

ASEA/AFSCME Local 52
Health Reimbursement Arrangement Plan

Amended and Restated
Effective February 19, 2020

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ARTICLE I

ESTABLISHMENT OF PLAN

1. Establishment of Plan

The Board of Trustees of the ASEA/AFSCME Local 52 Health Benefits Trust (Board of Trustees) established the ASEA/AFSCME Local 52 Health Reimbursement Arrangement Plan (HRA Plan) effective July 1, 2011, and hereby amends and restates the Plan effective February 19, 2020. Capitalized terms in this Plan that are not otherwise defined shall have the same meaning as set forth in Article II.

2. Legal Status

This Health Reimbursement Arrangement Plan (HRA Plan) is intended to qualify as a medical reimbursement plan under IRC Sections 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement (HRA) as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under IRC Section 105(b).

ARTICLE II DEFINITIONS

"Administrator" means the Board of Trustees of the ASEA/AFSCME Local 52 Health Benefits Trust or the contracted third-party administrator who is authorized by the Board of Trustees to perform the day-to-day administrative and business functions of the Trust.

"Anniversary Date" means the first day of any Plan Year.

"Benefits" means the reimbursement benefits for Medical Care Expenses.

"Benefits Booklet" means the current ASEA/AFSCME Local 52 Health Benefits Plan Booklet (which meets the requirements for a summary plan description), incorporated by reference and attached hereto as Appendix A. The Benefits Booklet includes descriptions of all Plans offered through the Trust including the HRA Plan.

"Benefit Plan" means those Qualified Benefits available to a Participant under Health Reimbursement Account Plan offered only in conjunction with a Plan D election under the ASEA/AFSCME Local 52 Health Benefits Plan.

"Board of Trustees" means the Board of Trustees of the ASEA/AFSCME Local 52 Health Benefits Trust.

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

"Collective Bargaining Agreement" means the collective bargaining agreement negotiated between an Employer and a labor organization representing the Employer's Employees' providing for participation in the Trust and governing the Contribution requirements (Employer and Employee) that fund some or all of the Benefits provided by this Plan.

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

"Contributions" means the payment required by the participating Employer pursuant to the terms of a collective bargaining agreement, or special agreement for the purpose of providing employee welfare benefits to the Employees covered by said collective bargaining agreement or special agreement, and their Spouses and Dependents under this Plan; and the self-payment rules adopted by the Trustees.

"Dependent" means the Spouse (including persons legally separated, but not divorced) of the Employee, or a child of the Employee who is—

The Employee's natural child, adopted child or child placed for adoption, legally placed foster child, child for whom the Employee is the legal guardian, who meets one of the foregoing categories, up to the attainment of age 26.

A mentally or handicapped child who reaches age 19 while covered under the Plan may continue coverage beyond their 26th birthday, if the child is:

- Chiefly dependent upon the Employee for support;

- Is living with the Employee or an institution
- Is not capable of self-sustaining employment; and
- Is claimed as a dependent on the Employee's Federal income tax return for the Plan Year.

Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order, as defined by the Public Health Service Act.

"Election Form" means the form provided by the Administrative Agent for the purpose of allowing an eligible Employee or new hire to elect, during an Open Enrollment Period, upon being hired, or as a result of a Change in Status, to participate in this Plan by electing benefits from the options available through the Plan.

"Employee" means—

- an individual the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll and covered by a collective bargaining agreement executed between the Employer and the labor organization representing the Employee, or through a Special Agreement, requiring contribution payments to the Plan,
- an ASEA/AFSCME Local 52 member who is on leave without pay or who is a layoff Employee, or
- an Employee of an Employer participating in the Trust through a Special Participation Agreement.

"Employer" means the State of Alaska or other such Employer who is entitled to participate in the benefit plans provided through this Trust, pursuant to collective bargaining and/or a Special Participation Agreement approved by the Board of Trustees.

"Enrollment Guide" means the ASEA/AFSCME Local 52 Health Benefits Plan Enrollment Guide for the applicable Plan Year.

