CHEROKEE COMMUNITY SCHOOL DISTRICT

Health Reimbursement Arrangement

Plan Document and Summary Plan Description

GROUP # 42830000

Revised and Effective: July 1, 2018

Produced By:
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MID-AMERICAN BENEFITS, INC.
For all the right reasons!

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PURPOSE

The purpose of the Plan document is to set forth the provisions of the Plan, which provides for the payment or reimbursement of all or a portion of eligible medical expenses. It is intended that the terms of this Plan are legally enforceable and that the Plan be maintained for the exclusive benefit of eligible participants. This Plan exclusively follows the regulatory framework of the integrated fully insured health plan including, but not limited to, COBRA, FMLA, and HIPAA.

THIRD-PARTY ADMINISTRATOR

Mid-American Benefits, Inc.
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NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Fiduciary and Plan Administrator is CHEROKEE COMMUNITY SCHOOL DISTRICT who shall have authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The company shall have the authority to amend the Plan, to determine its policies, to appoint and/or remove the Third-Party Administrator.

PLAN INTERPRETATION

The Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan provisions, including, but not limited to, all issues concerning eligibility for and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan connected services; however, final authority to construe and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator, made in good faith, shall be final and binding. In the event that the company terminates the Plan, then as of the effective date of termination, the company and participant shall have no further obligation to make additional contributions to the Plan, with respect to claims incurred beyond the termination date of this Plan.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the company shall find that such an attempt has been made with respect to any payment due or to become due to any participant, the company in its sole discretion may terminate the interest of such participant or former participant, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative or a dependent of such participant or former participant, as the company may determine, any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN AMENDMENTS

This document contains all the terms of the Plan and may be amended from time to time by the company. Any changes so made shall be binding on each participant and on any other participant referred to in this Plan Document.

TERMINATION OF THE PLAN

The company reserves the right to terminate the Plan by providing a written thirty day notice to the effect. All previous contributions by the company shall continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to participants, until all contributions are exhausted.

PLAN IS NOT A CONTRACT

This Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any employee of the company the right to be retained in the service of the company or to interfere with the right of the company to discharge or otherwise terminate the employment of any employee.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan reserves the right to allocate the deductible amount to any eligible expenses and to apportion the benefits to the participant and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the participants and all assignees.

COORDINATION OF BENEFITS

This section describes how benefits under this Plan are coordinated with other benefits to which participants might be entitled.

Non-Duplication of Benefits / Coordination of Benefits

If a participant is covered by another plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your benefits are coordinated with benefits from:

- Other employers' plans
- Individual plans
- Certain government plans
- Motor vehicle plans when required by law

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- The primary plan is determined and pays the full amount it normally would pay first. It pays all benefits that it would pay if there were no other plans
- The secondary plan pays next. It pays a reduced amount which when added to the benefits paid by the primary plan will pay no more than 100% of total expenses. However, no secondary plan ever pays more than it would pay without the coordination of benefits provision.
- If another plan is primary and this Plan is secondary, the Plan will calculate the amount it would pay as if there were no other coverage, subtract the amount payable by the primary plan, and then pay any eligible remaining amount. If any balance remains, it is your responsibility.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, your company's Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.
    - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
    - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
    - If the remarried parent with custody has no coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
    - When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will continue and this Plan will be your primary coverage, with Medicare as secondary coverage. If you choose to have Medicare as your primary coverage, your coverage under this Plan will terminate.

The Plan also coordinates with Medicare as follows:

- End-stage renal disease - If a participant is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- Mandated coverage under another group plan—If a participant is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense. This also applies to the benefit that an auto insurance plan would pay if auto insurance is legally required but not in force. Coverage under the Plan will be secondary regardless of the participant's coverage election on an auto insurance policy.

If a participant incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- Any deductible under the automobile coverage
- Any co-payment under the automobile coverage
- Any expense properly denied by the automobile coverage that is a covered expense;
- Any expense that the Plan is required to pay by law

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Allowable Charge

For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the participant does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the participant used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Claims determination period

Benefits will be coordinated on a calendar year basis. This is called claims determination period.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "coverage").

