Title: **Medicare Premium Reimbursement Arrangement (PRA) Plan**	Original Adoption: 01 January 2020
Approved by DMI BOD: 16 January 2020	Revised/Reviewed:

Districts Mutual Insurance & Risk Management Services

Medicare Premium Reimbursement Arrangement (PRA) Plan

Effective January 1, 2020

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PLAN INFORMATION

The following Plan information is applicable as of January 1, 2020. Participants will receive timely notice of any changes in such information in accordance with applicable law.

Plan Name:	Districts Mutual Insurance & Risk Management Services Medicare Premium Reimbursement Arrangement (PRA) Plan
Type of Plan:	The Plan is a welfare benefit plan providing a premium reimbursement arrangement for Medicare Premium Expenses and is integrated with qualifying group health plan coverage.
Plan Year:	January 1 – December 31
Plan Number:	501
Effective Date:	The original effective date is January 1, 2020.
Plan Sponsor's Fiscal Year End:	December 31
Funding:	All of the amounts payable under the Plan shall be paid from the general assets of the Plan Sponsor.
Type of Plan Administration:	Districts Mutual Insurance & Risk Management Services is responsible for administering the Plan. Reimbursements under the Plan are entirely paid through the Plan Sponsor Contributions. Participants are responsible for paying for premiums for Medicare coverage. Participation in the Plan is voluntary.
Plan Sponsor:	Districts Mutual Insurance & Risk Management Services 212 West Pinehurst Trail Dakota Dunes, SD 57049 Phone: (605) 422-2655
Plan Sponsor's Employer Identification Number:	76-0756043

Companies Providing Insurance or Administrative Services:	The Plan Sponsor is responsible for the administration of this Plan. Medicare coverage is provided through an Insurance Carrier providing Medicare Part B or Part D coverage or Medicare supplement coverage. Each Insurance Carrier provides insurance services with respect to the benefits it provides.
Plan Administrator:	Districts Mutual Insurance & Risk Management Services 212 West Pinehurst Trail Dakota Dunes, SD 57049 605-422-2655
Third-Party Administrator	Districts Mutual Insurance & Risk Management Services 212 West Pinehurst Trail Dakota Dunes, SD 57049 605-422-2655
Claim Administrator	District Mutual Insurance & Risk Management Services 212 West Pinehurst Trail Dakota Dunes, SD 57049 605-422-2655
Named Fiduciary:	Districts Mutual Insurance & Risk Management Services 212 West Pinehurst Trail Dakota Dunes, SD 57049 605-422-2655
Agent for Service of Legal Process	Service of legal process may be made on the Plan Administrator. Districts Mutual Insurance & Risk Management Services c/o CT Corporation Systems 301 South Bedford Street, Suite 1 Madison, WI 53703
Combined Plan Document and Summary Plan Description:	This document and its attachments constitute the written plan document required by ERISA Section 402 and the summary plan description (“SPD”) required by ERISA Section 102.

ARTICLE 1
Introduction

Establishment of Plan

Districts Mutual Insurance & Risk Management Services hereby establishes the Districts Mutual Insurance & Risk Management Services Medicare Premium Reimbursement Arrangement (PRA) Plan (the "Plan") effective January 1, 2020. This Plan is intended to permit an Eligible Employee to obtain reimbursement of certain Medicare Premium Expenses on a nontaxable basis from his or her PRA Account.

Legal Status

This Plan is intended to be Medicare premium reimbursement arrangement as defined under IRS Notice 2015-17. The Medicare Premium Expenses reimbursed under the Plan are intended to be eligible for exclusion from the Participant's gross income under Code Section 105(b). This Plan is intended to be an employer-provided premium reimbursement plan under Code Sections 105 and 106 and the regulations issued thereunder. This Plan is integrated with the Group Health Plan, but does not provide reimbursements for any medical-related expenses related to the Group Health Plan. This Plan is not intended to be integrated with Medicare Parts B or D.

ARTICLE 2
Definitions

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

2.1 "**Board**" means the Board of Directors of Districts Mutual Insurance & Risk Management Services.

2.2 "**Claim Administrator**" means Districts Mutual Insurance & Risk Management Services or such other third-party administrator to whom such authority has been delegated and is identified herein.

2.3 "**COBRA**" means Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

2.5 "**Dependent**" means (a) any individual who is a Participant's child as defined by Code Section 152(f)(1) and who has not attained age 26, and (b) any tax dependent of a Participant as defined in Code Section 105(b) provided, however, that any child to whom Code Section 152(e) (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) applies is treated as a dependent of both parents. Notwithstanding the foregoing, this Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of "Dependent.

2.6 "**Effective Date**" means January 1, 2020.

2.7 "**Eligible Employee**" means an Employee eligible to participate in this Plan pursuant to Section 3.1

2.8 "**Employee**" means, unless specifically otherwise indicated herein, an individual whom the Plan Sponsor classifies as a common-law employee of the Plan Sponsor and who is on the Plan Sponsor's W-2 payroll, but does not include the following: (a) any agency or leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)) or an individual classified by the Plan Sponsor as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Plan Sponsor's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Plan Sponsor; (b) any individual who performs

services for the Plan Sponsor but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Plan Sponsor; (c) any employee covered under a collective bargaining agreement; and (d) any self-employed individual.

2.9 "**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

2.10 "**FMLA**" means the Family and Medical Leave Act of 1993, as amended.

2.11 "**Group Health Plan**" means the Districts Mutual Insurance & Risk Management Services Health Plan.

2.12 "**Highly Compensated Individual**" means an individual defined under Code §105(h), as amended, as a "highly compensated individual."

2.13 "**Insurance Carrier**" means the insurance carrier selected by the Participant to provide Medicare insurance coverage.

2.14 "**IRS**" means the Internal Revenue Service.

