PERU ELEMENTARY SCHOOL DISTRICT #124 HEALTH REIMBURSEMENT ARRANGEMENT PLAN

SUMMARY PLAN DESCRIPTION

Summary Plan Description

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Article I

INTRODUCTION TO YOUR PLAN

Peru Elementary School District #124, offers a "Health Reimbursement Arrangement Plan" as part of your employee benefits program. This Plan was implemented as of September 1, 2014. This Plan is intended to qualify under Section 105 of the Internal Revenue Code (IRC). Under IRC Section 105, you can take advantage of the tax-free benefits offered under the Plan, as described in this summary.

Your Employer pays the full cost of the Health Reimbursement Arrangement Plan. Before the start of each Plan Year, your Employer will tell you the maximum reimbursement that will be available to you for the year. You must, however, complete an enrollment form listing your covered dependents.

This Summary Plan Description is a brief description of the Plan and your rights, benefits and obligations under the Plan. This Summary Plan Description is not meant to interpret, extend or change any provision contained in the main Plan Document. The provisions of Peru Elementary School District #124 Health Reimbursement Arrangement Plan can only be accurately understood by reading the Plan Document. This Document is on file with the Employer and may be read by you or your dependents or your legal representative by contacting the Benefits Coordinator. The Benefits Coordinator's office will make the Document available to you at any reasonable time. You may request a copy of the Plan from the Plan Administrator, who may charge you a fee for copying the Plan for you.

Article II

GENERAL INFORMATION

You may need the following information if you have any questions about your Plan.

1. GENERAL PLAN INFORMATION

The name of this Plan is the Peru Elementary School District #124 Health Reimbursement Arrangement Plan.

Your Employer has assigned Plan Number 551 to this Plan.

The provisions of your Plan became effective as of September 1, 2014.

This Plan's records are maintained on a 12-month period known as the Plan Year. The Plan Year for your Plan is January 1st through December 31st, with the exception of the first Plan Year which begins September 1, 2014 and ends December 31st, 2014 resulting in a short Plan Year.

Your Plan shall be governed by the Laws of the State of Illinois.

2. EMPLOYER INFORMATION

The name, address and tax identification number of the Employer are:

Peru Elementary School District #124
1800 Church St.
Peru, IL 61354
(815) 223-0486
36-6004953

3. PLAN ADMINISTRATOR INFORMATION

The name, address and telephone number of your Plan Administrator are:

Peru Elementary School District #124
1800 Church St.
Peru, IL 61354
(815) 223-0486

Your Plan Administrator is responsible for the administration of your Plan. Should you need to see any records or have any questions regarding the Plan, contact the Plan Administrator.

4. BENEFITS COORDINATOR

Human Resources has been named as the Plan's Benefits Coordinator Department. If you need additional information about the plan or the benefits offered, the Benefits Coordinator Department will be able to assist you.

5. LEGAL REPRESENTATIVE

The following person has been named your Plan's agent for service of legal process:

Michael Lieber
Peru Elementary School District #124
1800 Church St.
Peru, IL 61354

Service of process can also be made upon the Plan Administrator.

Article III

PARTICIPATION IN YOUR PLAN

All employees who meet the participation requirements are eligible to participate in this Plan.

To qualify as a participant under this Plan, you must meet the following requirements:
- You must be participating in the employer's group health insurance plan.
- You must be working at least 30 hours per week.

If you become eligible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for coverage by an Accident or Health Benefit available under the Plan you shall be allowed to participate in the Plan, so long as you comply with the provisions set out in HIPAA. See your Plan Administrator for details.

Your Plan Entry Date, the date you may actually join the Plan, will be the first day of the next month immediately following satisfaction of the eligibility requirements.

MAXIMUM ANNUAL REIMBURSEMENT BENEFITS

The Employer, with the approval of the Board of Directors, determines the maximum reimbursement benefit each eligible employee will receive before the start of the new plan year. Every employee who meets the eligibility requirements will be assigned the same maximum amount of benefit, to be used in receiving reimbursement of qualified medical expenses.

BENEFITS ENROLLMENT FORM

You will be required to file a Benefits Enrollment Form. The benefits enrollment form needs to be filed before any applicable benefit or plan entry dates.

ENDING PLAN PARTICIPATION AND LEAVES OF ABSENCE

Ending Plan Participation

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.

Continuing Plan Participation under COBRA and FMLA

Special rules, called COBRA provisions, apply to certain health or medical plans. If you terminate employment or have another "qualifying event" that affects your health plan, your Benefits Coordinator will give you an explanation of COBRA and your rights to continued coverage, if COBRA applies to your plan. This applies only to employers that have 20 or more employees during the plan year.

The Family and Medical Leave Act ('the FMLA') requires employers with 50 or more employees to provide unpaid leave for eligible employees at the time of the birth or adoption of a child or at the time of a serious health condition affecting the employee or a family member.

If you are on an unpaid leave under the FMLA rules, you may continue to participate in the plan, by making contributions under the option elected by your employer.

The payment option for coverage while on unpaid Family Medical Leave Act leave for group health plans is:

i) Pay-as-you-go. Under this option, you will pay the premium payments on the same schedule as if you were not on leave, or under another schedule according to Department of Labor regulations. If you fail to make payments under this Pay-as-you-go option, your Employer is not required to continue coverage. However, if your Employer chooses to continue coverage, your employer is entitled to collect these amounts from you after you return from the FMLA leave.

Ending your participation in a reimbursement benefit affects the way the Plan Administrator will handle your requests for reimbursement, too. These rules for reimbursement benefits are explained in Article V.

