Plan Administrator

   b. Such other classes of individuals identified by the Plan’s Privacy Officer as necessary for the Plan’s administration.

iii. Plan Administrator and Privacy Officer Agreement to Restrictions: The Plan will not disclose protected health information to the Plan Administrator and Privacy Officer until the Plan Sponsor has certified to the Plan that it agrees to:
a. Not use or disclose protected health information other than as permitted or required by law or as specified above;

b. Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan;

c. Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which City becomes aware;

d. Make protected health information accessible to the subject individual in accordance with 45 CFR § 164.524;

e. Allow the subject individuals to amend or correct their protected health information in accordance with 45 CFR § 164.526;

f. Make available the information to provide an accounting of its disclosures of protected health information in accordance with 45 CFR § 164.528;

g. Make its internal practices, books and records available to the Secretary of Health and Human Services for determining compliance;

h. Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses as required by 45 CFR § 164.504(f)(2)(ii)(I);

i. Ensure that any agents, including a subcontractor, of the Plan Sponsor to whom the Plan Sponsor provides protected health information shall also agree to these same restrictions;

j. Restrict access to protected health information to those classes of employees or individuals identified above; and

k. Restrict the use of protected health information by those employees identified above for plan administration functions within the meaning at 45 CFR § 164.504(a).

iv. **Noncompliance Resolution:** If there is noncompliance with the above restrictions by a designated employee or other individual receiving protected health information on behalf of the Plan Sponsor, the employee or other individual shall be subject to
appropriate discipline in accordance with the City’s disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan’s Privacy Official.

7.3 HIPAA Security Compliance:

i. **Plan Administrator Obligations:** The Plan Administrator shall do the following:

   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

   b. Ensure that the adequate separation required by 45 CFR § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

   c. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information;

   d. Report to the Plan any security incident of which it becomes aware;

   e. Make the Plan Sponsor's internal practices, books, and records relating to security of electronic PHI received from the Plan available to the Secretary of Health and Human Services (or any other officer or employee of the U.S. Department of Health and Human Services to whom the authority involved has been delegated) for purposes of determining compliance by the Plan with the HIPAA security standards.

**Exclusions:** The provisions of (a) apply to all disclosures of electronic PHI by the Plan to the Plan Administrator except:

   a. Disclosures of summary health information to the Plan Sponsor as reasonably requested by the Plan Sponsor to allow it to modify, amend or terminate the Plan, or to obtain premium bids from insurers to provide health insurance coverage under the Plan;

   b. Disclosures of information on whether an individual is participating or enrolled in the Plan; and
c. Disclosures of information authorized by an individual in accordance with 45 CFR §164.508.

ARTICLE VIII
GENERAL PROVISIONS

8.1 Amendment and Termination:
Although the City intends to maintain the Plan for an indefinite period, the City reserves the right to amend, modify, or terminate this Plan at any time, including but not limited to the right to modify eligibility for participation, benefits paid by the Plan, and the amount of Benefit Credits to be credited, and the right to reduce or eliminate existing HRA Accounts. Notwithstanding anything to the contrary contained in this Section 9.1 or elsewhere in the Plan, the Plan Administrator shall have the authority to approve all technical, administrative, regulatory and compliance amendments to the Plan, and any other amendments that will not increase the cost of the Plan to the City, as the Plan Administrator shall deem necessary or appropriate.

8.2 City Liability:
Benefits under the Plan are paid by the City out of their general assets. Specifically, and notwithstanding anything herein to the contrary, the City who employs the Participant as of the date of the Participant’s qualifying retirement shall be solely responsible for the payment of benefits to such Participant and his or her family members under this Plan. The City shall have no liability with respect to the payment of any benefits hereunder to any Participant last employed by any other Company prior to eligibility under the Plan or his or her family members.

8.3 QMCSO:
In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA Section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan’s procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA Section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

8.4 Facility of Payment:
If the Plan Administrator deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator
to disburse it, whose receipt shall be complete acquittance therefore. Such payments shall, to the extent thereof, discharge all liability of the Plan Administrator, Plan Sponsor and the City.

8.5 **Lost Distributees:**

Any benefit payable shall be deemed forfeited if, after reasonable efforts, the Plan Administrator is unable to locate the Participant to whom payment is due.

8.6 **Status of Benefits:**

Neither the City nor the Plan Administrator 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 Plan Administrator or City if the Participant has any reason to believe that such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

8.7 **Applicable Law:**

The Plan shall be construed and enforced according to the laws of the state of State of Colorado, to the extent not preempted by any Federal law.

8.8 **Capitalized Terms:**

Capitalized terms shall have the meaning set forth in Article II.

8.9 **Severability:**

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.
ADOPTION

The City of Colorado Springs hereby adopts the provisions of this plan, and its duly authorized officer has executed this plan document and summary plan description effective the first day of January, 2014.

Executed this 3rd day of January, 2014.

Plan Sponsor: City of Colorado Springs

By: ____________________________

Title: Director, Human Resources