2.15 "**Medicare Premium Expense**" means the amount paid by the Participant to purchase Medicare Part B coverage.

2.16 "**Participant**" means an Eligible Employee who is eligible to participate as provided in Section 3.5 and whose coverage in the Plan has not ceased as provided in Sections 3.6.

2.17 "**Plan**" means the Districts Mutual Insurance & Risk Management Services Medicare Premium Reimbursement Arrangement (PRA) Plan, as amended.

2.18 "**Plan Administrator**" means Districts Mutual Insurance & Risk Management Services.

2.19 "**Plan Sponsor**" means Districts Mutual Insurance & Risk Management Services.

2.20 "**Plan Sponsor Contributions**" mean the contributions made by the Plan Sponsor on behalf of the Participant as described in Sections 4.2 and 5.3

2.21 "**Plan Year**" means the twelve-month period beginning each January 1 and ending the following December 31.

2.22 "**Period of Coverage**" means the Plan Year except [(a) for Eligible Employees who first become Participants, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.5; and (b)] for Participants who

terminate participation, it shall mean the portion of the Plan Year prior to the date participation in the Plan terminates, as described in Section 3.6. A different Period of Coverage (e.g., a calendar month) may be established by the Plan Administrator and timely communicated to Eligible Employees.

2.23 "**PRA Account**" means the premium reimbursement recordkeeping account established for a Participant to track his or her Plan Sponsor Contribution credits and debits.

2.24 "**Spouse**" means the person to whom an Eligible Retiree is legally married, unless legally separated by court decree.

2.25 "**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE 3
Eligibility and Participation

3.1 Eligibility

An individual is an Eligible Employee and may participate in this Plan, subject to Section 3.3 and 3.4, if the individual is an Employee who is eligible for the Group Health Plan and has obtained and maintains Medicare Part A and Part B coverage. An Eligible Employee's Spouse or Dependent will never be considered eligible to participate in this Plan; however, the Employee may obtain reimbursement for Medicare Premium Expenses incurred by such Spouse or Dependent.

3.2 Notice of Medicare Coverage

An Employee who intends to enroll in Medicare coverage or for which an eligible Spouse or Dependent intends to enroll in Medicare is encouraged to notify the Plan Administrator in writing of such intent to enroll at least 3 months prior to enrollment. Failure to provide the Plan Administrator with sufficient notice may delay or forfeit the otherwise Eligible Employee's coverage in this Plan.

3.3 Enrollment

For an Eligible Employee to become a Participant in the Plan, the Eligible Employee must complete and submit the enrollment form and other enrollment procedures as may be required by the Plan Administrator, including notice of Medicare coverage in accordance with Section 3.2 within 90-days of the Medicare coverage effective date. The Plan Administrator may require the Participant to submit proof of Medicare coverage (i.e., a copy of the Medicare enrollment card) when available and before any claims are processed. The Participant must promptly notify the Plan Administrator if any information on the enrollment form changes.

3.4 Participant's Obligation to Have Accurate Information on File

An Eligible Employee may only participate in this Plan if accurate documents, including enrollment forms and other relevant documents associated with the Employee's employment and benefits as may be required by the Plan Administrator, have been filed with the Plan Administrator and other appropriate entities providing benefits and services under the Plan. Such documents and information on file must at all times remain fully accurate in all respects. If any such information changes, it is the Participant's responsibility to inform the Plan Administrator and other appropriate entities providing benefits and services of such change. A failure to do so could result in a denial of coverage or benefits with respect to a Participant or possibly a rescission or revocation of coverage in the event a Participant engages in an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact.

Any employer, company, insurer, claim administrator or other person or entity who suffers any harm or loss due to any false statement contained in information the Participant has provided may bring a civil action against either the Participant to recover losses, including reasonable attorney's fees.

3.5 Participation

An Eligible Employee will become a Participant in this Plan on the first day of the calendar month immediately following the date on which the Employee obtains and maintains Medicare Part B coverage, provided the Eligible employee provides notice of Medicare Coverage as required by the Plan Administrator pursuant to Section 3.2 and properly completes the enrollment forms and other enrollment documents as required by the Plan Administrator pursuant to Section 3.3. Notwithstanding the preceding sentence, an Eligible Employee may become a Participant in this Plan on the first day of such calendar month as the Eligible Employee becomes a Medicare participant eligible as long as documentation as requested in Section 3.2 and 3.3 is provided within 90-days of such Medicare effective date. No Medicare Premium Expenses will be processed until the requirements of Section 3.2 and 3.3 are completed. Once an Eligible Employee is enrolled as a Participant, his or her participation will continue year to year until his or her participation ceases pursuant to Sections 3.6.

3.6 Termination of Participation

Eligibility to participate in the Plan terminates upon the earlier of:

(a) The date the Participant ceases to satisfy any requirement necessary to be an Eligible Employee under this Plan for any reason, including death;

(b) The effective date of any amendment terminating the Participant's eligibility under this Plan or the Group Health Plan;

(c) The day before the date in which the Group Health Plan is no longer secondary to Medicare (i.e., the date Medicare eligible Employees are no longer required to enroll in Medicare Part B to be covered by the Group Health Plan);

(d) The date the Plan Administrator discovers fraud or intentional misrepresentation of material fact by the Participant; or

(e) The date this Plan is terminated.

Any reimbursements from the PRA Account after termination of participation will be made pursuant to Section 5.6.

3.7 Participation Following Termination of Employment or Loss of Eligibility

If either: (i) a Participant terminates his or her employment or is terminated for any reason (including, but not limited to, disability, layoff, or voluntary resignation), and is rehired; or (ii) a Participant loses eligibility for any reason and subsequently regains eligible status, then the Employee will be reinstated immediately upon rehire or re-eligibility. For purposes of this Plan, the Participant's available balance shall be prorated based on the amount which existed in the account on the date of termination or loss of eligibility, less any reimbursements which were made to the Participant following such date, plus a prorated amount for the remaining months of the Plan Year in which reinstatement occurs.

