PERU ELEMENTARY SCHOOL DISTRICT #124 HEALTH REIMBURSEMENT ARRANGEMENT PLAN

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PERU ELEMENTARY SCHOOL DISTRICT #124 HEALTH REIMBURSEMENT ARRANGEMENT PLAN

ARTICLE I

INTRODUCTION

1.1 <u>Creation and Title.</u> The Employer hereby adopts their welfare benefit plan under the terms and conditions set forth in this document. The Plan is known as Peru Elementary School District #124 Health Reimbursement Arrangement Plan.

1.2 <u>Effective Date.</u> The provisions of the Plan shall be effective as of September 1, 2014. Each Plan Year begins January 1st and ends December 31st, with the exception of the first Plan Year which begins September 1st, 2014 and ends December 31st, 2014.

1.3 <u>Purpose.</u> The purpose of the Plan is to provide reimbursement for certain medical expenses of Participants not otherwise covered by insurance or by the Employer. The Employer intends that the Plan qualify as an accident and health plan under Section 105(e) of the Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participants' income under Section 105(b) of the Code.

ARTICLE II

DEFINITIONS

As used in this Plan document, the following terms shall have the following meanings:

2.1 **"Agreement to Participate"** means the agreement evidencing an Eligible Employee's election to participate in the Plan and setting forth the amount of Health Reimbursement Benefits to be made available to the Participant for a Plan Year or portion of a Plan Year as reimbursement for Qualified Expenses.

2.2 **"Benefits Enrollment Form"** means a form provided by the Employer on which an Eligible Employee will list all of their dependents insured under the employer's group health plan.

2.3 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

2.4 **"Compensation"** means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Code.

2.5 **"Dependent"** means an individual who is a dependent within the meaning of Section 152(a) of the Code of a Participant in the Plan.

2.6 **"Effective Date"** shall be September 1, 2014.

2.7 **"Eligible Employee"** means an Employee who works at least thirty (30) hours per week, and is participating in the Employer's group health care program, except for: (1) employees who are self-employed individuals as defined in section 401(c) of the Internal Revenue Code(including sole proprietors and partners in a partnership), and (2) employees who own (or are considered to own within the meaning of section 318 of the Internal Revenue Code) more than 2 percent of the outstanding stock of an S corporation or stock possessing more than 2 percent of the total combined voting power of all stock of such corporation

2.8 **"Employee"** means a person who is currently or hereafter employed by the Employer, or by any other employer aggregated under sections 414(b), (c), (m), (n) or (o) of the Code and the regulations there under, including a Leased Employee subject to section 414(n) of the Code. Excluding individuals who are not contemporaneously classified as Employees of the Employer for purposes of the Employer's payroll system (including, without limitation, individuals employed by temporary help firms, technical help firms, staffing firms, employee leasing firms, professional employer organizations or other staffing firms whether or not deemed to be "common law" Employees or "Leased Employees" within the meaning of section 414(n) (o) of the Code) are not considered to be Eligible Employees of the Employer and shall not be eligible to participate in the Plan. In the event any such individuals are reclassified as Employees for any purpose, including without limitation, common law or statutory employees, by any action of any third party, including, without limitation, any government agency, or as a result of any private lawsuit, action, or administrative proceeding, such individuals shall notwithstanding such reclassification, remain ineligible for participation hereunder. Notwithstanding foregoing, the exclusive means for individuals who are not contemporaneously classified as an Employee of the Employer on the Employer's payroll system to become eligible to participate in this Plan is through an amendment to this Plan, duly executed by the Employer, which specifically renders such individuals eligible for participation hereunder.

The Plan Administrator shall have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member). The Plan Administrator's decision shall be final, binding and conclusive on all parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude all individuals who are not considered Employees for purposes of the Employer's payroll system, and the Plan Administrator is authorized to do so, despite the fact that its decision may result in the loss of the Plan's tax qualification.

2.9 **"Employer"** means Peru Elementary School District #124 , or any of its affiliates, successors or assignors, which adopt the Plan.