"Family Information Form" means the form supplied by the Administrative Agent to be completed, signed and returned listing any eligible Dependents and providing proof of dependent status.

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

"Group Health Plan" means the health plan offered under the ASEA/AFSCME Local 52 Health Benefits Plan, Plan D.

"Health FSA" means a health flexible spending arrangement as defined by Prop. Treasury Regulation Section 1.125-2, Q/A-7(a), including the Health Care Reimbursement Account Plan offered through the Trust in conjunction with an election of Group Health Plan, Plan D.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

"HRA Account" means the recordkeeping account maintained by the Plan Administrator for the purpose of keeping track of contributions made on behalf of the Employee and available reimbursement amounts for Medical Care Expenses from the account.

"Health Reimbursement Arrangement Plan" or "HRA Plan" means a health reimbursement arrangement as defined in IRS Notice 2002-45.

"Layoff Employee" means an Employee who—

- (a) has received notification of layoff by the Employer;
- (b) is not currently working for the Employer;
- (c) has a reserved position with the Employer; and
- (d) is subject to recall for a maximum of two years from the date he ceases work for such Employer.

A Layoff Employee is not considered to have separated from service with the Employer unless—

- (a) he/she fails to return to work when recalled from the Employer;
- (b) two years expire from the date he/she ceases work for the Employer due to layoff; or
- (c) he/she formally terminates or resigns.

"Maximum Benefit" means the maximum dollar amount that may be credited to the HRA Account for an Employee who participates for a Period of Coverage.

"Named Fiduciary" means the Board of Trustees of the ASEA/AFSCME Local 52 Health Benefits Trust.

"Open Enrollment" means the period specified by the Plan Administrator for annual election of benefits under the Plans offered through the Trust.

"Participant" means an eligible Employee who becomes a Participant pursuant to Article II and/or eligible Dependents of the Employee. To be eligible for reimbursements under the HRA Plan, the Dependent must qualify as a dependent under Section 152 of the Code.

"Plan" means the ASEA/AFSCME Local 52 Health Benefits HRA Plan.

"Plan Administrator" means the Board of Trustees for the ASEA/AFSCME Local 52 Health Benefits Trust. The contact person is the Third-Party Administrator for the Plan who has the full authority to act on behalf of the Board of Trustees to conduct the day-to-day administration of the Trust and Plans offered through the Trust.

"Plan Year" means the 12-month period from July 1 until the following June 30, provided that a period of fewer than 12 months may be a Plan Year for the final Plan Year, or a transition period to a different Plan Year.

"Special Agreement" means an agreement whereby the Board of Trustees approves participation in the benefit plans offered through the Trust by Employees of an Employer other than an Employer participating pursuant to a Collective Bargaining Agreement.

"Spouse" means an individual who is legally married to an Employee as determined by applicable State law, and who is treated as a Spouse under the Code (may be separated but not divorced).

"Terminated Employee" means an Employee who has separated from employment with the Employer who is not on Layoff status.

"Trust Agreement" means the Trust Agreement for the ASEA/AFSCME Local 52 Health Benefits Trust, as amended from time to time by the Plan Administrator.

"Trust Fund" or "Trust" means the ASEA/AFSCME Local 52 Health Benefits Trust.

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

ARTICLE III ELIGIBILITY AND PARTICIPATION

1. Eligibility to Participate

Benefits are provided under this Plan to permanent and long-term non-permanent Employees (and their Dependents) covered under the General Government bargaining unit, or Employees participating under a Special Agreement, as described below:

- Full-time Employees (scheduled to work 30 or more hours a week on a regular basis);
- Full-time seasonal Employees; or
- Part-time Employees who elect to participate in the Plan (scheduled to work at least 15 but less than 30 hours a week on a regular basis). A part-time Employee must elect coverage within the first 31 consecutive calendar days of employment and complete an Enrollment Form in order to participate in the HRA Plan in conjunction a Group Health Plan election.

Employees must be actively at work and receiving Compensation from the Employer as a result of their performance of their duties, or otherwise eligible to participate under the provisions of the underlying collective bargaining agreement in force for the Plan Year.