ARTICLE 4
Methods of Funding

4.1 Plan Funding

All of the amounts payable under this Plan will be provided by the Plan Sponsor out of its general assets; no assets are segregated or earmarked for the purpose of providing benefits under this Plan. Nothing herein will be construed to require the Plan Sponsor or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Plan Sponsor from which any payment under this Plan may be made. There is no trust or other fund from which payments are made.

4.2 Plan Sponsor and Participant Contributions

The Plan Sponsor funds the full amount of the PRA Account. Contributions to the Plan by Participants are not permitted. Under no circumstances will a PRA Account be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

4.3 PRA Account

When an Eligible Employee becomes a Participant in accordance with Article 3, a PRA Account will be established for such Participant to receive reimbursements for Medicare Premium Expenses. The Plan Administrator or its delegate will record the amounts credited and debited against the Participant's PRA Account in accordance with Section 5.4. Amounts credited to a PRA Account do not represent actual deposits made on behalf of the Participant to a separate irrevocable account or trust, but are recordkeeping accounts representing contributions that may be paid by the Plan Sponsor for purposes of funding this Plan from which payments will be made to Participants in accordance with the terms of the Plan. These recordkeeping accounts are not the property of any Participant and the benefits associated with such accounts are subject to forfeiture pursuant to the terms of this Plan, as determined by the Plan Administrator.

Medicare Premium Expense Reimbursements

5.1 Benefits Offered

The Plan will reimburse a Participant for Medicare Premium Expenses up to the unused amount in the Participant's PRA Account. Participants are wholly responsible for paying all Medicare Premium Expenses due to an Insurance Carrier or other provider. Payments under this Plan will be made only to Participants, except as otherwise provided in Section 5.7. No payments will be made directly to any Insurance Carrier or other provider.

5.2 Eligible Plan Reimbursements

Under the PRA Account, a Participant may receive reimbursement for those after-tax Medicare Premium Expenses incurred by the Participant during a Period of Coverage. An expense is incurred for purposes of this Plan when the Medicare Premium Expense is paid. A Participant may not receive reimbursement for the following under this Plan:

(a) Medicare Premium Expenses which were incurred by an Employee or his or her Spouse or Dependents before the date the Employee became a Participant.

(b) Any expenses that are not Medicare Premium Expenses.

(c) Any portion of an eligible Medicare Premium Expense for which payment was made to the Participant on a pretax basis or for which the Participant has received reimbursement from any other employer-provided reimbursement arrangement; flexible spending account plan; insurance company, group, individual, or third-party; or any governmental insurance program.

(d) Medicare Premium Expenses which were incurred by an Employee or his or her Spouse or Dependents after the date the Employee is no longer a Participant.

(e) Medicare Premium Expenses based on false, misleading, or incomplete statements by, or on behalf of the Participant.

(f) Medicare Premium Expenses, which are in violation of applicable law, the terms of the Plan, or where the Plan Administrator determines that the reimbursement would be administratively burdensome or infeasible.

If a claim is processed for an ineligible expense, a refund by the Participant will be pursued in accordance with Section 8.8.

If a Participant has other coverage that will provide reimbursement for the unpaid Medicare Premium Expense first, the Participant must determine from which plan to request reimbursement. The Participant is solely responsible for ensuring that reimbursement on a pretax basis for eligible expenses does not occur more than once.

5.3 Maximum Annual Plan Sponsor Contributions

The maximum dollar amount that will be credited to a PRA Account for a Participant who participates for an entire 12-month Period of Coverage will be determined annually by the Board and timely communicated to Eligible Employees through the Employer electronic communications or other documentation, which are hereby incorporated by reference and made a part of this Plan.

Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code Section 105(h), as may be determined by the Plan Administrator in its sole discretion.

5.4 Credits and Debits to the PRA Account

The Plan Administrator will establish and maintain a PRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The PRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts as determined in this Section 5.4.

(a) A Participant's PRA Account will be credited in an amount equal to the applicable maximum dollar amount for the Period of Coverage. The maximum dollar amount will be credited upon the date the Employee becomes a Participant in the Plan pursuant to Section 3.5 and as soon as administratively possible upon the beginning of each subsequent Period of Coverage as long as the Employee remains a Participant in the Plan and will be available for reimbursement of Medicare Premium Expenses in accordance with this Article 5.

(b) A Participant's PRA Account will be debited during each Period of Coverage for any reimbursement of Medicare Premium Expenses incurred during the Period of Coverage.

(c) Participants are eligible to receive reimbursement for eligible Medicare Premium Expenses up to the actual amount remaining in the Participant’s PRA Account at the time the claim for reimbursement is made. The amount available for reimbursement is the amount credited to the Participant's PRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b). No reimbursements will be made for any amount that exceeds the amount available in the Participant’s PRA Account.

5.5 Forfeitures

Any balance remaining in a Participant's PRA Account for a Period of Coverage after all reimbursements have been made for that Period of Coverage will be forfeited following the close of the run-off period described in Section 5.8. If an individual ceases to be a Participant for any reason described in Sections 3.6, expenses incurred after such time will not be reimbursed, and any balance remaining will be forfeited after all reimbursements have been made subject to Section 5.8. In addition, any reimbursement payments that are unclaimed (e.g., uncashed benefit checks) more than 180 days following the close of the Plan Year in which the Medicare Premium Expense was incurred will be forfeited. Forfeited amounts remain in the general assets of the Plan Sponsor.