2.10 **"Health Reimbursement Benefits"** means, for any Plan Year, the amount available to a Participant as benefits in the form of reimbursements of Qualified Expenses.

2.11 **"Health Reimbursement Benefits Account"** means the account established by the Plan Administrator under the Plan for each Participant from which benefits in the form of reimbursements of Qualified Expenses shall be paid.

2.12 **"Participant"** means any Employee who has met the eligibility requirements of Section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Benefits Enrollment Form.

2.13 **"Plan"** means Peru Elementary School District #124 Health Reimbursement Arrangement Plan, as described herein.

2.14 **"Plan Administrator"** means the Employer or such other person or committee as may be appointed by the Employer to administer the Plan.

2.15 **"Plan Entry Date"** means for each Eligible Employee, the 1st day of the next month immediately following satisfaction of the eligibility requirements.

2.16 **"Plan Year"** means the 12-consecutive month period beginning on January 1st and ending on December 31st, with the exception of the first Plan Year which begins September 1st, 2014 and ends December 31st, 2014 resulting in a short Plan Year.

2.17 **"Qualified Expenses"** mean the medical expenses incurred during a Plan Year by a Participant, the Participant's Spouse or the Participant's Dependents while the Participant is a Participant and are approved deductible expenses through the employer's group health insurance plan. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

2.18 **"Spouse"** means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

ARTICLE III

PARTICIPATION

3.1 Eligibility. Each Employee, working at least thirty (30) hours per week, so long as the Employee is employed by the Employer as of his or her Entry Date and is participating in the employer's group health insurance plan.

3.2 Commencement of Participation. An Eligible Employee shall become a Participant in the Plan after providing the Plan Administrator with an executed Benefits Enrollment Form and will enter on the first day of the month immediately following satisfaction of the eligibility requirements.

3.3 Term of Participation. Each Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

(a) the date the Participant dies, resigns or terminates employment with the Employer, subject to the provisions of Section 3.4;

(b) the date the Participant ceases to be an Employee; or

(c) the date the Plan terminates.

3.4 Treatment of Rehired Employees. A Participant whose employment terminates and who is subsequently re-employed with less than 30 days separation of service will immediately rejoin the Plan.

A Participant whose employment terminates and who is subsequently re-employed with more than 29 days separation of service will need to re-satisfy Plan eligibility requirements to rejoin the Plan.

3.5 HIPAA Portability. Notwithstanding any other provisions in this Article III, any Employee who becomes eligible under the Health Portability and Accountability Act of 1996("HIPAA") for coverage by an Accident or Health benefit under the Plan shall be allowed to participate in the Plan, so long as such Employee complies with the provisions set out in HIPAA.

3.6 COBRA Continuation Coverage. Under COBRA, This section 3.6 shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Notwithstanding any other provisions in this Article III, any Participant, Spouse or Dependent eligible for continuation coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, shall be allowed to continue to participate in the Plan, so long as such Participant, Spouse or Dependent complies with the provisions set out in COBRA.

The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

3.7 Family Medical Leave Act. Under the FMLA, the provisions of this section 3.7 shall not be available to Employees for such Plan Years in which the Employer has 50 or fewer Employees. For Plan Years in which the Employer has more than 50 Employees, the Employer must make FMLA leave available to Employees for up to 12 weeks in connection with the birth or adoption of a child, or to care for a close relative, or because of a serious health condition of the Employee.

Payment Option for coverage while on unpaid Family Medical Leave Act leave for group plans:

(a) Pay-as-you-go. Employees may pay the premium payments on the same schedule as payments would be made if the employee were not on leave, or under another schedule permitted under Department of Labor regulations.

The Employer shall not be required to continue the health coverage of an Employee who fails to make required premium payments while on FMLA leave. However, if the Employer chooses to continue the health coverage of an Employee who fails to make required premium payment while on FMLA leave, the Employer is entitled to recoup those payments after the Employee returns from FMLA leave.

