PLAN AND

SUMMARY PLAN DESCRIPTION

OF THE

SPOON RIVER VALLEY CUSD #4

HEALTH REIMBURSEMENT ARRANGEMENT

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ARTICLE I
GENERAL INFORMATION

The following information, together with the information contained in this booklet, form the MASTER PLAN and SUMMARY PLAN DESCRIPTION.

1. Name of Plan:

   Spoon River Valley CUSD #4 Health Reimbursement Arrangement

2. Name and Address of Plan Sponsor and Plan Administrator:

   Spoon River Valley CUSD #4
   35265 North IL 97
   London Mills, IL 61544

3. Plan Number: 503

4. Type of Plan:

   Welfare benefit plan providing medical benefits.

5. Funding

   The Plan is self-funded by the Spoon River Valley CUSD #4.

6. Agent for Service of Legal Process:

   Service of legal process may be made upon the Plan Administrator.

7. Name and Address of Contract Administrator:

   Consociate, Inc.
   2828 N. Monroe
   P.O. Box 1068
   Decatur, IL 62525-1068
   (217) 423-7788
   (800) 798-2422

8. Required Notices:

   Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for

a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Federal law requires this plan to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

reconstruction of the breast on which the mastectomy has been performed;

surgery and reconstruction of the other breast to produce a symmetrical appearance; and

prostheses and physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to all other HRA terms and limitations.

ARTICLE II
PREAMBLE

2.01. Establishment of HRA

This Spoon River Valley CUSD #4 Health Reimbursement Arrangement ("HRA") is made in duplicate this 1st day of January, 2017, by the Spoon River Valley CUSD #4, Illinois ("Employer") as follows:

2.02. Purpose of HRA

This HRA has been established to reimburse the eligible Employees of the Employer for the cost of providing reimbursement for medical expenses incurred by them, their Spouses and Dependents. It is intended that the HRA meet the requirements for qualification under Code Sec. 106, so that the Employer's contributions on behalf of participating Employees will be excludable from gross income for federal income tax purposes, and Code Sec. 105, so that benefits paid Employees hereunder will be excludible from their gross incomes.

ARTICLE III
DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

3.01. "Benefits" means any amounts paid to a Participant in the HRA as reimbursement for Eligible Medical Expenses incurred by the Participant during a Plan Year by him, his Spouse, or his Dependents.

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

3.03. "Coverage Period" means the Plan Year, during which period the benefits provided by this HRA shall be available to a Participant hereunder.

3.04. "Dependent" means a Spouse or any child of the Participant who is a dependent of the Participant for whom amounts expended by the HRA for medical care are entitled to be excluded from gross income of the Participant under Code Sec. 105(b)and who is covered by the Health Plan.

3.05. "Effective Date" means January 1, 2017.

3.06. "Eligible Medical Expenses" means those expenses incurred by the Employee, or the Employee's Dependents, after the effective date of the Employee's participation herein and during the Plan Year for medical care as defined by Code Sec. 213(d) which are covered by the Health Plan but are not payable by the Health Plan solely because they constitute deductible or coinsurance cost sharing amounts thereunder. Eligible Medical Expenses must be legally owed by the Employee or the Employee's Dependents. Eligible Medical Expenses shall not include an expense incurred for:

(a) dental or vision benefits payable under the Health Plan; or

(b) an illness or injury (or aggravation of an illness or injury) incurred by an Employee during a period of duty with the Uniformed Services.

For purposes of this HRA, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

3.07. "Employee" means an employee of the Employer for federal withholding tax purposes who is covered by the Health Plan.

3.08. "Employer" means the Spoon River Valley CUSD #4.

3.09. "FMLA" means the Family and Medical Leave Act of 1993 (29 USC §2601 et seq.).

3.10. "FMLA Leave" means a leave of absence that the Employer is required to extend to an Employee under the provisions of the FMLA.

3.11. "Health Plan" means the Western Area School Health Benefit Plan White Plan.

3.12. "Marriage" means either (a) a legal marriage between 2 persons, or (b) a legal relationship between 2 persons, of either the same or opposite sex, established or recognized as such by the Illinois Religious Freedom Protection and Civil Union Act.

3.13. "Participant" means any Employee who has met the eligibility requirements set forth in Article IV who is participating in the HRA.

3.14. "Plan Administrator" means the entity or person appointed by the Employer who has the authority and responsibility to manage and direct the operation and administration of the HRA. The Employer has appointed itself the Plan Administrator.

3.15. "Plan Year" means the period that begins on January 1, and ends on December 31.

3.16. "Spouse" means an individual who is in a Marriage with the Participant, but shall not include an individual separated from the Participant under a legal separation decree.