Participation pursuant to a Special Agreement may provide for separate eligibility rules, such as hours of employment or probationary status.

Employees must complete, sign and return a Family Information Form and proof of Dependent status before benefits will be paid on eligible Dependents. In order to receive reimbursement from this HRA Plan for Dependents, the Dependent must qualify as a dependent under Section 152 of the Code.

2. Termination of Participation

Participation and/or coverage under the Plan will terminate as follows:

- ***Employees on Leave Without Pay or Layoff:*** Participation and coverage under the Plan terminates on the last day of the month in which the Employee was last in pay status or in which the Employee begins seasonal overtime conversion. If coverage ends while the Employee is on Family Medical Leave Act (FMLA) leave, coverage will be extended to the end of the month in which FMLA leave ends, provided the required premium is paid
- ***Employees Who Terminate Employment:*** Participation and coverage ends on the last day of the month in which the Employee last worked.
- ***Dependent Participation and Coverage:*** Coverage for a Dependent ends on the same day as the Employee's coverage ends, except in the case of:

- Divorce—Coverage terminates for the Spouse on the date the divorce is final.
- Dependent Child Ceases to Meet Eligibility Requirements—Coverage ends on the last day of the month in which the Dependent Child fails to meet any of the eligibility requirements.
- **Employees Moving to a Nonparticipating Unit:** Participation and coverage ends on the last day of the month in which the Employee moves out of the General Government bargaining unit.
- **Employees Moving from Full-Time to Part-Time Status:** Employees who move from full-time to part-time status will cease to be covered as a full-time employee on the last day of the month in which the status change occurred. An Employee may elect to continue coverage as a part-time employee, effective on the first day of the month following the date of the status change, if the Employee makes a part-time plan election within 30 days of the change in status.
- **Failure to Pay the Required Premium:** Participation and coverage terminates at the end of the month for which the last required premium was paid (including COBRA and continuation coverage).

3. **Participation in Group Health Plan, Plan D Mandatory for Participation in HRA Plan**

An active election in Group Health Plan, Plan D is required to participate in this HRA Plan. Group Health Plan, Plan D and this HRA Plan are integrated and participation in the HRA component is automatic upon election of Group Health Plan, Plan D. There is no independent right to participate in this HRA Plan without active election of Group Health Plan, Plan D.

4. **No Funding from Salary Reduction**

The HRA Plan is funded exclusively with Employer contributions. No salary reduction amounts contributed by the Employee to the major medical cafeteria plan component of Plan D are used to fund the HRA Account.

5. **Election to Participate**

- During Open Enrollment.** During each Open Enrollment Period with respect to a Plan Year, the Administrative Agent shall provide an Election form to each Employee who is eligible to participate in this Plan (by mail or electronically). The Election Form shall enable the Employee to elect this Plan only if the Employee elects Group Health Plan, Plan D under the ASEA/AFSCME Local 52 Health Benefits Plan for the next Plan Year. The election rules and deadlines for the Group Health Plan will govern the election in this HRA Plan.
- New Employees.** An Employee will be covered on the 1st day of the month following 30 consecutive days in paid status, provided the Employee has elected Group Health Plan, Plan D, and the required contributions have been paid by the Employer. The election rules and deadlines for the Group Health Plan will govern

the election in this HRA Plan, including the rules for seasonal deferment.

