Southwest Region School District HRA Plan
Health Reimbursement Arrangement (HRA) Plan

Summary Plan Description

Effective: January 1, 2012

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TABLE OF CONTENTS

Southwest Region School District HRA Plan
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Article I
INTRODUCTION

Southwest Region School District, (the "Employer") sponsors the **Southwest Region School District HRA Plan** for Eligible Employees. Under the federal tax law, the HRA Plan is known as a "Health Reimbursement Arrangement" or "HRA" plan.

The purpose of the HRA Plan is to reimburse Eligible Employees, up to certain limits, for their own Medical Care Expenses. Reimbursements for Medical Care Expenses paid by the HRA Plan generally are excludable from taxable income.

This Summary Plan Description (SPD) describes the basic features of the HRA Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the HRA Plan and is not meant to interpret or change the provisions of your Plan. A copy of the Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. In the event of any inconsistencies or conflict between the actual provisions of the HRA Plan Document and this Summary, the HRA Plan Document shall govern.

Article II
PARTICIPATION IN YOUR PLAN

How can I participate in the HRA Plan?
Once an Employee has met the Plan's eligibility requirements, and provided that the procedures outlined under **How do I become a Participant and when is my Entry Date?** section are followed, the Eligible Employee may participate in the Plan.

What are the Eligibility Requirements to participate in the Plan?
Employees who **have enrolled in the Employer's group Medical Insurance Plan** may participate in the Plan; provided that the election procedures outlined under **How do I become a Participant and when is my Entry Date?** section are followed.

How do I become a Participant and when is my Entry Date?
After you satisfy the eligibility requirements described under **What are the Eligibility Requirements to participate in the Plan?,** you will automatically be enrolled and become a Participant in the HRA Plan **on the first day of the first full month following the date of hire.**

Employees who actually participate in the HRA Plan are called "Participants." An Employee continues to participate in the HRA Plan until: (a) termination of the HRA Plan; or (b) the **end of the month** on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction of hours or any other reason).

What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?
If you cease to be an Eligible Employee (for example, if you die, retire, or terminate employment), your participation in the HRA Plan will terminate as of **the end of the month** following your termination, unless you elect COBRA continuation coverage as described below. You will be reimbursed for any Medical Care Expenses incurred prior to **the end of the month** of your termination, up to your account balance in the HRA account, provided that a claim is submitted within **12 months** following **the end of the month** of your termination. (see **How will the HRA Plan work?** for more information on the reimbursement request process).

However, if you are rehired within 30 days or less during the same Plan Year, you may immediately rejoin the Plan and be reinstated with the same HRA account balance that you had before termination.

If you are rehired more than 30 days after you terminated employment, you will be treated as a new hire and must re-satisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan as described in Section 3.1 before becoming eligible to participate in the Plan. Any unused reimbursement benefits account balance prior to the initial separation of service date will be forfeited.

If you cease to be an Eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must re-satisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan as described in Section 3.1 (or before becoming eligible to participate in the Plan).

What is COBRA continuation coverage and how does it work? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the Plan?
COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the HRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the HRA Plan if he or she pays the applicable premium for such coverage.

"Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

* Your termination from employment or reduction of hours;
* Your divorce or legal separation from your Spouse;
* Your becoming eligible to receive Medicare benefits;
* Your Dependent child's ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Plan Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual, disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

Under Federal law, State-Registered Domestic Partners are not eligible for COBRA continuation coverage.

FMLA and USERRA Leaves of Absence

If you go on a qualifying leave under FMLA, any applicable state leave law, or USERRA, then to the extent required by FMLA, state leave law or USERRA, as applicable, the Employer will continue the Participant's Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

Non-FMLA and Non-USERRA Leaves of Absence

If you go on a leave of absence that is not subject to benefit protections under FMLA, state leave law, USERRA, or other applicable laws, the Participant will be treated as having terminated participation, as described under Section 3.2.

Article III
WHAT BENEFITS ARE PROVIDED UNDER THE PLAN

What Benefits are offered under the HRA Plan?