3.17. "Uniformed Services" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

All other defined terms in this HRA shall have the meanings specified in the various Articles of the HRA in which they appear.

ARTICLE IV
ELIGIBILITY

4.01. General requirements

Each Employee is eligible to participate in the HRA on or after the Effective Date and during the time period the Employee is employed by the Employer and covered by the Health Plan. An Employee is automatically enrolled for coverage on the date he is eligible to participate in the HRA. An Employee may decline to participate in the HRA or may later terminate such participation by providing the Plan Administrator written notice of such election. An Employee's election to decline to participate in the HRA shall be effective on the Employee's initial eligibility date, provided such election is received by the Plan Administrator within 30 days of such date. An Employee will also have the opportunity to enroll or disenroll in the HRA during the annual open enrollment period

from August 15 - September 15 of each year with coverage change to be effective as of the next following October 1.

4.02. Reentry After Uniformed Service Duty

No reentry eligibility requirements will be imposed on any Employee who returns to active employment within 90 days of completing a period of absence from employment for duty in the Uniformed Services, except as noted in Section 4.01.

4.03. Termination of a Participant's coverage

Coverage of a Participant shall terminate automatically on the date:

(a) the Participant is no longer employed by the Employer or covered by the Health Plan;

(b) the Participant fails to return to active employment with the Employer at the earlier of (i) the end of an FMLA leave or (ii) the date the Participant who is on FMLA leave gives notice to the Employer of an intent not to return to active employment;

(c) the Participant is absent from employment for more than 31 days for a period of duty in the Uniformed Services; or

(d) the HRA terminates.

4.04. Termination of coverage of a Dependent

A Dependent's coverage shall terminate on the date:

(a) the Dependent no longer qualifies as a Dependent; or

(b) the HRA terminates.

ARTICLE V
AMOUNT OF BENEFITS

5.01. Annual benefits provided by the $1,000 HRA option

Each Participant shall be entitled to reimbursement for his documented, Eligible Medical Expenses Incurred during the Plan Year in an annual amount not to exceed, in the aggregate $6,500 if the Participant maintains single and $13,000 if the participant maintains employee plus dependent coverage under the Health Plan.

The table below indicates per person or family the payment schedule for the HRA.

Employee Eligible Expenses	**Employee Pays**	**HRA Pays**	**Health Plan Pays**
First $1,000 deductible	$1,000	$0	$0
Next $4,000 – Deductible Employee/HRA split by Tier	Applicable Individual Coinsurance under Health Plan (20%, 30%, or 60%)	Applicable Health Plan Coinsurance (80%, 70%, or 40%)	
Of the next $5,000 Employee/Health Plan split by Tier until maximum out-of-pocket ($3,500) is met by the employee	Applicable Individual Coinsurance under Health Plan (20%, 30%, or 60%)	Applicable Individual Coinsurance under Health Plan (20%, 30%, or 60%) after $3,500 employee out-of-pocket met	Applicable Health Plan Coinsurance (80%, 70%, or 40%)
Of the remaining HRA/Health Plan split – up to the Health Plan maximum out-of-pocket of $10,000	$0	Applicable Individual Coinsurance under Health Plan (20%, 30%, or 60%)	Applicable Health Plan Coinsurance (80%, 70%, or 40%)
Medical care covered by Health Plan over $10,000 Health Plan out-of-pocket	$0	$0	All eligible amounts

5.02. Annual benefits provided by the $2,000 HRA option

Each Participant shall be entitled to reimbursement for his documented, Eligible Medical Expenses Incurred during the Plan Year in an annual amount not to exceed, in the aggregate $5,500 if the Participant maintains single and $11,000 if the participant maintains employee plus dependent coverage under the Health Plan.

The table below indicates per person or family the payment schedule for the HRA.

Employee Eligible Expenses	**Employee Pays**	**HRA Pays**	**Health Plan Pays**
First $2,000 deductible	$2,000	$0	$0
Next $3,000 – Deductible Employee/HRA split by Tier	Applicable Individual Coinsurance under Health Plan (20%, 30%, or 60%)	Applicable Health Plan Coinsurance (80%, 70%, or 40%)	
Of the next $5,000 Employee/Health Plan split by Tier until maximum out-of-pocket ($4,500) is met by the employee	Applicable Individual Coinsurance under Health Plan (20%, 30%, or 60%)	Applicable Individual Coinsurance under Health Plan (20%, 30%, or 60%) after $4,500 employee out-of-pocket met	Applicable Health Plan Coinsurance (80%, 70%, or 40%)
Of the remaining HRA/Health Plan split – up to the Health Plan maximum out-of-pocket of $10,000	$0	Applicable Individual Coinsurance under Health Plan (20%, 30%, or 60%)	Applicable Health Plan Coinsurance (80%, 70%, or 40%)
Medical care covered by Health Plan over $10,000 Health Plan out-of-pocket	$0	$0	All eligible amounts

5.03 Exclusive benefits

A Participant can only receive HRA benefits under one of the two preceding Sections during a Plan Year. A participant who has received an HRA benefit under either Section 5.01 or 5.02 is prohibited from any reimbursement from the other Section with respect to the same Plan Year. A Participant may only make a change to a current election to receive HRA benefits under one of the two preceding Sections during the month of December each year with such change effective as of the next following January 1.