5.6 Reimbursements after Termination

When a Participant ceases to be a Participant under Section 3.6, the Participant (or the Participant's estate) will not be able to receive reimbursements for Medicare Premium Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medicare Premium Expenses incurred during the Period of Coverage prior to termination of participation, subject to the provisions in Section 5.8.

5.7 Reimbursements upon Mental or Physical Incompetency or Death

If the Plan Administrator determines that a Participant is incompetent by reason of illness, infirmity or any other incapacity, the Plan Administrator may direct reimbursements for such Participant's Medicare Premium Expenses to any other person for the Participant's benefit.

If a Participant dies, the Plan Administrator may direct reimbursements for such Participant's Medicare Premium Expenses to the Participant's estate or personal representative. The Participant's estate or personal representative may submit claims for Medicare Premium Expenses incurred by the Participant prior to his or her death, as long as such claims are submitted no later than 90 days after the Participant's death.

Payments made pursuant to this Section 5.7 will discharge all liability of the Plan Administrator, the Claim Administrator and the Plan Sponsor.

5.8 Reimbursement Procedures

Claims for reimbursement must be made on the appropriate form or forms, which may be requested from the Plan Administrator or the Claim Administrator. To receive reimbursements under this Plan, the Participant must submit the completed form or forms to the Claim Administrator along with a copy of the paid insurance bill or invoice related to the Medicare Premium Expense for which reimbursement is sought. If there is no bill or invoice, the Claim

Administrator may require a written statement from an independent third-party evidencing that the reimbursable expense has been incurred including:

(a) The name of the Participant, Spouse or Dependent on whose behalf the Medicare Premium Expense was incurred;

(b) The effective date of the coverage for which the Medicare Premium Expense was incurred;

(c) The amount of the Medicare Premium Expense;

(d) A statement evidencing proof of payment of the Medicare Premium Expense and the name of the service provider.

In addition, the Claim Administrator will require the Participant to attach a signed Medicare PRA claim form which provides that the reimbursable expense will not be claimed as a tax deduction and has not been paid by the Participant or his or her Spouse or Dependents on a pre-tax basis. Further, the Participant must confirm that he or she has not and will not be reimbursed for this expense under any other health plan coverage including a Section 125 flexible spending account plan.

Reimbursement requests should be submitted as soon as possible after reimbursable Medicare Premium Expenses are incurred. Nevertheless, a Participant must submit reimbursement requests for Medicare Premium Expenses incurred during the Period of Coverage no later than 90 days following the close of the Period of Coverage in which the expenses were incurred (the "run-off period"). However, if a Participant ceases to be a Participant during the Period of Coverage, such Participant (or Participant's estate as may be applicable) must apply for reimbursement no later than 90 days from the date the Participant loses coverage for any reason described under Section 3.6. Any requests for reimbursements that are not timely submitted may be denied.

5.9 USERRA Leaves of Absence

The Plan is subject to federal law providing special rights for an individual to continue health coverage while the Participant serves in the United States uniformed services, such as the Navy or Army. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Plan Sponsor will continue to maintain the Participant's benefits on the same terms and conditions as if the Participant were still an active Eligible Employee. A Participant should receive notice of these special rights from an appropriate government agency. Please contact the Plan Administrator for additional information, including how this coverage may be administered.

5.10 COBRA Continuation Coverage

This Plan is not subject to the requirements of COBRA. As such, individuals covered by the Plan do not have a right to continuation coverage following any events that result in a loss of coverage.

5.11 Special Medicaid Rules

For each benefit program that constitutes a "group health plan" under ERISA Section 609, the Plan will ensure that payment for benefits will be (a) made in accordance with any assignment of rights made by or on behalf of a Participant or beneficiary under a state Medicaid plan; (b) made without regard to participation in the state Medicaid plan; and (c) to the extent the State has acquired rights to a payment with respect to a participant, the Plan will pay benefits in accordance with State law, in accordance with ERISA Section 609.

ARTICLE 6
HIPAA Protected Health Information

In the event that the Plan Sponsor receives protected health information, as defined below, the Plan Sponsor will only use and disclose protected health information received from the Plan for administrative plan purposes as permitted by federal law.

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

6.1 Introduction

The Plan is dedicated to maintaining the privacy of a covered individual's health information. The Plan is required by law to take reasonable steps to ensure the privacy of personally identifiable health information or "Protected Health Information" ("PHI") and to inform covered individuals about:

(a) The Plan's uses and disclosures of PHI;

(b) Privacy rights with respect to PHI;

(c) The Plan's duties with respect to PHI;

(d) A covered individual's right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and

(e) The person or office to contact for further information about the Plan's privacy practices.

The term "PHI" includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is changed, a revised version of this notice will be provided to all individuals then covered under the Plan for whom the Plan still maintains PHI. The revised notice will be provided by mail or by another method permitted by law.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Please note that the Plan Sponsor obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing PHI are created and retained by a third-party administrator for the Plan. In the event that the Plan Sponsor receives PHI, the Plan Sponsor shall only use and disclose PHI received from the Plan for administrative plan purposes as permitted by federal law.

6.2 Notice of PHI Uses and Disclosures

Except as otherwise indicated in this notice, uses and disclosures will be made only with a covered individual's written authorization, subject to the covered individual's right to revoke such authorization.

(a) Required PHI Uses and Disclosures. Upon a covered individual's request, the Plan is required to give the covered individual access to certain PHI in order to inspect and copy it.

Use and disclosure of PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations. The Plan also will disclose PHI to the Plan Sponsor for administrative purposes permitted by law and related to treatment, payment or health care operations.

The Plan contracts with business associates for certain services related to the Plan. PHI about covered individuals may be disclosed to the business associates so that they can perform contracted services. To protect a covered individual's PHI, the business associate is required to appropriately safeguard the health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose a covered individual's PHI.