Article IV

ADMINISTRATION OF YOUR PLAN

The Plan Administrator is responsible for the administration of your Health Reimbursement Arrangement Plan. The duties of the Plan Administrator include determining who is eligible to participate, interpreting laws and regulations and how they apply to your Plan and whether or not certain expenses should be allowed under the Plan.

When you are ready to enter the Plan, you must file a Benefits Enrollment Form with the Plan Administrator. After becoming a participant in the Plan, file all requests for reimbursement with the Plan Administrator. The Plan Administrator will determine, in accordance with the various laws that apply to Health Reimbursement Arrangement Plans, whether or not to grant your requests.

The Plan Administrator can demand any documents or evidence deemed necessary to properly administer your Plan. If the Plan Administrator feels that you have submitted insufficient data to make a determination, or that the request made is not allowed under the Plan, the Plan Administrator can deny your request. After the request has been denied, you will be allowed an opportunity to appeal. The Plan Administrator must furnish you in writing the reasons for the denial of your claim for benefits. The written denial must be provided to you within 30 days of the date the claim for benefits was denied by the Plan Administrator. The written denial must refer to the Plan provision, or section of the Internal Revenue 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 is required to give you 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 you 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.

If your request was denied because the Plan Administrator felt your request is not covered under the Plan, you will be given the chance to show why it should have been allowed under the Plan. If the Plan Administrator rejects your reasons, you will not be able to appeal again.

You may, however, feel that you were treated unfairly. The Employee Retirement Income Security Act of 1974 (ERISA) provides all plan participants with certain rights. If you feel the Plan Administrator violated these rights, you may be able to take legal action in a court of law. Generally, this type of action can be taken only if you can prove that the Plan Administrator did not act in accordance with the terms of your Plan, or that the Plan Administrator acted in bad faith when making its decision.

In addition to interpreting the plan and making sure that benefits are properly paid, the Plan Administrator also keeps all the records of the Plan. Should you need a copy of anything filed with the Plan Administrator, contact the Plan Administrator directly.

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 V

BENEFITS UNDER YOUR PLAN

There is one type of benefit offered under your plan, reimbursement benefits. Your Employer pays the entire cost of these benefits. You do not contribute to the cost of the Plan.

Reimbursement benefits are benefits where employer contributions are to be credited to an account for you. You can later have the Plan reimburse you when you have expenses that are considered "Qualified Expenses" under the Plan. Your Plan offers reimbursement for certain medical expenses, as authorized under the Internal Revenue Code.

REIMBURSEMENT PROGRAMS

INTRODUCTION

Your Health Reimbursement Arrangement Plan allows employer contributions to be credited to your account so that this money can later be returned to you, tax-free, to pay for certain allowed expenses, called qualified expenses.

In order for an expense to be eligible for reimbursement it must be "qualified", as explained below. It must also be incurred during the period of coverage (usually the plan year). This means that you must have received services, such as having seen the doctor, on a date during the period covered by your Benefits Enrollment Form.

Assume that your enrollment is effective as of March 1. If you saw the doctor on February 28, that expense would not be eligible for reimbursement, even if you received an invoice dated after March 1.

If your participation in the reimbursement program ends, perhaps because you terminate employment, your period of coverage ends on the day you terminate employment. Any expenses incurred after that date are ineligible for reimbursement. If you have not incurred expenses equal to the amounts deposited to your account BEFORE that date, you forfeit the unused amount.

ANY MONEY LEFT OVER AT THE END OF THE PLAN YEAR IN THIS PROGRAM BECOMES THE PROPERTY OF THE EMPLOYER. THE PLAN ADMINISTRATOR WILL FINISH THE ACCOUNTING FOR THE PLAN YEAR 90 DAYS AFTER THE LAST DAY OF THE PLAN YEAR. YOU MUST SUBMIT ANY REMAINING CLAIMS FOR REIMBURSEMENT BEFORE THAT DATE. **SHOULD YOU FAIL TO SPEND ALL THE MONEY IN YOUR ACCOUNT BEFORE THE END OF A PLAN YEAR, YOU CANNOT CARRY THAT MONEY OVER TO THE NEXT PLAN YEAR.**

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The maximum benefit payable is $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.

BENEFITS DUE TO A MEDICAL CHILD SUPPORT ORDER

Peru Elementary School District #124, established the Peru Elementary School District #124 Health Reimbursement Arrangement Plan for your benefit as an employee who participates in the plan. Under certain circumstances, your child might be treated as a Participant, also, even if you do not have custody of your child or the child is not your dependent. Those circumstances must be established through a Qualified Medical Child Support Order (QMCSO).

A QMCSO is a decree or order issued by a court that obligates you to provide health benefits for your child. If you incur this type of obligation as a result of a court ordered medical child support order, you must inform the Plan Administrator. The Plan Administrator can provide you with a copy of the Qualified Medical Child Support Order Procedure. This procedure explains the rules that the Plan Administrator must follow to properly handle a QMCSO.

The Plan Administrator will determine if a medical child support order is a Qualified Medical Child Support Order in accordance with the provisions of the Procedure, the Plan Document and Section 609(a)(3) of ERISA. If a medical child support order is found to be a QMCSO, the Plan may be obligated to provide coverage or benefits to the child under any medical benefit offered to you under the Plan.

Article VI

STATEMENT OF ERISA RIGHTS

As a participant in Peru Elementary School District #124 Health Reimbursement Arrangement Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, copies of the latest annual report (Form 5500 series if applicable), updated Summary Plan Description, collective bargaining agreements and copies of all documents filed by the plan with the Department of Labor, such as detailed annual reports and plan descriptions.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.