5.04. Cost of coverage

The Employer shall bear the entire expense of providing the benefits set out in Sections 5.01 and 5.02.

ARTICLE VI
PAYMENT OF BENEFITS

6.01. Eligibility for benefits

Each Participant in the HRA shall be entitled to a benefit hereunder for all Eligible Medical Expenses incurred by the Participant on or after the effective date of his participation, (and after the effective date of the HRA) subject to the limitations contained herein, regardless whether the mental or physical condition for which the Participant makes application for benefits under this HRA was detected, diagnosed, or treated before the Participant became covered by the HRA.

6.02. Claims for benefits

No benefit shall be paid hereunder unless either the Health Plan or the Participant has first submitted a written claim for benefits to the Plan Administrator on a form specified by the Plan Administrator, and pursuant to the procedures set out in Article IX, below. Upon receipt of a properly documented claim, the Employer shall pay the Participant the benefits provided under this HRA as soon as is administratively feasible within the time periods set forth in Article IX. A Participant may submit a claim for reimbursement for an Eligible Medical Expense arising during the Plan Year at any time during the period that begins when the expense is incurred, and ends 90 days after the close of the Plan Year.

ARTICLE VII
CONTINUATION COVERAGE

7.01. Continuation Coverage after termination of normal participation

During any Plan Year during which the Employer has more than 20 employees (including persons who are considered to be "employees" within Code Sec. 401(c), directors, and independent contractors to the extent that any of the three categories is eligible to participate in this HRA), each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under this HRA upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage hereunder. Such extended coverage under the HRA is known as "Continuation Coverage."

7.02. Who is a "Qualified Beneficiary"

A "Qualified Beneficiary" is any person who, as of the day before a Qualifying Event, (a) an Employee of the Employer (including persons who are considered to be "employees" within Code Sec. 401(c), directors and independent contractors) covered under the HRA as of such day (such persons are called "Covered Employees"), (b) the Spouse of the Covered Employee, or (c) a Dependent of the Covered Employee. (For these purposes, a Spouse or other Dependent is called a "Covered Dependent.") A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists

of termination of employment (for any reason other than gross misconduct), or reduction of hours of the Covered Employee's employment.

7.03. Who is not a "Qualified Beneficiary"

A person is not a Qualified Beneficiary if, as of such day, either the individual is covered under the HRA by virtue of the election of continuation coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event, or becomes entitled to Medicare coverage under Title XVIII of the Social Security Act. Furthermore, an individual who fails to elect Continuation Coverage within the election period provided in Section 7.07, below, shall not be considered to be a Qualified Beneficiary.

7.04. What is a "Qualifying Event"

Any of the following is a "Qualifying Event":

(a) Death of a Covered Employee.

(b) Termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment below any minimum level of hours required for participation herein. In the case of a Covered Employee who:

(1) does not return to covered employment at the end of an FMLA leave, the Qualifying Event of termination occurs on the *earlier* of the last day of the FMLA Leave or the date that the Employee notifies the Employer of the intention not to return to active employment, or

(2) is absent more than 31 days due to a period of duty with the Uniformed Services, the Qualifying Event occurs on the first day of such absence.

(c) Divorce or legal separation of a Covered Employee from the Employee's Spouse.

(d) A Covered Employee's becoming eligible to receive Medicare benefits under title XVIII of the Social Security Act.

(e) A dependent child of a Covered Employee ceasing to be a Dependent.

(f) A proceeding in bankruptcy under Title 11, United States Code, with respect to the Employer if the Participant is a retiree.

In the case of any person treated as a Covered "Employee" but who is not a common-law employee, termination of "employment" means termination of the relationship that originally gave rise to eligibility to participate in the HRA.

7.05. What benefit is available under Continuation Coverage

Each person who is eligible to elect to continue coverage under Article VII shall have the right to continue the level of coverage in effect for the Covered Employee on the day before the Qualifying Event. Such coverage shall be the same as the coverage the Employee would have been entitled in the absence of a Qualifying Event. If a Qualified Beneficiary of another group health plan maintained by the Employer is prevented from receiving a previous level of benefits due to change in plan benefits or plan termination, such individual will be entitled to elect any available level of coverage under this HRA.