- (c) **Rehired Employees.** If an Employee was previously covered under the Plan as an active employee and is rehired within 7 calendar days of the date coverage terminated, then coverage will begin on the 1st day of the period for which contributions are paid by the Employer for such Employee. If an Employee was previously covered under the Plan and is rehired more than 7 calendar days after coverage terminated, the Employee will be considered a new Employee and coverage for the Employee and their Dependents will begin on the 1st day of the month following 30 consecutive days in paid status, as specified for new Employees. The election rules and deadlines for the Group Health Plan will govern the election in this HRA Plan, including the rules for seasonal deferment.
- (d) **Employees Moving from a Nonparticipating Unit.** Employees who move from another bargaining unit will be covered on the 1st day of the month after the bargaining unit change occurs. If the Employee is not in paid status at the time the change occurs, the Employee will not be covered until the day the Employee returns to pay status and the Trust receives the Employer contribution on the Employees behalf. The Employee must make an Election into Plan D within the first 30 days of employment in the bargaining unit.
- (e) **Employees Moving from Part-Time to Full-Time Status.** Employees who move from part-time to full-time status and who make a timely Election into Group Health Plan, Plan D will be covered on the first day of the month following the date of the change in status. If the Employee had elected coverage as a part-time Employee in Group Health Plan, Plan D, then that election will remain in force as a full-time Employee, and the Employee will have 60 days from the date of the status change to change the Election. If the Employee did not elect coverage as a part-time Employee, the Employee will have 30 days from the date of the status change to elect coverage as a full-time Employee.
- (f) **Employees Moving from Non-Benefit-Eligible to Benefit-Eligible Status.** Employees who move from non-benefit-eligible to benefit-eligible status will be covered on the first day of the month following the date of the status change. . If the Employee is not in paid status at the time the change occurs, the Employee will not be covered until the day the Employee returns to pay status and the Trust receives the Employer contribution on the Employees behalf. The Employee must make an Election into Plan D within the first 30 days of employment in the bargaining unit.
- (g) **Special Rules for Employees on Leave Without Pay and Layoff.** Employees who were covered prior to going on leave without pay are covered starting on the 1st day the Employee returns to work and is in paid status, provided the Employer contribution is received by the Trust on the Employee's behalf (unless the Employee defers coverage). Employees who were on leave without pay or on layoff will still be considered Employees of the Employer for purposes of Open Enrollment election of benefits.

Returning seasonal Employees may elect to defer the effective date of coverage for 1 month. The coverage then ends on the last day of the month following the month in which the Employee begins seasonal leave without pay again. The

Employee must follow the administrative procedures detailed in the Benefit Booklet, including timely submission of the deferral form. Once filed, a deferral cannot be revoked.

6. FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan, if an Employee goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Plan will continue to maintain the Participant's benefits on the same terms and conditions as if the Employee were still an active Employee, provided the Employee meets the notice requirements of the Employer for such leave and the Employer makes the appropriate contribution to the HRA Plan.

ARTICLE IV BENEFITS OFFERED AND METHOD OF FUNDING

1. Eligible Medical Care Expenses

The HRA 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 3 below. The full HRA benefit will for the Plan Year will be available on the first day of coverage for the Plan Year.

Participants may receive reimbursement for Medical Care Expenses incurred during a 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 Participant first becomes covered by the HRA Plan are not eligible for reimbursement.
- (b) ***Medical Care Expenses Generally.*** "Medical Care Expenses" means expenses incurred by a Participant or their Spouse or Dependents for medical care, as defined in Section 213 of the Code, but shall not include expenses that are described in subsection (c) below. Reimbursements due for Medical Care Expenses incurred shall be charged against the Participant's notional HRA Account.
- (c) ***Medical Care Expenses Exclusions.*** Medical Care Expenses shall not include (1) health insurance premiums for individual policies or for any other group health plan and (2) the expenses listed as exclusions in the Group Health Plan. Notwithstanding the foregoing, the HRA Plan may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health plan (excluding payment of COBRA for Group Health Plan, Plan D).
- (d) ***Cannot Be Reimbursed or Reimbursable from Another Source.*** Medical Care Expenses can only be reimbursed to the extent that the Participant is not reimbursed for the expense (nor is the expense reimbursable) through the Group Health Plan, other insurance, coverage, Health FSA, or other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Group Health Plan imposes a co-payment or deductible), the HRA Plan can reimburse the remaining portion of such Expense if it otherwise meets the requirements of the HRA Plan.

2. Maximum Benefits

The maximum dollar amount that may be credited to the HRA Account for an Employee who participates for a Period of Coverage is \$1,000. Unused amounts may be carried over to the next Coverage Period, as provided by Section 4 below. The maximum dollar limit may be changed by the Plan Administrator for subsequent Plan Years and shall be communicated to the Employees through the Open Enrollment Form, the Benefit Booklet or other written communication.