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the participant(s) and/or their attorney from any source and said funds shall be

held in trust until such time as the obligations under this provision are fully satisfied. The participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the participant shall be a trustee over those Plan assets.

3. In the event a participant(s) settles, recovers, or is reimbursed by any coverage, the participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the participant(s). If the participant(s) fails to reimburse the Plan out of any judgment or settlement received, the participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

<u>Subrogation</u>

1. As a condition to participating in and receiving benefits under this Plan, the participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the participant(s) fails to so pursue said rights and/or action.

2. If a participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any participant(s) may have against any coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the participant(s) commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the participant(s) fails to file a claim or pursue damages against:
   a. The responsible party, its insurer, or any other source on behalf of that party.
   b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
   c. Any policy of insurance from any insurance company or guarantor of a third party.
   d. Workers' compensation or other liability insurance company.
   e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Participant is a Trustee over Plan Assets

1. Any participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the participant understands that he/she is required to:
    a. Notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
c. In circumstances where the participant is not represented by an attorney, instruct the insurance company or any third party from whom the participant obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the participant disputes this obligation to the Plan under this section, the participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the participant(s), such that the death of the participant(s), or filing of bankruptcy by the participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the participant(s) and all others that benefit from such payment.

Obligations

1. It is the participant's/participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the participant may have against any responsible party or coverage.
    h. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    i. In circumstances where the participant is not represented by an attorney, instruct the insurance company or any third party from whom the participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
    j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and participant over settlement funds is resolved.

2. If the participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the participant's/participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the participant(s) in an amount equivalent to any outstanding amounts owed by the participant to the Plan. This provision applies even if the participant has disbursed settlement funds.

Minor Status

1. In the event the participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) BENEFIT SUMMARY
CHEROKEE COMMUNITY SCHOOL DISTRICT – SPLIT-FUNDED CARRIER PLAN

FULLY INSURED PLAN: Embedded Out-of-Pocket
Plan 1 & 2 In-Network Out-of-Pocket: $5,400.00 (Single) - $10,800.00 (Family)
Plan 1 & 2 Out-of-Network Out-of-Pocket: $5,400.00 (Single) - $10,800.00 (Family)

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ADMINISTERED AS: Embedded Benefit
Plan 1 & 2 In-Network Single Coverage: Employee Liability $900.00 / Employer Liability $4,500.00 + copay liability
Plan 1 & 2 In-Network Family Coverage: Employee Liability $1,400.00 / Employer Liability $9,400.00 + copay liability
Plan 1 & 2 Out-of-Network Single Coverage: Employee Liability $900.00 / Employer Liability $4,500.00
Plan 1 & 2 Out-of-Network Family Coverage: Employee Liability $1,400.00 / Employer Liability $9,400.00

Plan 1 & 2 In-Network Illustration for Single Coverage
Family is 2 times deductible + $400.00 coinsurance

$5,400.00 Out-of-Pocket					
$2,700.00 Deductible				$2,700.00 Coinsurance	
First $500.00	Next $2,200.00				
Employee	Employee	Employer		Employee	Employer
$500.00	$220.00	$1,980.00		$180.00	$2,520.00

Plan 1 & 2 In-Network: For single coverage, once the employee satisfies the first $500.00 in deductible, the next $2,200.00 of claims are processed at 10% being paid by the employee, up to a maximum of $220.00, and 90% being paid by the employer, up to a maximum of $1,980.00. At that point, the $2,700.00 deductible that must be met before the Fully Insured Carrier will pay claims has been fulfilled by a combination of the employee and the employer. For the coinsurance with the Fully Insured Carrier, the employee pays 10%, up to a maximum of $180.00. The employer and the Fully Insured Carrier pay the balance of the coinsurance amount. After the out-of-pocket has been met, the Fully Insured Carrier pays 100%.