7.06. Notice requirements

(a) When an Employee becomes covered under this HRA, the Plan Administrator must inform the Participant (and spouse, if any) in writing of the rights to continued coverage, as described in Article VII.

(b) The Employer shall give the Plan Administrator written notice of a Qualifying Event within 30 days of the occurrence thereof.

(c) Within 14 days of receipt of the Employer's notice, the Plan Administrator shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the HRA, as well as a recital of the rights of any such Beneficiary to elect Continuation Coverage, as required by Code Sec. 4980B and ERISA §601, in accordance with the terms of this HRA.

(d) In the case of a Qualifying Event described Section 7.04(c) or (e), a Covered Employee or a Qualified Beneficiary who is a Spouse or Dependent of such Employee must notify the Plan Administrator in writing within 60 days of the occurrence thereof. The Plan Administrator shall give written notification of Conversion Coverage rights to any other affected Qualified Beneficiary within 14 days of receipt of the notice described in this Section 7.06(d). Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

The notification of election rights will generally be made by U.S. Mail to the Qualified Beneficiary’s last known address. As a result, it is important for each person to timely provide the Plan Administrator with his current address.

7.07. Election period

Any Qualified Beneficiary entitled to Continuation Coverage shall have 60 days from the date of the notice required by Section 7.07, in the case of occurrence of a Qualifying Event, in which to return a signed election to the Plan Administrator indicating the choice to continue benefits under this HRA.

7.08. Duration of Continuation Coverage

(a) Continuation Coverage shall extend for a period of 18 months after the date that regular coverage ends due to the Employee's termination of employment or reduction of hours of employment to a level that disqualifies him or participation in the HRA, or for a period of 29 months if the Social Security Administration (SSA) determines within the 18 month period that any Qualified Beneficiary was disabled during the first 60 days of Continuation Coverage. However, if the Covered Employee was entitled to Medicare benefits less than 18 months prior to the Qualifying Event of his termination of employment or reduction of hours, each Covered Dependent shall be eligible to continue coverage for up to 36 months from the date the Covered Employee first became so entitled. For purposes of determining continuation coverage rights "entitlement" means actual enrollment for Medicare benefits.

(b) In order to secure the extended coverage after a determination of disability, the disabled Qualified Beneficiary must notify the Plan Administrator of SSA's finding within 45 days of the determination by providing the Plan Administrator with a copy of the SSA award letter. If, during the 18 month period, a subsequent Qualifying Event occurs, the Covered Employee and each other Qualified Beneficiary having Continuation Coverage shall be entitled to elect to continue coverage under the HRA for up to 36 months following the date coverage was originally lost due to termination of employment or reduction of hours.

(c) In addition, 36 months of Continuation Coverage shall be available to: (i) the Employee's spouse who loses coverage under this HRA by ceasing to be a "Dependent" (as defined in Section 3.04) by virtue of a divorce or legal separation; (ii) a dependent child of the Employee who loses coverage by ceasing to be a dependent as defined by Code Sec. 152; (iii) any Covered Dependent who loses coverage where the Qualifying Event is the Employee's death; (iv) any Covered Dependent, where the Employee's entitlement to Medicare benefits results in loss of coverage under this HRA; or (v) any of the Employee's Covered Dependents if the Qualifying Event is the Employer's entering bankruptcy proceedings (or 36 months from the Employee's death, if later). In no event, however, shall Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

7.9. Automatic termination of Continuation Coverage

Continuation Coverage shall automatically cease if (a) the Employer no longer offers group health coverage to any of its employees, (b) the required premium for

continuation coverage is not paid within 30 days of the date due, (c) an electing Beneficiary becomes covered under another group health plan, or (d) an electing Beneficiary becomes eligible to receive benefits under Medicare.

7.10. Continuation Coverage for employees in the uniformed services

For purposes of this Article VII, an Employee is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services has a Qualifying Event as of the first day of the Employee's absence for such duty. Such an individual shall be treated as any other Qualified Beneficiary for all purposes of COBRA under this Article VII. The Plan Administrator shall furnish the Employee a notice of the right to elect COBRA continuation coverage (as provided in Section 7.06) and shall afford the Employee the opportunity to elect such coverage (in accordance with Section 7.07), except the maximum period of coverage available to the Covered Employee and the Employee's Covered Dependents is the lesser of (a) 24 months beginning on the date of the employee's absence or (b) the day after the date on which the employee fails to apply for or return to active employment with the Employer.