(b) Uses and Disclosures to Carry out Treatment, Payment and Health Care Operations. The Plan and its business associates will use PHI without a covered individual's consent, authorization, or opportunity to agree or object, to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of the covered individual's providers. For example, the Plan may disclose to a

treating cardiologist the name of a covered individual's treating physician so that the cardiologist may ask for the covered individual's lab results from the treating physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorization). For example, the Plan may tell a doctor whether a covered individual is eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about a covered individual's claims to refer the covered individual to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Plan may also use PHI to contact a covered individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the covered individual.

(c) Authorized Uses and Disclosures. A covered individual must provide the Plan with his or her written authorization for the types of uses and disclosures that are not identified by this notice or permitted or required by applicable law. In addition, a covered individual's written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about the covered individual from his or her mental health professional. Psychotherapy notes are separately filed notes about the covered individual's conversations with his or her mental health professional during a counseling session. They do not include summary information about the covered individual's mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by a covered individual.

Any authorization a covered individual provides to the Plan regarding the use and disclosure of his or her health information may be revoked at any time in writing. After a covered individual revokes his or her authorization, the Plan will no longer use or disclose the covered individual's health information for the reasons described in the authorization, except for the two situations noted below:

(i) The Plan has taken action in reliance on the covered individual's authorization before it received his or her written revocation; and

(ii) The covered individual was required to give the Plan his or her authorization as a condition of obtaining coverage.

(d) Uses and Disclosures that Require an Opportunity to Agree or Disagree Prior to the Use or Release. Disclosure of a covered individual's PHI to family members, other relatives and his or her close personal friends is allowed if:

(i) The information is directly relevant to the family or friend's involvement with the covered individual's care or payment for that care; and

(ii) The covered individual has either agreed to the disclosure or has been given an opportunity to object and has not objected.

(e) Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required. Use and disclosure of a covered individual's PHI is allowed without his or her consent, authorization or request under the following circumstances:

(i) When required by law.

(ii) When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if the covered individual has been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

(iii) When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that the covered individual may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform the covered individual that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(iv) To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal

investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(v) When required for judicial or administrative proceedings. For example, a covered individual's PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to the covered individual, and the notice provided sufficient information about the proceeding to permit the covered individual to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(vi) For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(vii) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(viii) For research, subject to conditions.

(ix) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(x) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

6.3 Rights of Individuals

(a) Right to Request Restrictions on PHI Uses and Disclosures. A covered individual may request that the Plan restrict uses and disclosures of his or her PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by the covered individual who are involved in the covered individual's care or payment for the covered individual's care. However, the Plan is not required to agree to the covered individual's r request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. A covered individual or his or her personal representative will be required to complete a form to request restrictions on uses and disclosures of the covered individual's PHI. Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where the covered individual wishes to be contacted.

(b) Right to Inspect and Copy PHI. A covered individual has a right to inspect and obtain a copy of his or her PHI contained in a "designated record set," for as long as the Plan maintains the PHI. "Designated Record Set" includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used by the Plan entity to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A covered individual or his or her personal representative will be required to complete a form to request access to the PHI in the covered individual's designated record set. Requests for access to PHI should be made to the Plan Sponsor at the address provided in in the Plan Information section above.

If access is denied, a covered individual or his or her personal representative will be provided with a written denial setting forth the basis for the denial, a description of how the covered individual may exercise his or her rights and a description of how he or she may complain to the Secretary of the U.S. Department of Health and Human Services.

(c) Right to Amend PHI. A covered individual has the right to ask the Plan Administrator to amend his or her PHI or a record about the covered individual in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide the covered individual with a written denial that explains the basis for the denial. The covered individual or his or her personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of the covered individual's PHI. The covered individual or his or her personal representative will be required to complete a form to request amendment of the PHI in the designated record set. Requests for amendment of PHI in a designated record set should be made to the Plan Sponsor at the address provided in the Plan Information section above.

(d) Right to Receive an Accounting of PHI Disclosures. At a covered individual's request, the Plan will also provide the covered individual with an accounting of disclosures by the Plan of the covered individual's PHI during the six years prior to the date of the request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to a covered individual about his or her own PHI; (3) prior to April 14, 2004; or (4) pursuant to a covered individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the covered individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If a covered individual requests more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. A covered individual or his or her personal representative will be required to complete a form to request an accounting. Requests for an accounting should be made to the Plan Sponsor at the address provided in the Plan Information section above.

(e) Right to Receive a Paper Copy of this Notice upon Request. To obtain a paper copy of this Notice at any time contact the Plan Administrator. Even if the covered individual has agreed to receive this Notice electronically, the covered individual is still entitled to a paper copy of this Notice.

(f) A Note about Personal Representatives. A covered individual may exercise his or her rights through a personal representative. The personal representative will be required to produce evidence of his or her authority to act on the covered individual's behalf before that person will be given access to the covered individual's PHI or allowed

to take any action for the covered individual. Proof of such authority may take one of the following forms:

(i) A power of attorney for health care purposes, notarized by a notary public;

(ii) A court order of appointment of the person as the conservator or guardian of the individual; or

(iii) An individual who is the parent of a minor child.

The Plan retains discretion to deny access to a covered individual's PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

6.4 Right to File a Complaint with the Plan or the HHS Secretary

If a covered individual believes that his or her privacy rights have been violated, the individual may complain to the Plan in care of the Plan Administrator. A covered individual may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against a covered individual for filing a complaint.

6.5 Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). These rules may be found at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations. If a covered individual wishes to exercise one or more of the rights listed in this Notice, contact the Plan Administrator.

