SUMMARY PLAN DESCRIPTION

OF THE

STARK COUNTY COMMUNITY UNIT

SCHOOL DISTRICT #100

HEALTH REIMBURSEMENT ARRANGEMENT

Received - 10/9/14

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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:

   Stark County Community Unit School District #100 Health Reimbursement Arrangement

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

   Stark County Community Unit School District #100
   300 Van Buren
   Wyoming, IL 61491
   (309) 695-6123

   Employer Identification Number (EIN): 36-3823225

3. Plan Number: 502

4. Type of Plan:

   Welfare benefit plan providing medical and dental benefits.

5. Funding

   The Plan is self-funded by Stark County Community Unit School District #100.

6. Agent for Service of Legal Process:

   David N. Schellenberg
   Elias, Meginnes & Seghetti, P.C.
   416 Main Street, Suite 1400
   Peoria, IL 61602

   Service of legal process may also 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. Original Effective Date of Plan:

September 1, 2006

9. 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.

The Plan Administrator believes the HRA is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the contact information listed in Article 1, General Information Section.

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

ARTICLE II
PREAMBLE

2.01. Establishment of HRA

This Stark County Community Unit School District #100 Health Reimbursement Arrangement ("HRA") is restated in duplicate this 1st day of October, 2014, by Stark County Community Unit School District #100 ("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 and dental 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 and Dental Expenses incurred by the Participant during a Plan Year by him, his Spouse, or his Dependents (as defined by Code Sec. 152).

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 any individual who is a dependent of the Participant within the meaning of Code Sec. 152.

3.05. "Effective Date" means September 1, 2006.

3.06. "Eligible Medical or Dental Expenses" means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the effective date of the Employee's participation herein and during the Plan Year otherwise

allowable as deductions under Code Sec. 213 (without regard to the limitations contained in Sec. 213(a)), but shall not include an expense incurred for:

(a) the payment of premiums under a health insurance plan not sponsored by the Employer or other entity;

(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; or

(c) an item or service incurred after the person's coverage under the HRA terminates under Article IV.

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

3.07. "Employee" means any individual who is considered to be in a legal employer-employee relationship with the Employer for federal withholding tax purposes.

3.08. "Employer" means Stark County Community Unit School District #100.

3.09. "Entry Date" means the Effective Date, with respect to those who meet the eligibility requirements of Article IV as of such Date, or the first day of any subsequent Plan Year following the completion of the requirements of Article IV, with respect to those meeting the requirements at a future date.

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

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

3.12. "Health Plan" means the group medical plan of the Employer. It shall not include a plan which is plan qualified under Code Sec. 125.

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

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 annual accounting period of the HRA, which begins September 1, and ends on August 31.

3.16 "PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

3.17. "Retiree" means a former Employee of the Employer who is retired from the Employer and entitled to an immediate pension benefit from a pension plan of or contributed by the Employer.

3.18. "Spouse" means an individual who is legally married to a Participant, but shall not include an individual separated from the Participant under a legal separation decree.

3.19. "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

In lieu of receiving Employer medical insurance benefits, any full time Employee who has a spouse who is employed full time by the Employer or an Employee who can show evidence of coverage with another group health plan that provides minimum value in accordance with the requirements of the PPACA may elect to participate in the HRA. An Employee may apply for coverage under the HRA at any time on a prospective basis. However, an Employee who applies for coverage under the HRA during the 30 day period following the date he has first met the eligibility requirements for coverage under the Health Plan shall be covered by the HRA on the first day of such 30 day period.

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.

4.03. Termination of a Participant's coverage

Coverage of a Participant shall terminate automatically on the date that the Participant:

(a) is no longer employed by the Employer;

(b) fails to return to active employment with the Company 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 Company of an intent not to return to active employment.

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

(d) is no longer in a class of Employees that is eligible for HRA coverage;

(e) provides the Plan Administrator notice in writing that the Participant elects to terminate coverage under the HRA (such election shall be permanent and irrevocable); or

(f) the HRA terminates.

Notwithstanding subsections (a) through (d) above, a terminated Employee or Retiree shall continue to participate in the HRA until his carryover balance set forth in Section 6.03 is exhausted.

4.04. Termination of coverage of a Dependent

An Eligible Dependent's coverage shall terminate on the date:

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

(b) the Participant's HRA coverage terminates; or

(b) the HRA terminates.

4.05. Certificates of Coverage

The HRA normally will provide a Certificate of Coverage to any Participant or Dependent automatically after the individual loses coverage in the HRA. For the applicable timeframes when the Participant or Dependent has the right to elect Continuation Coverage, see Article VII. In addition, a Certificate will be provided upon request, if the request is made within twenty-four (24) months after the individual loses coverage under the HRA. In that case, the Certificate

will be provided at the earliest time that the HRA, acting in a reasonable and prompt fashion, can furnish it. In either case, the Certificate will contain the following information:

(a) the date the Certificate was issued;

(b) the name of the group health plan that provided the coverage;

(c) the name of the Participant or Dependent to whom the certificate applies;

(d) the name, address, and telephone number of the plan administrator or issuer providing the certificate;

(e) a telephone number for further information (if different);

(f) either (i) a statement that the Participant or Dependent has at least eighteen (18) months (546 days) of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage (which means a period of sixty-three (63) or more consecutive days during all of which an individual did not have any Creditable Coverage, exclusive of waiting periods and affiliation periods); or (ii) the date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and

(g) the date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate.