Plan 1 & 2 Out-of-Network Illustration for Single Coverage
Family is 2 times deductible + $400.00 coinsurance

$5,400.00 Out-of-Pocket					
$2,700.00 Deductible				$2,700.00 Coinsurance	
First $500.00	Next $2,000.00		Last $200.00		
Employee	Employee	Employer	Employer		Employer
$500.00	$400.00	$1,600.00	$200.00		$2,700.00

Plan 1 & 2 In-Network: For single coverage, once the employee satisfies the first $500.00 in deductible, the next $2,000.00 of claims are processed at 20% being paid by the employee, up to a maximum of $400.00, and 80% being paid by the employer, up to a maximum of $1,600.00. The last $200.00 of the deductible is paid by the employer. At that point, the $2,700.00 deductible that must be met before the Fully Insured Carrier will pay claims has been fulfilled by a combination of the employee and the employer. For the coinsurance with the Fully Insured Carrier, the employer pays 40%, up to a maximum of $2,700.00. The Fully Insured Carrier pays the balance of the coinsurance amount. After the out-of-pocket has been met, the Fully Insured Carrier pays 100%.

PLAN 1 & 2 IN-NETWORK COPAYMENT REIMBURSEMENT
- Office visits – The HRA Plan will reimburse $10.00 of the Fully Insured Carrier's $25.00 copayment.

PLAN 1 IN-NETWORK PRESCRIPTION COPAYMENT REIMBURSEMENT
- Tier 1 – The HRA Plan will reimburse $5.00 of the Fully Insured Carrier's $15.00 copayment
- Tier 3 & Tier 4 – The HRA plan will reimburse $15.00 of the Fully Insured Carrier's $40.00 copayment
- Specialty – The HRA Plan will reimburse $60.00 of the Fully Insured Carrier's $85.00 copayment.

PLAN 2 IN-NETWORK PRESCRIPTION COPAYMENT REIMBURSEMENT
- Tier 1 – The HRA Plan will reimburse $5.00 of the Fully Insured Carrier's $15.00 copayment.
- Tier 2 – The HRA Plan will reimburse $10.00 of the Fully Insured Carrier's $25.00 copayment.
- Tier 3 & Tier 4 – The HRA Plan will reimburse $25.00 of the Fully Insured Carrier's $40.00 copayment.
- Specialty – The HRA Plan will reimburse $70.00 of the Fully Insured Carrier's $85.00 copayment.

CONTRIBUTIONS TO THE PLAN

Contributions to the Plan are to be made as follows:

1. Employee coverage is contributory; and
2. Dependent coverage is contributory.

The company shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the company and the amount to be contributed (if any) by each participant.

Notwithstanding any other provisions, the company's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall completely discharge the company's obligation with respect to such payments.

In the event that the company terminates the Plan, then as of the effective date of termination, the company and participant shall have no further obligation to make additional contributions to the Plan, with respect to claims incurred beyond the termination date of this Plan.

ELIGIBILITY FOR COVERAGE

Eligibility will be determined by the fully insured carrier. The Third-Party Administrator will not be held responsible for determining or verifying eligibility under the Plan.

Therefore, if the fully insured carrier approves payment for services rendered, the Third-Party Administrator will assume eligibility to be verified.

HEALTH REIMBURSEMENT ADMINISTRATION

Eligible expenses will be determined by the fully insured carrier. The Third-Party Administrator will not be responsible for determining or verifying whether or not the expense is a covered expense.

Therefore, if the fully insured carrier approves payment for services rendered, the Third-Party Administrator will assume the expense is a covered expense.

The fully insured carrier will submit copies of all explanations of benefits (EOB's) to the Third-Party Administrator. The Third-Party Administrator will review the EOB’s and identify services which have been applied to the deductible. All other EOB's will be destroyed.

HEALTH REIMBURSEMENT COVERED EXPENSES

The following are eligible expenses under this Plan. Benefits for these eligible expenses will be payable as shown in the *Benefit Summary.*

1. Services applied to the Fully Insured Carrier's deductible and out-of-pocket maximum.

GENERAL PROVISIONS

NOTICE AND PROOF OF EXPENSES

Written proof of expenses will be provided by the fully insured carrier.