3. Establishment of Account

When an Employee becomes a Participant by properly enrolling in Group Health Plan, Plan D, the Plan Administrator will establish and maintain a HRA Account with respect to each Participant, but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts. All benefits under this HRA Plan shall be paid from the general assets of the Trust. Nothing herein will be construed to require the Board of Trustees to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Trust from which any payment under this Plan shall be made.

- (a) **Crediting of Accounts.** A Participant's HRA Account will be credited upon enrollment with an amount equal maximum benefit.
- (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 under subsection (a) reduced by prior reimbursements debited under subsection (b).

4. Carryover of Accounts

If any balance remains in the Participant's HRA Account for such Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Period of Coverage. However, upon termination of employment or other loss of eligibility, the Participant's coverage ceases, and expenses incurred after such time will not be reimbursed unless COBRA is elected as provided by Section 7. below. In addition, any HRA benefits that remains in the Account (including un-cashed reimbursement checks) by the close of the Plan Year shall be forfeited.

5. Reimbursement Procedure

- (a) **Timing.** Within 30 days after receipt by the Third-Party Administrator of a reimbursement claim from a Participant, the Plan will reimburse the Participant for the Participant's Medical Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that their claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide notice of any extension, including the reasons for the extension, and will allow the Participant 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 a form as the Administrator may prescribe, no later than 12 months 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 were incurred;
- The nature and date of the Expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA (Health Care Reimbursement Account Plan) coverage, if any, for such 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 Expenses, together with any additional documentation that the Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least \$25.

- (c) **Claims Denied.** To challenge the Plan's decision to deny a claim, see appeals procedure in the Benefit Booklet for the ASEA/AFSCME Local 52 Health Benefits Plan. Participants must follow the procedure and timelines in the Plan Booklet for redressing a denied claim or the Employee will lose their right to challenge the denial.

6. Reimbursements After Termination

When a Participant ceases to be a Participant under Article III, Section 2, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after their participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during a Period of Coverage prior to termination of participation, provided that the Participant (or Participant's estate) files a claim within 12 months following the end of the Plan Year in which the Medical Care Expenses was incurred.

7. COBRA

To the extent required by COBRA, the Participant and their Spouse or Dependents (Qualified Beneficiaries), whose coverage terminates under the HRA Plan because of a COBRA qualifying event, shall be given the opportunity to continue (on a post-tax, self-pay basis) the same coverage that he or she had under the HRA Account the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). In order to continue coverage under the HRA Plan under COBRA, the Participant, Spouse and/or Dependents must continue coverage under COBRA in the Group Health Plan. In the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is elected, qualified beneficiaries shall be eligible to continue the same coverage that is provided to similarly situated non-COBRA Participants. A premium for continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be

payable at such times as are established by the Plan Administrator and are permitted by COBRA.

All rules applicable to the Group Health Plan for COBRA continuation coverage apply to the HRA Plan. The Plan Administrator has the discretion to establish the method by which the COBRA premium to the Health Care Reimbursement Arrangement is calculated and such method and calculation shall be communicated to the Participant with the COBRA Election Notice.

8. Coordination of Benefits; Health FSA to Reimburse First

Benefits under this HRA Plan are intended to pay 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 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 have been exhausted.

9. Named Fiduciary; Compliance With Federal Law Mandates

- (a) ***Named Fiduciary.*** The Board of Trustees is the named fiduciary for the Plan.
- (b) ***Laws Applicable to Group Health Plans.*** Benefits shall be provided in compliance with the Public Health Service Act (PHSA), COBRA, HIPAA, FMLA and USERRA, and other group health plan laws to the extent required by such laws.

ARTICLE V APPEALS PROCEDURES

If a claim for reimbursement under this Plan is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in the Benefit Booklet for all benefit Plans offered through the Trust. The procedures in the Benefit Booklet are the sole and exclusive remedy for Participant's who challenge a benefit claim determination.