ARTICLE 7
Claims and Appeals Procedures

7.1 Claim Review

The Insurance Carrier, as defined herein, is the named fiduciary under the Medicare coverage for purposes of the benefits provided under the insurance contract entered into between the Participant and the Insurance Carrier. Claims for such benefits are sent to the Insurance Carrier, and it is the Insurance Carrier, not the Plan Administrator, that is responsible for paying claims. The Insurance Carrier is responsible for (1) determining eligibility for and the amount of any benefits payable under the insurance contract; and (2) prescribing claims procedures to be followed and the claims forms to be used. To obtain benefits from the Insurance Carrier, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the Insurance Carrier's form. In that case, the form is available directly from the Insurance Carrier. The Insurance Carrier also has the authority to require eligible individuals to furnish it with such information as it deems necessary for the proper administration of coverage under the insurance contract.

A Participant may have a claim related to his or her eligibility to participate in the Plan, contributions to the PRA Account, reimbursements or other Plan matter determined by the Plan Administrator that is not governed by the Insurance Carrier. For such determinations made by the Plan Administrator, a Participant must follow the claims and appeals procedures described in this Article 7. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part.

7.2 Submitting a Claim

All claims made pursuant to this Article 7 must be in writing and delivered to the Claim Administrator, postage paid. Claims for reimbursement must be made on the appropriate form or forms furnished by the Claim Administrator for purposes of the Plan in accordance with Section 5.8.

Reimbursement requests should be submitted as soon as possible after reimbursable Medicare Premium Expenses are incurred. Nevertheless, a Participant must submit reimbursement requests for Medicare Premium Expenses incurred during the Period of Coverage no later than 90 days following the close of the Period of Coverage in which the expenses were incurred (the "run-off period"). However, if a Participant ceases to be a Participant during the Period of Coverage, such Participant (or Participant's estate as may be applicable) must apply for reimbursement no later than 90 days from the date the Participant loses coverage for any reason described under Section 3.6. Any requests for reimbursements that are not timely submitted may be denied.

7.3 Timing of a Claim Review

A Participant's claim (for purposes of this Article 7, a "claimant") will be approved or denied within 90 days of receipt (45 days for a disability related claim) unless the Claim Administrator determines that an extension of time is necessary due to matters beyond the control of the Claim Administrator. If an extension of time is necessary, the Claim Administrator will notify the claimant within the initial 90-day period (45-day period, if applicable) that an extension of up to an additional 90 days (30 days for a disability related claim) will be required. Such notice for a disability claim will also explain the special circumstances requiring the extension.

If the extension is necessary because the claim is incomplete, the claimant will be notified and will have at least 45 days to provide the requested information. The time in which the Claim Administrator will respond to the claim will be tolled from the date on which the notice is sent to the claimant until the date on which the claimant responds to the request for additional information. If the claimant does not provide the requested information, the Claim Administrator will approve or deny the claim within 30 days of the expiration of the 45-day period. Claims for disability benefits will be adjudicate in a manner designed to ensure the independence and impartiality of the person involved in making the decision.

7.4 Notice of an Adverse Benefit Determination

An adverse benefit determination is the denial, reduction, termination of, or a failure to provide or make payment for a benefit, including a denial, reduction, or termination based on eligibility to participate in the Plan. The claimant will receive written notice of an adverse benefit determination within the timeframe specified above. If a claim is denied by the Plan Administrator, in whole or in part, the Claim Administrator will send a written notice stating:

(a) Specify reason(s) for the adverse determination;

(b) Specify Plan provision(s) on which the determination was based;

(c) Describe additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary;

(d) Describe the Plan's review procedures and the time limits applicable to such procedures, including describing the claimant's right to bring a civil action under ERISA Section 502 following an adverse benefit determination on review;

(e) Either specify the internal rules, guidelines, protocols, or other similar criteria relied upon in making the determination or state that such rules, guidelines, protocols, or criteria were relied upon and a copy will be provided free of charge upon request, if applicable;

(f) Either explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or state that such explanation will be provided free of change upon request, if applicable; and

7.5 Appealing an Adverse Benefit Determination

The claimant (or an authorized representative) may appeal an adverse benefit determination within 120 days after receiving the notice of the denial. The appeal should be filed with the Plan Administrator. In connection with an appeal, the claimant (or an authorized representative) may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The claimant (or an authorized representative) may also submit written comments, documents, records and other information supporting the claim to the Plan Administrator. The Plan Administrator's review on appeal will take into account all information submitted by the claimant (or an authorized representative), regardless of whether it was submitted or considered in the initial claim determination. If the claimant (or an authorized representative) does not submit an appeal request within such 120-day period, the claimant will be barred and estopped from challenging the Plan Administrator's determination.

The Plan Administrator's review the claimant's on appeal will not rely on the initial claim determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual. If an appeal is related to disability benefits, the review will be adjudicated in a manner designed to ensure the independence and impartiality of the person involved in making the decision.

7.6 Timing of an Appeals Decision

The Plan Administrator will issue a written decision regarding the claimant's appeal within 60 days after the Plan Administrator's receives the request for appeal (or 45 days for appeal of disability related benefits).

7.7 Notice of an Appeal Denial

If the Plan Administrator denies a claim on appeal, the Plan Administrator will send a written notice, in a manner calculated to be understood by the claimant, stating the following:

(a) Specify reason(s) for the adverse determination;

(b) Specify Plan provision(s) on which the determination was based;

(c) State that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;

(d) Describe any voluntary review procedures of the Plan and the time limits for requesting such a review, including describing the claimant's right to bring a civil action under ERISA section 502 following an adverse decision on appeal;

(e) Either specify the internal rules, guidelines, protocols, or other similar criteria relied upon in making the determination or state that such rules, guidelines, protocols, or criteria were relied upon and a copy will be provided free of charge upon request, if applicable;

(f) Either explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or state that such explanation will be provided free of change upon request, if applicable; and

(g) State that the claimant or the Plan may have other voluntary alternative dispute resolution options and that one way to find out what may be available is to contract the local office of the U.S. Department of Labor and state insurance regulatory agency.