7.11. Premium requirements

(a) A Qualified Beneficiary who has elected Continuation Coverage under this Article VII must pay a premium of 102% of the applicable premium for the period of coverage. In the case of an individual who is determined to have been disabled (as described in Section 7.08), the premium for Continuation Coverage is 150% of the applicable premium for any month after the 18th month of Continuation Coverage, as described in Section 7.08.

(b) The required premium for Continuation Coverage may, at the Qualified Beneficiary's election, be paid in monthly installments.

(c) Premiums for Continuation Coverage become payable 45 days after the day on which the Qualified Beneficiary makes the initial election for Continuation Coverage.

(d) "Applicable premium" means the cost of providing the coverage under the HRA, as determined by law.

ARTICLE VIII
PLAN ADMINISTRATION

8.01. Allocation of authority

The Plan Administrator shall control and manage the operation and Administration of the HRA. The Plan Administrator shall have the exclusive right to interpret the HRA and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the

Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as it may request for the purpose of the proper administration of the HRA as a condition to receiving any benefits under the HRA;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the HRA;

(c) To decide on questions concerning the HRA and the eligibility of any Employee to participate in the HRA, in accordance with the provisions of the HRA;

(d) To determine the amount of benefits that shall be payable to any person in accordance with the provisions of the HRA; to inform the Employer, as appropriate, of the amount of such Benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part; and

(e) To designate other persons to carry out any duty or power that would otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the HRA.

8.02. Provision for third-party administrative service providers

The Plan Administrator may employ the services of such persons as it may deem necessary or desirable in connection operation of the HRA. The Plan Administrator, the Employer (and any person to whom it may delegate any duty or power in connection with the administration of the HRA), and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant, (including Employees who are actuaries or accountants), consultant, third party administration service provider, legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive and binding as to all persons.

The Plan Administrator has assigned ministerial claims processing duties to the Contract Administrator. "Ministerial claims processing duties" for this purpose means the receipt and routine processing of claims for benefits under the HRA.

8.03. Several fiduciary liability

To the extent permitted by law, neither the Plan Administrator nor any other person shall incur any liability for any acts or for failure to act except for his own willful misconduct or willful breach of this HRA.

8.04. Compensation of Plan Administrator

The Plan Administrator shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of his duties shall be paid by the Employer.

8.05. Bonding

Unless required by any Federal or State law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this HRA.

8.06. Payment of administrative expenses

All reasonable expenses incurred in administering the HRA, including but not limited to administrative fees and expenses owing to any third party administrative service provider, actuary, consultant, accountant, attorney, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, shall be paid by the Employer.

8.07. Funding policy

The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the HRA and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the HRA but shall be the property of, and shall be retained by, the Employer.

8.08. Source of benefit payments

The Employer shall self-fund any non-insurance benefits to which a Participant is entitled under this HRA.

8.09. Disbursement reports

The Plan Administrator shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the HRA.

8.10. Timeliness of benefit payments

Payments shall be made as soon as administratively feasible after the required forms and documentation have been received by the Plan Administrator, subject to the Claims Procedure requirements set out in Article IX.

8.11. Limit on coverage

Any coverage elected by a Participant under this HRA shall cease if the Participant fails to make any required contributions toward such coverage.

8.12. Annual statements

The Plan Administrator may furnish each Participant with an annual statement of his medical expense reimbursement account within 90 days after the close of each Plan Year.

ARTICLE IX
CLAIM PROCEDURES

9.01. Claims for benefits

Any Participant (who, for purposes of obtaining benefits under this HRA is called a "Claimant"), or his authorized representative, may file a claim for a HRA benefit to which the Claimant believes that he is entitled if the Health Plan has not already done so on his behalf. Such claim must be in writing, and delivered to the Contract Administrator, in person or by mail, postage prepaid. No HRA benefit will be paid unless a Claimant has first submitted a written claim for benefits to the Contract Administrator. Upon receipt of a properly documented claim, the Contract Administrator or Plan Administrator shall adjudicate the claim as soon as is administratively feasible. A Claimant may submit a claim for reimbursement for an eligible charge arising during the Plan Year at any time during the period that begins when the expense is incurred, and ends 90 days after the close of the Plan Year. If an individual terminates participation in the HRA, such individual shall be entitled to submit to the Plan Administrator any claims for reimbursement for eligible charges incurred up to the date that coverage ceases at any time within 90 days after the date on which coverage ceased. Claims filed late will be denied. Adjudication of claims and related reimbursements of benefits shall be made as soon as administratively feasible after the required claim forms have been received by the Contract Administrator but not later than 30 days after receipt of a complete claim. Reimbursements shall be made as soon as administratively feasible after the required claim forms have been received by the Contract Administrator but not later than 30 days after receipt of a complete claim.