ACTIONS AT LAW

No legal action may be brought to recover on this Plan prior to the last day after proof of expenses incurred has been filed. No such action may be brought after three (3) years from the time written proof of expenses is required to be given.

PAYMENT OF BENEFITS

All benefits are payable when Plan Administrator receives written proof of expenses.
All benefits are payable to the provider unless otherwise specified.

ASSIGNMENT OF BENEFITS

The Plan Administrator may revoke an assignment of benefits at its discretion and treat the participant as the sole beneficiary. Benefits for medical expenses covered under this plan may be assigned by a participant to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the participant, the plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No participant shall at any time, either during the time in which he or she is a participant in the Plan, or following his or her termination as a participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an assignment of benefits, in accordance with this Plan, does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

FACILITY OF PAYMENT

If a participant is a minor or is physically or mentally incapable of giving a valid release for payment, the Plan Administrator, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until claim is made by a guardian. If a participant dies while benefits remain unpaid, benefits will be paid, at the Plan Administrator's option to:

1. A person or institution on whose charges claim is based; or
2. A surviving relative (spouse, parent, or child).

Such payment will release the Plan Administrator of all further liability to the extent of payment.

NOTICE OF PAYMENT DUE

lf the Plan Administrator cannot locate any person to whom a payment is due, after six (6) months from the date such payment is due, a notice of payment due will be mailed to the last known address of that person. If, within three (3) months after that mailing, such person has not made written claim, the Plan Administrator may direct

that such payment and all remaining payments otherwise due to such person to be canceled. The Plan shall have no further liability upon such cancellation.

WAIVER OR ESTOPPEL

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

RESPONSIBILITY FOR PAYMENT OF CLAIMS

The Plan shall be the sole source of benefits under the Plan, and to the maximum extent permitted by law, the company assumes no liability or responsibility for payment of benefit, and each employee or other person who shall claim the right to any payment with respect to benefits under the Plan shall be entitled to look only to the Plan for such payment and shall not have any right, claim or demand thereof against the company or the medical board or any officer, employee, or director of the company.

CONSTRUCTION

Wherever found in this Plan, a masculine pronoun includes the feminine pronoun.

CLAIMS PROCEDURE

The company shall provide adequate notice in writing to any person whose claim for benefits under this plan has been excluded, setting forth the specific reasons for such exclusions and written in a manner calculated to be understood by the person. Further, the company shall afford a reasonable opportunity to any person whose claim for benefits has been excluded for a full and fair review of the decision by the party designated by the company for the purpose.

The Third-Party Administrator shall have no power to add to, subtract from, or modify any of the terms of the plan, or to change or add to any benefits provided by the plan, or to waive or fail to apply any requirements of eligibility for a benefit under the plan.

FILING OF BENEFIT CLAIMS

A claim is considered filed in accordance with plan provisions when the Third-Party Administrator receives the fully insured carrier's explanation of benefits. Once the claim is received, the claim will be handled according to the administrative guidelines.

Written proof of claim for each eligible expense must be given to the Third-Party Administrator or the Plan Administrator within six (6) months following the date in which the expense was incurred, unless it is not reasonably possible to give claim sooner. However, when coverage terminates for any reason, written proof of claim must be given to the Third-Party Administrator within thirty (30) days of the termination of coverage, provided that the plan remains in force. However, upon termination of the plan itself, final claims must be received by the date of termination in such form that final claim determination can be made.

Claims will be paid immediately upon receipt of satisfactory written proof from available fund deposits made by the Employer. If the employee dies before all benefits have been paid, the remaining benefits may be paid to any relative of the employee or to any person appearing to the Plan Administrator to be entitled to payment. The Plan Administrator shall fully discharge its liability by such payments.

STANDARDS FOR PRIVACY OF PROTECTED HEALTH INFORMATION

PRIVACY POLICY

THIS PRIVACY POLICY DESCRIBES HOW MEDICAL INFORMATION ABOUT A PARTICIPANT MAY BE USED AND DISCLOSED, AND HOW A PARTICIPANT CAN GET ACCESS TO THIS INFORMATION

The Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) took effect on April 14, 2001. The Privacy Rule creates national standards to protect participant's personal health information and gives patients increased access to their medical records. As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Privacy Rule covers health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions electronically.