Once you become a Participant, the HRA Plan will maintain an "HRA Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from any health insurance plan before any Benefits are payable from this Plan. In the event that an expense is eligible for reimbursement under both the HRA and a Health FSA, you must seek reimbursement from the HRA first until that account balance has been exhausted before you can seek reimbursement from the Health FSA.

Before the start of each Plan Year, the Employer will determine a maximum annual amount that may be credited during that Plan Year to the HRA Account of each Participant in the HRA Plan. The maximum dollar amount that may be credited to an HRA account for an Employee for deductible expenses is **$3,750** for employee-only coverage, **$7,500** for employee plus spouse coverage and **$11,250** for family coverage. The maximum dollar amount that may be credited to an HRA account for an Employee for Tier 4 drug expenses is **$4,700** for employee-only coverage, **$9,400** for employee plus spouse coverage and **$14,100** for family coverage.

Your HRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses. The amount available for reimbursement of Medical Care Expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date. After the end of the Plan Year, **the unused amount, if any, in your HRA Account will be forfeited.**

How will the HRA Plan work?

The HRA Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your HRA Account. **The following procedure should be followed**:

* You must submit a claim to BenefitHelp Solutions and provide any additional information requested by BenefitHelp Solutions;
* A request for payment must relate to Medical Care Expenses incurred by during the time you were a Participant under this Plan;
* A request for payment must be submitted within **12 months** following **the close of the Plan Year** in which the Medical Care Expense was incurred;

Claims must be submitted in writing. BenefitHelp Solutions may require that Participants submit claims on a form provided by BenefitHelp Solutions. The claim must set forth:

* The individual(s) on whose behalf the Medical Care Expenses were incurred;
* The nature and date of the Medical Care Expenses so incurred;
* The amount of the requested reimbursement; and
* A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source, and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred and showing the amounts of such Medical Care Expenses, along with any additional documentation that BenefitHelp Solutions may request.

Are there any limitations on Benefits available under the HRA Plan?

Bridge HRA Option

For purposes of this Option, "Medical Care Expenses" means only health care expenses incurred once the Participant meets the minimum annual deductible (providing a bridge between the out-of-pocket expenses and insurance coverage). The HRA reimburses **100%** of deductible expenses between the amounts of **$250.01** and **$4,000.** The HRA also reimburses **100%** of prescription expenses for **Tier 4** drugs between the amounts of **$300.01** and **$5,000**.

The maximum dollar amount that may be credited to an HRA account for an Employee for deductible expenses is **$3,750** for employee-only coverage, **$7,500** for employee plus spouse coverage and **$11,250** for family coverage. The maximum dollar amount that may be credited to an HRA account for an Employee for Tier 4 drug expenses is **$4,700** for employee-only coverage, **$9,400** for employee plus spouse coverage and **$14,100** for family coverage.

May I elect to suspend my HRA Account?

You may elect to suspend your HRA Account for any future Plan Year by submitting a Suspension Election Form to the Administrator before the beginning of that Plan Year. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to suspend your HRA Account for a Plan Year, you agree to permanently forgo reimbursements from your HRA Account for Medical Care Expenses incurred during that Plan Year. Medical Care Expenses incurred before the beginning of the suspended Plan Year will be reimbursed during the suspended Plan Year so long as no suspension election was in effect for the Plan Year in which such expenses were incurred. You must apply for reimbursement, by submitting an application in writing to the BenefitHelp Solutions, no later than **12 months** following **the close of the Plan Year** in which the Medical Care Expense was incurred.

Your Employer will cease to make contributions to your HRA account during any suspended Plan Year.

When must the Medical Care Expenses be incurred for the HRA?

For Medical Care Expenses to be reimbursed to you from your HRA Account for the Plan Year, they must have been **incurred during that Plan Year**. The Plan Year for the HRA is a **12-month period** beginning on **January 1st** and ending on **December 31st.**

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month).

You may not be reimbursed for any expenses arising before the HRA Plan became effective, before your Enrollment Form became effective, for any expense incurred after the close of the Plan or after a separation from service (except for Continuation Coverage, as described under **What is "Continuation Coverage" and how does it work?).**

Will I pay any administrative costs under the HRA Plan?