Following is a description of how the HRA processes claims for benefits. A claim is defined as a rescission of coverage or denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the HRA, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or

appropriate, made by a Claimant or by a representative of a Claimant, that complies with the HRA's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

9.02. Required information

Each Claimant's claim for HRA benefits shall contain a written statement containing the following information:

(a) the person or persons on whose behalf Eligible Medical Expenses have been incurred;

(b) the nature of the Eligible Medical Expenses incurred;

(c) the amount of the Eligible Medical Expenses incurred; and

(d) a statement as to the amount of the Eligible Medical Expenses that have been paid through insurance from any other source.

The Claimant also must submit such evidence as the Contract Administrator shall reasonably require to substantiate the nature, the amount, and the timeliness of any Eligible Medical Expenses incurred for which HRA benefits are claimed.

9.03. Types of claims

There are different kinds of claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the claim. If you have any questions regarding this procedure, please contact the Contract Administrator.

The definitions of the types of claims are:

Urgent Care Claim

A claim involving Urgent Care is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

A physician with knowledge of the Claimant's medical condition may determine if a claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of the HRA applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a claim involving Urgent Care, the following timetable applies:

Notification to Claimant of benefit determination	72 hours
Insufficient information on the claim, or failure to follow the HRA's procedure for filing a claim:	
Notification to Claimant, orally or in writing	24 hours
Response by Claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the HRA's benefit determination on review, may be transmitted between the HRA and the Claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service claim means any claim for a benefit under this HRA where the HRA conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

In the case of a Pre-Service claim, the following timetable applies:

Notification to Claimant of benefit determination	15 days
Extension due to matters beyond the control of the HRA	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Claimant	45 days
Notification, orally or in writing, of failure to follow	5 days

the HRA's procedures for filing a claim	
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	15 days per benefit appeal
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service claim means any claim for a HRA benefit that is not an Urgent Care claim or a Pre-Service claim; in other words, a claim that is a request for payment under the HRA for covered medical services already received by the Claimant.

In the case of a Post-Service claim, the following timetable applies:

Notification to Claimant of benefit determination	30 days
Extension due to matters beyond the control of the HRA	15 days
Extension due to insufficient information on the claim	15 days
Response by Claimant following notice of insufficient information	45 days
Review of adverse benefit determination	30 days per benefit appeal

9.04. Notice to Claimant of adverse benefit determinations

Except with Urgent Care claims, when the notification may be oral followed by written or electronic notification within 3 days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the Claimant:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific HRA provisions on which the determination was 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 description of the HRA's review procedures, incorporating any voluntary appeal procedures offered by the HRA, and the time limits applicable to such procedures.

(e) 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.

(f) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Claimant upon request.

(g) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the HRA to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

9.05. Appeals

When a Claimant receives an adverse benefit determination, the Claimant has 180 days following receipt of the notification in which to appeal the decision to the Contract Administrator for consideration by the Plan Administrator. A Claimant may submit written comments, documents, records, and other information relating to the claim, and if desired may present evidence and testimony regarding the claim to the Plan Administrator. If the Claimant so requests, he or she may review the claim file and will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The HRA will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the HRA in connection with the claim as soon as possible and sufficiently in advance of the date the appeal must be decided. Before the HRA can issue a final adverse benefit determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale as

soon as possible and suffieciently in advance of the date the appeal must be decided to give the Claimant a reasonable opportunity to respond prior to that date.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the HRA. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the benefit determination;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with HRA documents and HRA provisions have been applied consistently with respect to all Claimants; or

(d) constituted a statement of policy or guidance with respect to the HRA concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the HRA who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination nor the subordinate of any such professional. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the HRA in connection with the initial determination will be appropriately identified to the Claimant.

The HRA will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, personnel decisions, or other similar decisions, will not be based upon the likelihood that an individual will support the denial of benefits

The HRA will further ensure that:

(a) Any notice of adverse benefit determination or decision on appeal include information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable), and a statement describing the availability as soon as practicable, upon request, of the diagnosis code, and the treatment code and their corresponding meanings. A request for this information will not, in itself, be considered an appeal.

(b) In the case of a decision on appeal, the decision shall include a discussion of the decision.

(c) The HRA will proivde a description of available internal appeals and external review processes, including how to initiate an appeal and the availability of and contact information for any assistance or or ombudsman to assist individuals with internal claims and appeals and external review processes.

9.06. External Appeals

When a Claimant receives an adverse benefit determination on appeal of a claim that involves medical judgment or a recission of coverage, the Claimant has 4 months after the date of receipt of a notice of the notice of denial of the appeal in which to file a request for an external review of the adverse benefit determination. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the 5th month following the receipt of the notice. Claims involving "medical judgment" for this purpose include, but are not limited to, those based on the HRA's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the HRA's determination that a treatement is experimental or investigational. A claim that does not involve a medical judgment or recission is not eligible for an external review and the HRA's decision on appeal is final.