This section is to advise participants on how Protected Health Information (PHI) is collected, the type of PHI collected, and what may be disclosed to affiliates and non-affiliated third parties. It also details the steps taken to protect a participant's PHI, how the PHI may be used, how the PHI may be disclosed, and how participants can get access to their PHI.

COLLECTION OF INFORMATION

CHEROKEE COMMUNITY SCHOOL DISTRICT must collect a certain amount of PHI to provide customer service, offer new benefits, plans, products, or services, evaluate benefits and claims, administer its plans, and to fulfill legal and regulatory requirements. Specific language and examples may not apply to all participants, and the PHI that CHEROKEE COMMUNITY SCHOOL DISTRICT collects will vary accordingly. Examples of PHI include:

1. PHI on a participant's enrollment forms and related forms, such as name, address, date of birth, Social Security number, gender, marital status, income, medical history, life insurance beneficiary designations, and health care services received.

2. PHI about a participant's relationship with CHEROKEE COMMUNITY SCHOOL DISTRICT, such as plans, benefits, or services purchased or enrolled, account balances, payment history, and claims history.

3. PHI provided by the employer, benefits plan sponsor or association regarding any group products, such as name, address, Social Security number, age, income, and marital status.

4. PHI from a consumer reporting agency, such as consumer's credit worthiness and credit history.

5. PHI from other sources, such as motor vehicle reports, medical information and demographic information.

SHARING AND USE OF INFORMATION

While acknowledging the importance of protecting a participant's information, CHEROKEE COMMUNITY SCHOOL DISTRICT finds it necessary in the course of conducting business to disclose PHI collected, as described above, in some or all of the following circumstances:

1. PHI may be shared with CHEROKEE COMMUNITY SCHOOL DISTRICT affiliates and/or Business Associates to enable them to provide customer service or account maintenance;

2. PHI may be shared with non-affiliated third parties (as permitted by law) who are assisting CHEROKEE COMMUNITY SCHOOL DISTRICT by performing services or functions on its behalf, such as agents, brokers, brokerage firms, insurance companies, administrators, utilization review companies, disease management programs, case management services, pharmacy benefit managers, PPO' s, managing general underwriters, and other service providers;

3. PHI may be shared with other service companies, such as PPO' s, utilization review companies, case management companies, insurance companies, or managing general underwriters, disease management

companies with whom CHEROKEE COMMUNITY SCHOOL DISTRICT has a written service and/or marketing agreement;

4. PHI may be shared with non-affiliated third parties as permitted or required by law, such as compliance with a subpoena, fraud prevention, or compliance with an inquiry from a government agency or regulator;

5. PHI will be shared only with proper written authorization or as required by law. Neither CHEROKEE COMMUNITY SCHOOL DISTRICT nor its Business Associates will share PHI for marketing of its services;

6. PHI may be shared with CHEROKEE COMMUNITY SCHOOL DISTRICT Business Associates so they may inform clients about other products or services offered that might be useful or beneficial;

7. PHI may be shared with an interpreter working in an official capacity;

8. PHI may be shared with a law enforcement officials in response to a National Medical Support Notice; and

9. PHI may be shared by a Business Associate with CHEROKEE COMMUNITY SCHOOL DISTRICT for the sole purposes of managing the plan.

If any request is made for a participant's PHI that is not permitted by this policy, such disclosure will be made only with a participant's written authorization and the authorization may be revoked by the participant at any time.