7.8 No Verbal Modifications of Plan Provisions

No verbal statement made by anyone involved in administering this Plan can waive any of the terms or conditions of this Plan or prevent the Plan Administrator from enforcing any provision of this Plan. Waivers are valid only if they are contained in a written instrument signed by an authorized individual on behalf of the Plan Administrator. Any such written waiver will be valid only as to the specific plan, term or condition set forth in the written instrument. Unless specifically stated otherwise, a written waiver will be valid only for the specific claim involved at the time, and will not be a continuing waiver of the term or condition in the future.

7.9 Limitation on Legal Action

No action may be instituted against the Plan, the Plan Sponsor, the Plan Administrator, or any other entity to whom insurance, administrative, or claims processing functions have been delegated until the claimant has exhausted the Plan's claims and appeals procedures. If a claimant or other entity elects to challenge the Plan's final determination in any forum, including judicial or administrative proceedings, the action must be filed no more than 180 days following the day the Plan Administrator make its final determination on appeal. A review by a court of law or administrative law judge may be limited to the facts, evidence and issues presented during the claims and appeals procedure set forth above. Facts and evidence must be submitted for consideration in accordance with the time limits established above. Facts and issues not raised during the appeal will be deemed waived. Any determination made by the Plan Administrator shall be given deference, and shall be overturned only if it is arbitrary or capricious.

ARTICLE 8
Recordkeeping and Plan Administration

8.1 Plan Administrator

The Plan Administrator has the sole discretion and authority to control and manage the operation and administration of the Plan. The Plan Administrator has complete discretion to interpret and construe the provisions of the Plan (including any uncertain terms), make findings of fact, correct errors, supply omissions, and determine all questions of law and fact concerning eligibility and contributions under the Plan. All decisions and interpretations of the Plan Administrator are final, conclusive and binding on all persons. All rules, decisions, interpretations and designations by the Plan Administrator under the Plan will be made in a nondiscriminatory manner. The Plan Administrator has the authority to delegate all or any part of its responsibilities under the Plan, and any action by a delegate in the exercise of delegated responsibilities will have the same force and effect for all purposes as if the Plan Administrator had taken such action. Any determination made by the Plan Administrator shall be given deference, and shall be overturned only if it is arbitrary or capricious. Benefits will not be paid under the Plan unless the Plan Administrator determines that the claimant is entitled to them.

8.2 Provisions for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Board, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Plan Administrator

8.3 Fiduciary

The Plan Administrator shall be the named fiduciary of the Plan and shall have full authority to control and manage the operation and administration of the Plan, except as otherwise delegated. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for the Plan Administrator's own willful misconduct or willful breach of this Plan.

For purposes of benefits provided by an Insurance Carrier, the respective Insurer Carrier is the named fiduciary, with the full power to interpret and apply the terms of that coverage as it relates to the benefits provided under the applicable insurance contract.

8.4 Reliance on Participant

The Plan Administrator may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant.

8.5 Qualified Medical Child Support Order

If the Plan Administrator receives a medical child support order (within the meaning of ERISA Section 609(a)(2)(B)), the Plan Administrator shall review the order and determine whether it is a qualified medical child support order (within the meaning of ERISA Section 609(a)(2)(A)). The Plan Administrator will notify the Participant and alternate recipient of its determination.

8.6 Costs and Expenses

The Plan Sponsor will bear the incidental costs of administering this Plan. The Plan Sponsor may use forfeited account balances, in addition to general assets to pay Plan expenses.8.7

8.7 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it is unable to identity or locate the whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

8.8 Overpayment

If the Plan Administrator determines that a Participant received an overpayment or a payment was made in error, a request will be made for the Participant to refund the overpayment or erroneous payment to the Plan. If the Participant discovers an overpayment or an erroneous payment, the Participant must notify the Claim Administrator within 30 days of discovering such overpayment or erroneous payment and arrange to correct the error or overpayment.

If the overpayment or erroneous payment is not refunded, the Plan Administrator reserves the right to offset future reimbursements equal to the overpayment or erroneous payment, or to withhold the amount from any other amounts due the Participant from the Plan Sponsor. If the Plan Administrator is unable to recover the overpayment or erroneous payment from the Participant, the Plan Administrator may treat the amount as a bad debt, which may have adverse consequences for the Participant, including, but not limited to, adverse tax consequences. In such case the Plan Administrator may issue the Participant a Form 1099. In addition, if the Plan Administrator determines that the Participant has submitted a fraudulent claim, the Plan Administrator may terminate the coverage under this Plan, and to the extent permissible, under the Group Health Plan.

8.9 Insurance Carrier Terms and Conditions

A number of terms and conditions under this Plan are subject to the terms and conditions specified by the applicable Insurance Carrier and are anticipated to be described in such Insurance Carrier's benefit descriptions. If relevant circumstances apply to the Participant, he or

she should refer to the applicable provisions in the Insurance Carrier's benefit description. Such provisions may include:

(a) coordination of benefits;

(b) subrogation and reimbursement;

(c) claims and appeals procedures (to the extent the Participant believes that the benefit description calls for a claim to be paid, it has not been fully paid by the Insurance Carrier and wishes to challenge that non-payment or reduced payment);

(d) protected health information; and

(e) other terms and conditions in the Insurance Carrier's benefit description.

8.10 Amendment and Termination Procedures

Although the Plan Sponsor expects to maintain the Plan indefinitely, it retains the right to modify, amend or terminate the Plan at any time, in whole or in part, with or without notice (except for notice required by law). This specifically includes the right to change, reduce or eliminate Plan benefits for all Employees and their families, the right to change the amount credited to PRA Accounts or to reduce or eliminate any amounts currently credited to a Participant's PRA Account. It is also possible that future changes in state or federal tax laws may also require that the Plan be amended.