Within 5 business days following the date of receipt of the external review request, the HRA will complete a preliminary review of the request to determine whether:

(a) The Claimant is or was covered under the HRA at the time the claim was incurred;

(b) The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the HRA;

(c) The Claimant has exhausted the HRA's internal appeal process unless the Claimant is not required to exhaust the internal appeals process applicable law; and

(d) The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the HRA will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the HRA must allow the Claimant to perfect the request for external review within the 4-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The HRA will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The HRA will take action against bias and to ensure independence. The HRA will contract with at least 3 IROs for assignments under the HRA and rotate claims assignments among them. In addition, the IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the HRA and an IRO must provide the following:

(a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the HRA.

(b) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

(c) Within 5 business days after the date of assignment of the IRO, the HRA will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the HRA to timely provide the documents and information will not delay the conduct of the external review. If the HRA fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the Claimant and the HRA.

(d) Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the HRA. Upon receipt of any such information, the HRA may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the HRA will not delay the external review. The external review may be terminated as a result of the reconsideration only if the HRA decides, upon completion

of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the HRA must provide written notice of its decision to the Claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the HRA.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the HRA's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) The Claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the HRA or issuer, Claimant, or the Claimant's treating provider;

(4) The terms of the HRA to ensure that the IRO's decision is not contrary to the terms of the HRA, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the HRA, unless the criteria are inconsistent with the terms of the HRA or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(f) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claimant and the HRA.

(g) The assigned IRO's decision notice will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;

(6) A statement that judicial review may be available to the Claimant; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(h) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by the Claimant, HRA, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the HRA immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

9.07. Expedited External Appeals

The HRA shall allow a Claimant to request an expedited external review of an adverse benefit determination if:

(a) The adverse benefit determination involves an urgent care claim of the Claimant for which the timeframe for completion of an expedited internal appeal under the external review procedures would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(b) If the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the receipt of the request for expedited external review, the HRA will complete the preliminary review of the request as for a standard external review and immediately notify the Claimant of the Claimant's right to an expedited review.

Upon a determination that a request is eligible for external review following the preliminary review, the HRA will assign an IRO pursuant to the requirements applicable to a standard external review above. The HRA must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers the appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusion reached during the HRA's internal claims and appeals process.

The HRA's contract with the assigned IRO must require the IRO to provide notice of the final external review decisions, in accordance with the requirements applicable to a standard external review above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and the HRA.

9.08. Actions at Law

All claim appeal procedures provided for in the HRA must be exhausted before any legal action is brought. Any legal action against the HRA must be commenced within 30 days after the HRA's claim review procedures have been exhausted or are no longer required to be complied with under applicable law.

ARTICLE X
PROTECTED HEALTH INFORMATION

10.01 Permitted Disclosure of Enrollment/Disenrollment Information

The HRA may disclose to the Plan Sponsor information on whether the individual is participating in the HRA, or is enrolled in or has disenrolled.

10.02 Permitted Uses and Disclosure of Summary Health Information

The HRA may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the HRA; or (b) modifying, amending, or terminating the HRA.

"Summary Health Information" means information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor had provided health benefits under the HRA; and (b) 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.

10.03 Permitted and Required Uses and Disclosure of Protected Health Information for HRA Administrative Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 10.04, the HRA (or an Insurer on behalf of the HRA) may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for HRA administration purposes. "HRA administration purposes" means administration functions performed by the Plan Sponsor on behalf of the HRA, such as quality assurance, claims processing, auditing, and monitoring. HRA administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment related functions.

Notwithstanding the provisions of this HRA to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

10.04 Conditions of Disclosure for HRA Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than Enrollment/ Disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the HRA (or an Insurer on behalf of the HRA) the Plan Sponsor shall:

(a) Not use or further disclose the PHI other than as permitted or required by the HRA or as required by law.

(b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the HRA.

(c) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the HRA agrees to and complies with the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(d) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(e) Report to the HRA any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(f) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.

(g) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(i) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the HRA available to the Secretary of Health and Human Services for purposes of determining compliance by the HRA with HIPAA's privacy requirements.

(j) If feasible, return or destroy all PHI received from the HRA that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(k) Ensure that the adequate separation between the HRA and the Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

10.05 Adequate Separation Between HRA and the Plan Sponsor

The Plan Sponsor shall allow those classes of Plan Sponsor employees or other persons in the Plan Sponsor's control designated by the Plan Sponsor to be given access to PHI. No other persons shall have access to PHI except HRA business associates. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the HRA administration functions that the Plan Sponsor performs for the HRA. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

ARTICLE XI
AMENDMENT OR TERMINATION

It is the intention of the Employer to maintain the HRA indefinitely. However, the Employer may amend or terminate the HRA at any time, provided that no such amendment or termination shall diminish or eliminate any claim for any benefit to which a Participant shall have become entitled prior to such amendment or termination of the HRA.