PROTECTING THE INFORMATION

CHEROKEE COMMUNITY SCHOOL DISTRICT is committed to uphold its pledge to maintain the security of a participant's PHI. To ensure such information is used only in the manner described in this policy, CHEROKEE COMMUNITY SCHOOL DISTRICT has instituted the following safeguards:

1. CHEROKEE COMMUNITY SCHOOL DISTRICT employees are required to comply with established privacy policies and procedures that exist to protect the confidentiality of a participant's PHI. Any employee who violates the privacy policies will be subject to a disciplinary process;

2. CHEROKEE COMMUNITY SCHOOL DISTRICT employees are authorized to access PHI only on a business need-to-know basis, such as to pay benefits or claims, underwrite a policy, administer a plan, service a customer request, or to assist in purchasing an insurance policy; and

3. CHEROKEE COMMUNITY SCHOOL DISTRICT uses manual and electronic security procedures to maintain the confidentiality of the PHI collected and to guard against its unauthorized access. Such methods include locked files, user authentication, encryption, and firewall technology.

CONSUMER REPORTING INFORMATION

If required by law and upon written request, CHEROKEE COMMUNITY SCHOOL DISTRICT will inform a participant if a consumer report was requested, as well as the name and address of the consumer-reporting agency that requested the report.

REVIEW AND ACCESS TO INFORMATION

If required by law and upon written request, CHEROKEE COMMUNITY SCHOOL DISTRICT will make information from a participant's file available for review. CHEROKEE COMMUNITY SCHOOL DISTRICT is unable to provide information collected in connection with, or in anticipation of, any claim or lawsuit.

If a participant notifies CHEROKEE COMMUNITY SCHOOL DISTRICT that any information about the participant is incorrect, CHEROKEE COMMUNITY SCHOOL DISTRICT will review the information. If CHEROKEE COMMUNITY SCHOOL DISTRICT agrees, CHEROKEE COMMUNITY SCHOOL DISTRICT will correct the record. If CHEROKEE COMMUNITY SCHOOL DISTRICT does not agree, the participant may submit a short statement of dispute, which

will be included in any future disclosure of PHI.

If a participant has any questions about the right of access or wishes access to the participant's file (as permitted by law), the participant is instructed to contact CHEROKEE COMMUNITY SCHOOL DISTRICT and to include a copy of the participant's personal identification, such as a driver's license or photo identification.

If a participant has any concern or complaint that the participant's privacy rights were violated, the participant may contact CHEROKEE COMMUNITY SCHOOL DISTRICT or the Secretary of Health and Human Services.

Electronic Protected Health Information

Where Electronic Protected Health Information (PHI) will be created, received, maintained, or transmitted to or by the CHEROKEE COMMUNITY SCHOOL DISTRICT on behalf of the Plan, the CHEROKEE COMMUNITY SCHOOL DISTRICT shall reasonably safeguard the ePHI as follows:

1. CHEROKEE COMMUNITY SCHOOL DISTRICT will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that CHEROKEE COMMUNITY SCHOOL DISTRICT creates, receives, maintains, or transmits on behalf of the Plan;

2. CHEROKEE COMMUNITY SCHOOL DISTRICT will ensure that the adequate separation that is required by 45 C.F .R. § 164. 504(t)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

3. CHEROKEE COMMUNITY SCHOOL DISTRICT will ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such Information; and

4. CHEROKEE COMMUNITY SCHOOL DISTRICT will report to the Plan any Security Incidents of which it becomes aware as described below:

    a. CHEROKEE COMMUNITY SCHOOL DISTRICT will report to the Plan within a reasonable time after CHEROKEE COMMUNITY SCHOOL DISTRICT becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI; and

    b. CHEROKEE COMMUNITY SCHOOL DISTRICT will report to the Plan any other Security Incident on an aggregate basis every quarter or more frequently upon the Plan's request.

CONTINUING COMMITMENT

CHEROKEE COMMUNITY SCHOOL DISTRICT will continue to provide this notice, as the frequency required by law and will notify participants of any modification at least annually.

DEFINITIONS

Amendment: A formal document that changes the provisions of the Plan Document, duly signed by the authorizing person or persons as designated by the Plan Administrator.

Assignment of Benefits: An arrangement whereby the participant, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, co-payments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a participant, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and deductibles, co-payments and the coinsurance percentage that is the responsibility of the participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke an assignment of benefits at its discretion and treat the participant as the sole beneficiary.