The Plan may be modified, amended, suspended or terminated by a written instrument duly adopted by the Board or by any person to whom such authority has been delegated. No consent of any Participant or any other person referred to in the Plan will be required to terminate, modify, amend, or change the Plan.

If this Plan is modified, amended or terminated such that benefits are reduced or eliminated in any manner, Participants have no right to continued benefit payments. Upon plan termination, all eligible claims outstanding at that time will be paid in full or paid on a prorated basis. All previous Plan Sponsor Contributions and current year contributions by the Plan Sponsor will continue to be used for the purpose of paying benefits under the provisions of this Plan with respect to eligible expenses incurred before such termination

ARTICLE 9
General Plan Provisions

9.1 No Contract of Employment

Nothing contained herein shall be deemed to give any Employee the right to be retained in the employ of Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge such Employee at any time, nor shall it be deemed to give the Plan Sponsor the right to require the Employee to remain in its employ, nor shall it interfere with the Employee's right to terminate his/her employment at any time. All Employees shall be considered to be employed at the will of the Plan Sponsor.

9.2 Governing Law

The Plan shall be construed, administered, and enforced under the laws of the State of Wisconsin, except to the extent such laws are superseded by the Code, ERISA, or any other applicable Federal law or statute.

9.3 Legal Compliance

Benefits under this Plan shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent applicable and required by such laws and all applicable regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between this Plan and the applicable law, the applicable laws and regulations issued thereunder shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

9.4 No Guarantee of Tax Consequences

Neither the Plan nor the Plan Sponsor guarantees any particular tax treatment by state or federal tax authorities. Participants are subject to the particular treatment as applicable under the respective federal and state tax codes and corresponding regulations and as determined by the respective tax authorities. Participants have no recourse against the Plan, the Plan Administrator or Plan Sponsor if the tax treatment they encounter is other than as expected or desired. If a Participant questions about the potential tax consequences, the Participant should contact a tax adviser such as a certified public accountant or an attorney.

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Plan Sponsor for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

9.5 Assignment of Benefits Prohibited

No coverage, benefits or ERISA rights of any kind related to or arising under the Plan may be assigned to any third-party, except as may be required pursuant to the terms of a Qualified Medical Child Support Order (defined under ERISA), Medicaid or any other statute specifically requiring assignment and that is not preempted by ERISA. These prohibited assignments include, but are not limited to, the right to coverage or to receive benefits or benefit payments, the right to request and receive Plan documents, summaries, contracts, etc. pursuant to ERISA, the right to file a claim or appeal for benefits under the Plan, the right to initiate formal or informal complaints to any governmental agency that has jurisdiction over the Plan or Plan benefits, and the right to file suit in law or equity under ERISA or any federal or state law for any type of action recognizable under ERISA (including suits for breach of fiduciary duty) or recognizable under any other federal or state law. The term "any third-party" for purposes of this prohibition on assignment is construed broadly and includes, but is not limited to, service providers, medical providers, any other types of providers, creditors, insurers or any other persons or entities. Although the Plan may make payments directly to other parties, such payments do not make any such party an assignee or otherwise confer on the party any rights under the Plan or ERISA. Accordingly, the Plan cannot recognize any such third-parties as participants or beneficiaries under the Plan or ERISA. Without limiting the effect of the preceding, in no event shall the Plan pay benefits in excess of the amount that would otherwise be payable regardless of who is the payment recipient

9.6 Plan Provisions Controlling

In the event that the terms or provisions of any other instrument are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall control.

9.7 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

9.8 Gender and Number

Whenever used in this instrument and in all cases where the context requires, masculine pronouns shall be deemed to include the masculine and feminine gender, a singular word shall be deemed to include the singular and plural, and a plural word shall be deemed to include the plural and singular.

9.9 Headings

The headings of the Plan are inserted for convenience and reference and shall have no effect upon the meaning of the provisions hereof.

ARTICLE 10
Statement of ERISA Rights

Participants in the Districts Mutual Insurance & Risk Management Services Medicare Premium Reimbursement Arrangement (PRA) Plan 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:

10.1 Receive Information about the Plan and Benefits

Examine without charge, at the Plan Administrator's office and at other locations, such as worksites, all documents governing the Plan, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance, and copies of the latest annual report, as applicable, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

10.2 Continue Coverage

Continue health care coverage for the Participant and his or her Spouse of Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. A Participant, and his or her Spouse or Dependents, as applicable, may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing continuation coverage rights.

10.3 Prudent Action by Plan Fiduciaries

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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and beneficiaries. No one, including the Plan Sponsor or any other person, may fire an Employee or otherwise discriminate against Employee in any way to prevent the Employee or and eligible Spouse or Dependent from obtaining a welfare benefit or exercising his or her rights under ERISA.

10.4 Enforce Your Rights

If a claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal nay denial, all within certain time schedules.

Under ERISA there are steps the Participant can take to enforce the above rights. For instance, the Participant request materials from the Plan and does not receive them within 30 days, the Participant may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a state or Federal court. In addition, if the Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Employee or his or her eligible Spouse or Dependents is discriminated against for asserting his or her rights, such person may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If a claimant is successful, the court may order the person sued to pay these costs and fees. If a claimant loses, the court may order the claimant to pay these costs and fees, for example, if the court finds the claim is frivolous.

10.5 Assistance with Your Questions

If a Participant has any question about the Plan, the Participant should contact the Plan Administrator. If a Participant has any questions about this statement or about his or her rights under ERISA, or if the Participant needs assistance in obtaining documents from the Plan Administrator, the Participant should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington D. C. 20210. The Participant may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.