No. The cost of the plan includes administrative expenses and is paid entirely by the Employer.

Are my Benefits taxable?

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the HRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

How long will the HRA Plan remain in effect?

Although the Employer expects to maintain the HRA Plan indefinitely, it has the right to amend or terminate all or any part of the HRA Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the HRA Plan be amended accordingly.

Article IV
CLAIMS PROCEDURE

What happens if my claim for benefits is denied?

If your claim is denied in whole or in part, you will be notified in writing by BenefitHelp Solutions within 30 days after the date BenefitHelp Solutions received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of BenefitHelp Solutions, including in cases where a claim is incomplete. BenefitHelp Solutions will provide written notice of any extension, including the reasons for the extension and the date by which a decision by BenefitHelp Solutions is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.) Notification of a denied claim will set out:

* A specific reason or reasons for the denial;
* The specific Plan provision on which the denial is based;
* A description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
* Appropriate information on the steps to be taken if you wish to appeal BenefitHelp Solutions' decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals

If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the "Appeals Committee". Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided.

If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

* The specific reason(s) for the decision on review;
* The specific Plan provision(s) on which the decision is based;
* A statement of your right to review (upon request and at no charge) relevant documents and other information;
* If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
* A statement of your right to bring suit under ERISA § 502(a) (where applicable).

Duty of Beneficiary/Third Party Recoveries
Any Beneficiary under the Plan that receives a payment, whether by lawsuit, settlement, or otherwise, from third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party must reimburse the Plan to the extent the Beneficiary has received payments from the Plan for such sickness or injury. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

The Plan further requires covered Beneficiaries promptly advise the Plan Administrator of third-party claims and to execute any assignments, liens, or other documents the Plan Administrator requests. The Plan may withhold Benefits until such documents are received.

Subrogation/Acts of Third Parties
The Plan Administrator, on behalf of the Plan, has the right to recover any payments made to Beneficiaries, whether by lawsuit, settlement, or otherwise, by third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

Article VI
GENERAL INFORMATION

General Plan Information

* Name: **Southwest Region School District HRA Plan**
* Plan Number: 501
* Effective Date: **January 1, 2012**
* Plan Year: **January 1st** to **December 31st.** Your Plan's records are maintained on this **12-month** period of time
* Type of Plan: Welfare Plan
* Your plan shall be governed by the Laws of the **State of Alaska**

Employer/Plan Sponsor/Administrator Information

* Name and Address:

  Southwest Region School District
  P.O. Box 90
  Dillingham, AK 99576
  (907) 842-5287

* Federal Employer Tax Identification Number (EIN): **92-0058287**

Third Party Administrator Information
Name, address, and business telephone number:

BenefitHelp Solutions
PO Box 67230
Portland, OR 97268-1230
(888) 398-8057

The Plan Administrator appoints the BenefitHelp Solutions to keep the records for the Plan and to be responsible for the administration of the Plan. However, the Appeals Committee acts on behalf of the Plan Administrator with respect to appeals. The BenefitHelp Solutions will answer any questions that you may have about our Plan. You may contact the BenefitHelp Solutions at the above address for any further information about the Plan.

Funding and Type of Plan Administration
The HRA is a group health plan and is self-funded by the Employer. This is a contract administration plan. A third-party administrator processes claims for the Plan.

All of the amounts payable under this Plan may be paid from the general assets of the Employer.

Nothing herein will be construed to require the Employer 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 Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Named Fiduciary
The named fiduciary for the HRA is: **Southwest Region School District**

Agent for Service of Legal Process

Southwest Region School District
P.O. Box 90
Dillingham, AK 99576
(907) 842-5287

Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order
The HRA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

USERRA
Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

Women's Health and Cancer Rights Act of 1998 (WHCRA)
The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Michelle's Law
"Michelle's Law" requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

The Genetic Information Nondiscrimination Act of 2008 (GINA)
GINA (Genetic Information Non-Discrimination Act) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

Health Information Technology for Economic and Clinical Health Act was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

This new law amends the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.