A provider which accepts an assignment of benefits in accordance with this Plan does so as consideration in full for services rendered, and is bound by the rules and provisions set forth within the terms of this document.

Benefit Percentage: That portion of eligible expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any Out-of-Pocket expenses which are to be paid by the employee.

Company: The designated Plan Administrator as specified on the General Information page of the Master Plan Document.

Deductible: An amount which the participant must pay each calendar year for covered services before benefits are payable by the contract.

EOB (explanation of benefits): A statement sent by a health insurance company or health plan to covered individuals explaining what medical treatments and/or services were paid for on their behalf.

Fiduciary: The company, the board of directors, or the Plan Administrator, but only with respect to the specific responsibilities of each with respect to the administration of the Plan.

Fully Insured Carrier: The insurance company chosen by the employer to provide comprehensive medical insurance benefits for its employees.

Out-of-Pocket Maximum: The maximum dollar amount a participant will pay for medical expenses in any one Calendar Year. This will include charges applied to satisfy the calendar year deductible; however, deductible carry over from the previous benefit period will not count as credit toward the Out-of-Pocket Maximum.

Participant(s): An employee or dependent or a participating COBRA Beneficiary meeting the eligibility requirements for coverage as specified in the Plan and properly enrolled in the Plan. The term may also include retirees if such coverage is provided under this Plan.

Plan Administrator: The company which is responsible for the day-to-day functions and arrangements of the Plan. The Plan Administrator may also employ persons or firms to process claims and perform other Plan connected services.

Plan Administration Functions: Administration functions performed by the Plan Sponsor of this Plan on behalf of the Plan and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

Plan Sponsor: The employer, as specified on the General Information page, who sponsors this Plan.

Protected Health Information: Individually identifiable health information, as defined by the HIPAA Privacy Rule, whether oral or recorded, which is transmitted or maintained in any form or medium. However, this definition does not include education records covered by the Family Educational Rights and Privacy Act, as amended, records described at 20 U.S.C. §1232g(a)(4)(B)(iv), and employment records held by the covered entity in its role as employer.

Summary Health Information: Information, which may be individually identifiable health information, that summarizes the claims history, claims expenses, or type of claims experienced by individuals covered under this Plan, and from which all identifiers have been removed except for geographic information to the extent that it is aggregated to the level of a five-digit zip code.

Third Party Administrator (TPA): The organization contracted by the company to process claims, maintain Plan data, and perform other Plan connected services.

GENERAL PLAN INFORMATION

PLAN NAME:	CHEROKEE COMMUNITY SCHOOL DISTRICT Health Reimbursement Arrangement
PLAN NUMBER:	501
GROUP NUMBER:	42830000
TAX ID NUMBER:	42-6001118
PLAN YEAR:	July 1 through June 30
EMPLOYER INFORMATION:	CHEROKEE COMMUNITY SCHOOL DISTRICT 600 W. Bluff Street Cherokee, IA 51012 712-225-6767
PLAN ADMINISTRATOR:	CHEROKEE COMMUNITY SCHOOL DISTRICT 600 W. Bluff Street Cherokee, IA 51012 712-225-6767
NAMED FIDUCIARY:	CHEROKEE COMMUNITY SCHOOL DISTRICT 600 W. Bluff Street Cherokee, IA 51012 712-225-6767
AGENT FOR SERVICE OF LEGAL PROCESS:	CHEROKEE COMMUNITY SCHOOL DISTRICT 600 W. Bluff Street Cherokee, IA 51012 712-225-6767
CLAIMS ADMINISTRATOR:	Mid-American Benefits, Inc. 5310 North 99th Street – Suite One Omaha, Nebraska 68134 402-571-6224 or 800-364-9505

Adoption of the Plan

CHEROKEE COMMUNITY SCHOOL DISTRICT Health Reimbursement Arrangement, as stated herein, is hereby adopted as of July 1, 2018. This document constitutes the basis for administration of the Plan.

BY: _____
(Signature)

_____
(Printed Name)

TITLE: _____

DATE: _____