ARTICLE IV

BENEFITS

4.1 <u>Provision of Benefits.</u> Benefits under the Plan shall take the form of reimbursement of Qualified Expenses incurred by a Participant, the Participant's Spouse and the Participant's Dependents during the Plan Year. A Participant shall be entitled to benefits under the Plan for Qualified Expenses incurred only while a Participant.

4.2 <u>Amount of Reimbursement.</u> A Participant shall be entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's Health Reimbursement Arrangement Benefits. The amount of a Participant's Health Reimbursement Arrangement Benefits shall be available all during the Plan Year.

4.3 <u>Account Rollover.</u> If a Participant has any unused balance at the end of the Plan Year, they may not rollover the remaining balance into the subsequent Plan Year. The unused balance will be forfeited.

4.4 <u>Nondiscriminatory Benefits.</u> The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated employees from participation in the Plan if, in the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

4.5 <u>Maximum Benefits.</u> Notwithstanding any other provisions of this Plan, no Participant shall receive Health Reimbursement Benefits in excess of $1000 for single coverage or $3000 for family coverage per plan year.

The employee will be responsible for the first $500 of medical expenses approved by the Employer’s group health plan and are applied to the employee deductible. The HRA Plan will then reimburse the employee for the next $1000 of medical expenses approved by the Employer’s group health plan that are applied to the employee’s deductible, per self, spouse or dependent (family x 3).

The plan will run on a calendar year basis.

ARTICLE V

FUNDING AND PAYMENT OF BENEFITS

5.1 **Funding.** The Employer shall contribute amounts necessary to fund the Plan, as determined primarily by the amount of the Health Reimbursement Benefits to be made available for the Plan Year. Contributions to the Plan shall be made to, and all Plan assets shall be held in, such accounts or funds as the Employer deems appropriate.

5.2 **Participants' Accounts.** The Plan Administrator shall establish a separate Health Reimbursement Benefits Account for each Participant in the Plan. The Plan Administrator shall credit a Participant's Health Reimbursement Benefits Account with the amount of Health Reimbursement Benefits to be made available to the Participant. The Plan Administrator shall charge a Participant's Health Reimbursement Benefits Account in the amount of any reimbursements made to the Participant. The Plan Administrator may also establish a minimum reimbursement amount below which requests for reimbursement shall not be made during the Plan Year, but which, must be made by the end of the Plan Year (including the period set forth in Section 5.4).

5.3 **Payment of Benefits.** Reimbursement shall only be made under the Plan on the basis of Qualified Expenses incurred by the Participant, the Participant's Spouse or the Participant's Dependents, as presented to the Plan Administrator on a written form specified by the Plan Administrator and as evidenced by a written statement from a third party. It shall be the duty of the Plan Administrator to construe what are and what are not Qualified Expenses subject to reimbursement from a Participant's Health Reimbursement Benefits Account. If the Plan Administrator determines that an expense is a Qualified Expense subject to reimbursement, the Plan Administrator shall reimburse the Participant for the Qualified Expense within a reasonable time. To make the determination that a Qualified Expense subject to reimbursement has been incurred, the Plan Administrator may require proper evidence of any or all of the following:

(a) the name of the person or persons for whom the expenses have been incurred;

(b) the nature of the expenses incurred and provider;

(c) the date the expenses were incurred;

(d) the amount of the requested reimbursement; or

(e) that the expenses have not been otherwise paid through an insurance program offered by the Employer or any other employer, or reimbursed from any other source.

The Plan Administrator shall be the sole arbiter of what constitutes a Qualified Expense subject to reimbursement under the Plan.

In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority:

(a) Executor of the Estate of the deceased Participant,

(b) Spouse,

(c) Family member held responsible for payment of deceased's medical bills,

(d) Spouse of dependent with COBRA continuation rights.

5.4 Forfeiture of Benefits. A Participant forfeits any amount of Health Reimbursement Benefits under the Plan for a Plan Year if a claim for reimbursement is not provided to the Plan Administrator within 90 days after the last day of the Plan Year or the last day of participation in the Plan, if earlier. Upon such forfeiture, the Participant's Health Reimbursement Benefits Account shall be reduced to zero. Forfeitures of benefits shall become the sole property of the Employer.