ARTICLE XII
GENERAL PROVISIONS

12.01. No employment rights conferred

Neither this HRA nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

12.02. Payments to beneficiary

Any benefits otherwise payable to a Participant following the date of death of such Participant shall be paid to his Spouse, or, if there is no surviving Spouse, to his estate.

12.03. Nonalienation of benefits

Benefits payable under this HRA shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse or for any other relative of a Participant, prior to actually being received by the person entitled to the benefit under the terms of the HRA; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable hereunder, shall be void. The HRA shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagement or torts of any person entitled to benefits hereunder.

12.04. Right to Receive and Release Information

The Plan Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator deems necessary to carry out the provisions of the HRA, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq*., or other applicable law, the Plan Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any Claimant under the HRA shall furnish to the Plan Administrator such information as may be necessary to carry out this provision.

12.05. Coordination with Medicare and Medicaid

(a) Medicare

This HRA will be considered the primary plan for persons who are current Employees and their Dependents who are nevertheless eligible for Medicare benefits if (i) such persons are age 65 or older and their Employer employs 20 or more Employees, or (ii) such persons are disabled and the Employer under this HRA employs 100 or more Employees. Except to the extent required by law for end stage renal disease, Medicare shall be considered the primary plan for all other persons who become eligible for Medicare.

(b) Medicaid

Payment of claims with respect to a person under the HRA will be made in accordance with any assignment of rights made by or on behalf of such person as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling or in determining or making any payments for claims of a person, the fact that the person is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the HRA has a legal liability to make payment for the claims constituting such assistance, payment for the claims under this HRA will be made in accordance with any State law which provides that the State has acquired the rights with respect to a person to such payment for such claim.

12.06. Qualified Medical Child Support Order

The HRA shall comply with the terms of a Qualified Medical Child Support Order ("QMCSO"), directing the HRA to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

(a) An order which purports to be a QMCSO must be served on the Contract Administrator.

(b) The Contract Administrator shall, within 20 days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

(1) a clause which creates or recognizes the existence of a dependent's right to receive benefits under the HRA;

(2) the name and last known mailing address of the Participant with respect to whom the order is issued and each Dependent covered by the order;

(3) a reasonable description of the type of coverage to be provided by the HRA to each Dependent;

(4) the time period to which the order applies; and

(5) the order does not require the HRA to provide any type or form of benefit not otherwise provided under the HRA.

(c) An order which, in the judgment of the Contract Administrator, does not meet the requirements of a QMCSO shall be returned to legal counsel who prepared the order for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.

(d) When the Contract Administrator makes a preliminary determination that an order satisfies the requirements of a QMCSO, it shall forward the order to the Plan Administrator for review. The Plan Administrator shall make the final determination of the status of the order.

(e) The Contract Administrator shall notify all parties involved, including a designated representative of the Covered Dependent, of the Plan Administrator's decision and of the respective parties' entitlement to benefits.

Reimbursement of benefit payments under the HRA pursuant to a QMCSO may be made to the Covered Dependent or the Covered Dependent’s custodial parent.

12.07. Mental or physical incompetency

If the Plan Administrator determines that any person entitled to payments under the HRA is incompetent by reason of physical or mental disability, he may cause all payments thereafter becoming due to such person to be made to any other person for

his benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Plan Administrator and the Employer.

12.08. Inability to locate payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the HRA because he cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identity or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited 1 year after the date such payment first became due.

12.09. Requirement of proper forms

All communications in connection with the HRA made by a Participant shall become effective only when duly executed on forms provided by and filed with the Contract Administrator.

12.10. Source of payments

The Employer shall be the sole source of benefits under the HRA. No Participant or other person shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the HRA, and then only to the extent of the benefits payable under the HRA to such Participant or other person.

12.11. Tax effects

Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any payments received by a Participant hereunder will be treated as includible in gross income for federal or state income tax purposes.

12.12. Multiple functions

Any person or group of persons may serve in more than one fiduciary capacity with respect to the HRA.

12.13. Gender and number

Masculine pronouns include the feminine as well as the neuter gender, and the singular shall include the plural, unless indicated otherwise by the context.

12.14. Headings

The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

12.15. Applicable laws

The provisions of the HRA shall be construed, administered and enforced according to applicable Federal law and the laws of the State of Illinois (except where preempted by Federal law).

12.16. Severability

Should any part of this HRA subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

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