For Spouses and Dependents, the HRA will make reasonable efforts to locate and provide that person's name on the Certificate. The HRA will not issue an automatic Certificate for Spouses and Dependents until the HRA has reason to know that a Spouse or Dependent has lost coverage under the HRA.

For these purposes, "Certificate of Coverage" means a written certification of the period of creditable coverage of the individual under the HRA and the coverage (if any) under COBRA continuation described in Article VII, and the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under this HRA; and (2) "Creditable Coverage" means prior medical coverage that an individual had from any of the following sources: a group health plan (including this HRA), health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under Federal Employees

Health Benefits Program, a public health plan, a health benefit plan under the Peace Corps Act, or a state children's health insurance program.

ARTICLE V
AMOUNT OF BENEFITS

5.01. Annual benefits provided by the HRA

Each Participant shall be entitled to reimbursement for his documented, Eligible Medical or Dental Expenses incurred during the Plan Year in an annual amount not to exceed $2,500 in the aggregate, or such higher amount as announced by the Employer from time to time.

5.02. Cost of coverage

The Employer shall bear the entire expense of providing the benefits set out in Section 5.01.

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 and Dental 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 a 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. A Participant my submit a claim for reimbursement for an Eligible Medical or Dental Expense arising during the Plan Year at any time during the period that begins when the expense is incurred, and ends ninety (90) days after the close of the Plan Year.

A Participant's annual benefit available under Section 5.01 shall be divided by 12 (or, if the Participant enters this HRA after the beginning of the Plan Year, by the number of months or partial months remaining in that Plan Year) and claims shall be paid by this HRA only to the extent of one-twelfth

(1/12th) (or such lesser fraction for Participant's entering this HRA after the start of the Plan Year) of the annual benefit multiplied by the number of months (including partial months) in the Plan Year the Participant has been covered by this HRA at the time the claim is submitted to this HRA minus the amount of any previously submitted claims during the Plan Year and plus the amount of any carryover balance. Any claim remaining unpaid, or partially unpaid, at the end of the month in which it was submitted shall be automatically considered for payment in the next succeeding months in the Plan Year in accordance with the procedure set forth in the preceding sentence.

6.03. Carryover balances

In the event that, at the end of the Plan Year, a Participant's substantiated claims for reimbursement of medical and dental expenses are less than the maximum annual benefit provided by Section 5.01, any remaining amount shall be carried over to subsequent Plan Years to increase the reimbursement amounts that otherwise could be made out of the annual Employer contribution on the Participant's behalf. However, in no event shall the maximum annual benefit allowed by this section ever exceed the following if the Participant is a terminated Employee or Retiree:

(a) Thirty-three percent (33%) of the maximum annual benefit attributable to this section if the Participant has at least one (1) year of coverage in the HRA.

(b) Sixty-seven percent (67%) of the maximum annual benefit attributable to this section if the Participant has at least two (2) years of coverage in the HRA.

(c) One hundred percent (100%) of the maximum annual benefit attributable to this section if the Participant has at least three (3) years of coverage in the HRA.

ARTICLE VII
CONTINUATION COVERAGE

7.01. Continuation Coverage after termination of normal participation

During any Plan Year during which the Employer has more than twenty (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:

(i) 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 Company of the intention not to return to active employment, or

(ii) is absent more than thirty-one (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.

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, or a lesser level of coverage than the amount set out in Sections 5.01, above. 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 thirty (30) days of the occurrence thereof.

(c) Within fourteen (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 within sixty (60) days of the occurrence thereof. The Plan Administrator shall give written notification of Continuation Coverage rights to any other affected Qualified Beneficiary within fourteen (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 forty-five (45) 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 eighteen (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 twenty-nine (29) months if the Social Security Administration (SSA) determines within the eighteen (18) month period that any Qualified Beneficiary was disabled during the first sixty (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 thirty-six (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 in writing of SSA's finding within forty-five (45) days of its issue by providing the plan administrator with a copy of the SSA award letter. If, during the eighteen (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 thirty-six (36) months following the date coverage was originally lost due to termination of employment or reduction of hours.

(c) In addition, thirty-six (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 thirty-six (36) months beyond the date of the original Qualifying Event.

7.09. 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 thirty (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) twenty-four (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 eighteenth (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 forty-five (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.

7.12. Other Requirements

Any other Continuation Coverage requirements of the HRA shall be contained in the HRA's election notice form.