ARTICLE VI

PLAN ADMINISTRATION

6.1 <u>Plan Administrator.</u> The Plan Administrator shall be responsible for the administration of the Plan.

6.2 <u>Plan Administrator's Duties.</u> In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator shall have the following rights, duties and powers:

(a) to interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;

(b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;

(c) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;

(d) to develop appellate and review procedures for any Participant, Spouse, Dependent or beneficiary denied benefits under the Plan;

(e) to provide the Employer with such tax or other information it may require in connection with the Plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to report to the Employer, or any party designated by the Employer, after the end of each Plan year regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

However, nothing in this section 6.2 is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure, or Benefit Provider. Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he sees fit to assure that the Plan complies with the nondiscrimination requirements of Section 105 of the Code.

6.3 <u>Information to be Provided to Plan Administrator.</u> The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant or Dependent or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the Plan Administrator might reasonably request to insure the proper and efficient administration of the Plan.

6.4 <u>Decision of Plan Administrator Final.</u> Subject to applicable State or Federal law, and the provisions of Section 6.5, below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake

of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

6.5 Review Procedures. In cases where the Plan Administrator denies a benefit under this Plan for any Participant, Spouse or Dependent or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish in writing to said party the reasons for the denial of benefits. The written denial shall be provided to the party within 30 days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within 180 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his final decision on the reviewed claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

6.6 Extensions of Time. In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any Participant, Spouse, Dependent or designated beneficiary may need to appeal a claim, upon proper application to the Plan Administrator.

6.7 Rules to Apply Uniformly. The Plan Administrator shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

6.8 Indemnity. The Employer does hereby agree to indemnify and hold harmless, to the extent allowed by law and over and above any liability coverage contracts or directors and officers insurance, any sole proprietor, member, partner, officer or director of the Employer, designated by the Employer or the Plan Administrator who has been employed, hired or contracted to assist in the fulfillment of the administration of this Plan. In addition, the Employer agrees to pay any costs of defense or other legal fees incurred by any of the above parties over and above those paid by any liability or insurance contract.

6.9 HIPAA Privacy.

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Protected Health Information (PHI) provisions of the Health Insurance Portability and Accountability Act of 1997 (HIPAA) and its regulations (“Rules”) include privacy protections impacting group handling health plan medical or financial information that could identify an individual. Individually identifiable information is protected whether it is in electronic, paper or oral format. The HIPAA rules give individuals control over health and financial information related to their health care. PHI may be used only for limited purposes without consent, and in many situations only upon individual authorization. Regarding their own PHI, you have the right to:

(1) object to using information;

(2) gain access to information;

(3) change information; and

(4) obtain an accounting of any information disclosures.

An underlying principle of the rules is that the "minimum necessary" disclosure should be the standard when using or disclosing information in the normal course of treatment, payment or health plan operations.

You are guaranteed access to your PHI and have the right to: (1) copy and amend health information; (2) receive an accounting of PHI uses; and (3) receive notices of health plans' information practices. You have the right to request that PHI use and disclosure be restricted even for treatment and payment purpose.

The Plan places restrictions on the Employer's use or disclosure of PHI received from the plan or an insurer. Insurers may determine what information will be available to the Plan.

The Plan will meet the minimum necessary uses and disclosures provisions of HIPAA for PHI. However, the minimum necessary provisions do not apply to the following:

- Disclosures to or request by a health care provider for treatment purposes;
- Disclosures to the individual who is the subject of the information;
- Uses or disclosures made based on an authorization requested by the individual;
- Uses or disclosures required for compliance with HIPAA's transaction standards;
- Disclosures to HHS when the rule requires the disclosure of information for enforcement purpose; and
- Uses or disclosures that are required by other laws.

Any uses or disclosures for which the covered entity has a valid authorization is exempt.