ARTICLE VI RECORD KEEPING AND ADMINISTRATION

1. Administrator

The administration of this Plan shall be under the control and supervision of the Plan Administrator. It is the duty of the Plan Administrator to ensure that this Plan is carried out, in accordance with its terms, for the exclusive benefit of the Participants without discrimination between them.

2. Powers of the Administrator

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

- (a) 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 the Plan;
- (b) Prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;
- (c) Prepare and distribute information explaining this Plan and the benefits under this Plan in such a manner and form as the Administrator determines to be reasonable and appropriate;
- (d) Request and receive from all 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) Furnish to each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;
- (f) Receive, review and keep on file such reports and information concerning the benefits provided through this Plan as the Administrator determines to be reasonable and appropriate;
- (g) Pay all reasonable expenses of the administration of the Plan from the general assets of the Trust;
- (h) Appoint, employ, and/or contract with such individuals or entities to assist in the administration of this Plan as it determines to be reasonable and appropriate, including but not limited to professional benefits consultants, attorneys, and third-party administrators;

- (i) Enter into contracts with one or more insurance companies for the purposes of bonding or for liability coverage;
- (j) Sign documents for the purposes of administering this Plan, or designate an individual or individuals to sign documents for the purposes of administering this Plan;
- (k) Secure independent medical or other advice and require such evidence as it deems necessary to decide any claim on appeal; and
- (l) Maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet applicable audit, reporting and disclosure requirements.

3. Reliance on Information

The Administrator may rely upon the information submitted by a 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 a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, obligations and reports that are furnished by accountants, attorneys, benefits consultants or other experts or professionals employed or engaged by the Administrator.

4. Inability to Locate Payee

If the Administrator is unable to make payment to a 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 when such payment first became due.

5. Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, 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 Section 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 it will in its judgment deem appropriate accord to such Participant or other person the credits of the HRA Account or distributions to which he or she is entitled under the Plan. Such action may include offsetting against future benefit payments amounts equal to the amount which was paid in error to a Participant or other person.

6. No Guarantee of Tax Consequences

The Administrator makes no 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 the Participant to

determine when each payment under this Plan is excludable from the Participant's gross income and to notify the Plan if the Participant believes that any payment from the Plan is not excludable.

7. Rights Not Subject to Assignment

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 such attempt to cause such a right to be asserted shall not be recognized, except to the extent require by law.

ARTICLE VII GENERAL PROVISIONS

1. Expenses

All reasonable expenses incurred in administering the Plan shall be paid by the Trust.

2. Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. However, the Plan Administrator may amend or terminate all or part of this Plan at any time for any reason by action of the Board of Trustees.

3. Governing Law

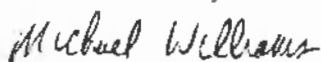
This Plan shall be construed, administered and enforced according to the laws of the State of Alaska to the extent not superseded by the Code and other federal law.

4. Severability

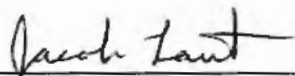
Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction or by any federal agency with oversight authority, the remainder of the Plan shall be given effect to the maximum extent possible.

SIGNATURES

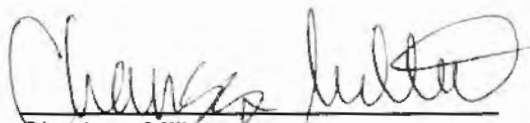
IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the ASEA/AFSCME Local 52 Health Reimbursement Arrangement Plan, the Board of Trustees of the ASEA/AFSCME Local 52 Health Benefits Trust has caused this Amended and Restated Plan to be executed and effective this February 19, 2020.



Michael Williams



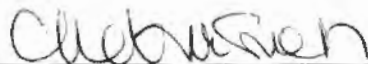
Jacob Lauten



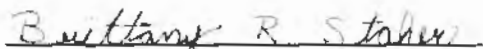
Charisse Millett



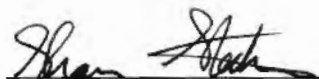
Rich Sewell



Chelsea Sieh



Brittany Staker



Shawn Staker