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, subject to approval of the Board, 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. Plan Administrator 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

Unless otherwise agreed to by the Board, 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 otherwise determined by the Board, or 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 Employees.

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 shall furnish each Participant with an annual statement of his medical and dental expense reimbursement account within ninety (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 Plan 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. Such claim must be in writing, and delivered to the Contract Administrator, in person or by mail, postage prepaid. No plan 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.

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 or Dental Expenses have been incurred;

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

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

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

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

9.03. Notifications of decisions on benefit claims

The Plan Administrator shall notify the Claimant or his authorized representative of the HRA's adverse benefit determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim, in accordance with Section 9.04, below. This period may be extended one time by the HRA for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the HRA and notifies the Claimant or his authorized representative before the end of the initial thirty (30) day period of the circumstances requiring the extension of time and the date by which the HRA expects to render a

decision. If such an extension is necessary due to a failure of the Claimant or his authorized representative to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant or his authorized representative shall be given at least forty-five (45) days from receipt of the Notice within which to provide the specified information.

For purposes of the various time periods set out in Section 9.03, the period of time within which a benefit determination must be made shall begin at the time a claim is filed in accordance with Section 9.02, above, regardless of whether all the information necessary to make a benefit determination is included with the filing. In the event that a period of time is extended as permitted by this Section 9.03 due to the failure of a Claimant or his authorized representative to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Claimant or his authorized representative until the date on which the Claimant or his authorized representative responds to the request for additional information.

9.04. Method and contents of denial notices

Any notice of the denial of a Claim for benefits shall be given the Claimant or his authorized representative either in written form or as an electronic notice. The notice of denial must include:

(a) the specific reason or reasons for the adverse benefit determination;

(b) reference to the specific plan provisions on which the determination is based;

(c) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) a description of the review procedures set out in this Article VIII and the time limits applicable to such procedures following an Adverse Benefit Determination on review;

(e) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request.

9.05. Appealing an adverse benefit determination

Within one hundred eighty (180) days after the receipt by the Claimant of written notification of the denial (in whole or in part) of his claim, the Claimant or his duly authorized representative, upon written application to the Plan Administrator, in person or by certified mail, postage prepaid, may request a review of such denial, may review pertinent documents, and may submit issues and comments in writing.

9.06. Decision on appeal of disputed claims

(a) Upon its receipt of a notice for a request for a review, the Plan Administrator shall make a prompt decision on the review. The individual who conducts the review shall not be the same individual who made the initial adverse benefit determination. If the adverse benefit determination is appealed on the basis of medical judgment, the Plan Administrator shall consult with an independent health care professional who is qualified in the areas of dispute who shall not have been involved in the initial claim denial.

(b) An appeal of an adverse benefit determination of a claim by a Claimant or his authorized representative shall be decided and a notice issued to the Claimant or his authorized representative within a reasonable period, but not more than sixty (60) days, after the Plan Administrator has received the request for the review on appeal.

9.07. Contents of notice of decision on appeal

The Plan Administrator shall provide the Claimant or his authorized representative with written or electronic Notice of the HRA's benefit determination on review in accordance with the applicable time frames set out in Section 9.03. In the case of an adverse benefit determination, the notice shall set forth, 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 plan provisions on which the benefit determination is based; and

(c) a statement that the Claimant is entitled to receive without charge reasonable access to any document (1) relied on in making the determination, (2) submitted, considered or generated in the course of making the benefit determination, (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (4) constitutes a statement of policy or guidance with respect to the HRA concerning the denied treatment without regard to whether the statement was relied on.

ARTICLE X
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 XI
GENERAL PROVISIONS

11.01. 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.

11.02. 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.

11.03. 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.

11.04. Right to Receive and Release Information

The Plan Administrator, pursuant to the reasonable exercise of its discretion, 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 Plan shall furnish to the Plan Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the HRA and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

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

(b) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the HRA agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

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

(d) Report to the appropriate representative of the Plan Administrator any use or disclose of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) Make available protected health information in accordance with 45 C.F.R. 164.524;

(f) Make available health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

(h) Make its internal practices, books and records relating to the use and disclosure of protected health information received from the HRA available to the Secretary of Health and Human Services for purposes of determining compliance by the HRA with the privacy requirements of 45 C.F.R. 164.500, *et seq.*;

(i) If feasible, return or destroy all protected health information 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;

(j) Ensure that the adequate separation between the HRA and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii);

(k) 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 Plan;

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

(m) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

The use of protected health information by the HRA shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, *et seq*. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

11.05. 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.

11.06. 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.

11.07. 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.

11.08. 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.

11.09. 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 or Plan Administrator.

11.10. 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.

11.11. 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.

11.12. Multiple functions

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

11.13. 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.

11.14. 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.

11.15. 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.

11.16. 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.

IN WITNESS WHEREOF, this HRA Agreement is executed as of the date and year first written above.

STARK COUNTY COMMUNITY UNIT SCHOOL DISTRICT #100

By: Jerry Klooster, Supt.
Its President

514-236.1