Marketing

The group health plan(s) and other covered entities, as defined by HIPAA, will not use or disclose PHI for marketing purposes without your authorization, except for face-to-face communications with the individual or promotional gifts of nominal value.

Communications that are part of treatment or are about a plan's benefits, services or operations are excluded from the definition of marketing, even if they promote the use or sale of a service or product.

Specifically excluded from the definition of marketing communications about:

- Participating providers and health plans in a network, the services offered by a provider or the benefits covered by a health plan;
- Treatment of the individual; and
- Case management or care coordination for the individual, or directions or recommendations for alternative treatments, therapies, health care providers or settings of care to that individual.

This health plan is not engaging in marketing when it advises enrollees about other available health coverage that could enhance or substitute for existing health coverage. For example, if a child is about to age out of coverage under a family policy, the plan may send the family information about

continuation coverage for the child. This exception does not extend to excepted benefits under HIPAA, such as accident-only policies or auto medical liability, nor to other lines of insurance. For example, a multi-line insurer may not use PHI to promote its life insurance policies.

It is not marketing for a health plan to communicate about health-related products and services available only to plan enrollees or members that add value to but are not part of a plan of benefits. To qualify for this exclusion, the communication must meet two conditions:

(1) It must be health-related. For example, offers of discounts for eyeglasses may be considered part of plan benefits. This exclusion appears to included wellness programs that offer incentives to adopt healthy lifestyle behaviors.

(2) It must offer an added value of plan membership and not merely be a pass-through of a discount or item available to the public at large. Thus, a plan could offer its members a special discount for a health/fitness club, but not pass along to its members discounts that the members could obtain directly from the club.

For marketing activities permitted by an authorization, if there is remuneration,

the marketing material must state that the entity making the communication is being paid by another entity.

Underwriting

An insurer that receives protected group health plan information for underwriting, premium rating and other similar purpose – and that coverage is not placed with the insurer- cannot use or disclose the information for any purpose other than as required by law.

Verification

In any disclosure other than those allowing the individual to agree or object, verifying the identity of anyone requesting PHI who is not known to the health plan or other covered entity must first occur.

If disclosure is conditional on documentation or statements from the person seeking PHI, that documentation or statement must be obtained before the PHI can be disclosed.

ARTICLE VII

GENERAL PROVISIONS

7.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant, Spouse, Dependent or beneficiary was entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendments apply retroactively to the extent necessary so that the Plan remains in compliance with Section 105 of the Code or any other provision of the Code applicable to the Plan.

7.2 Non-assignability. Any benefits to any Participants under this Plan shall be non-assignable and for the exclusive benefit of Participants, Spouses, Dependents and beneficiaries. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

7.3 Medical Child Support Orders. The Plan Administrator shall adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which

(i) relates to the provision of child support related to health benefits for a child of a Participant of a group health plan

(ii) is made pursuant to a state domestic relations law and

(iii) which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.

The Plan administrator shall promptly notify the Participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Any such Qualified Medical Child Support Order (QMCSO) must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Any such QMCSO shall not require the Plan to provide any type or form of benefit, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Reconciliation Act of 1993 (OBRA '93).

Upon determination of a Qualified Medical Child Support Order, the Plan must recognize the QMCSO by providing benefits for the Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

7.4 Not an Employment Contract. By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any employee or Participant under this Plan. Participation in this Plan shall in no way assure

continued employment with the Employer.

7.5 Participant Litigation. In any action or proceeding against the Plan, or the administration thereof, employees or former employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their registered representatives shall be the sole source for service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the Employer and any interested party to the Plan.

7.6 Addresses, Notice and Waiver of Notice. Each Participant shall furnish the Employer with his correct post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

7.7 Required Information. Each Participant, Spouse or Dependent shall furnish to the Employer such documents, evidence or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

7.8 Severability. In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

7.9 Applicable Law. The Plan shall be construed under the laws of the State of New York, to the extent not preempted by any Federal law.

Executed this _________ day of _____________, 2014.

Employer: Peru Elementary School District #124

____
Mark Cross, Superintendent