

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT

HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Sacramento City Unified School District (the “Employer”) has established the Health Reimbursement Arrangement (the “HRA”). The purpose of this HRA is to reimburse Participants for certain unreimbursed medical expenses (“Eligible Medical Expenses”) incurred by the Participant and their Covered Dependents. This HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code (“Code”) and a health flexible spending arrangement under Code § 106(c).

This Summary Plan Description, or “SPD,” describes the basic features of the HRA, including the rights and responsibilities of covered individuals, the Employer, and the Plan Administrator. Attached to this SPD is a Plan Information Appendix that provides important information specifically related to this HRA (i.e., the name of the Plan Administrator and the maximum level of reimbursement available under this particular HRA). If you do not have a Plan Information Appendix for this SPD, you should contact the Employer. The Plan Information Appendix may be replaced from time to time to reflect changes made in the Plan. You should check your Plan Information Appendix to ensure that you have the most recent Plan Information Appendix. You may contact the Employer if you have concerns that the Plan Information Appendix that you have is outdated. Other appendices may be attached to this SPD to the extent referenced in the SPD. The Plan Information Appendix and any other appendices referenced in this SPD should be considered a part of the SPD (i.e., the SPD, the Plan Information Appendix and any other applicable appendices together constitute the entire SPD).

This HRA has been established and is operated in accordance with both this SPD and the official Plan Document. This SPD (including the applicable appendices) has been incorporated into and made a part of the official Plan Document (i.e., the official Plan Document and this SPD together constitute the Plan Document for this HRA). Although the SPD has been incorporated into and made a part of the Plan Document, the terms of the official Plan Document will control if there is a conflict between this SPD and the official Plan Document.

PART I:
General Information about the Plan

**You will notice that certain terms and/or phrases are capitalized and italicized throughout this SPD. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined either in this SPD (see Q-2) or in the official Plan Document.*

Q-1. What is the HRA?

Generally, the HRA is a reimbursement account. The HRA works as follows:

- A *Reimbursement Account* is established for each *Participant* (see Q-3 for more information on how to become a *Participant*).
- Each *Plan Year*, a specified amount of *HRA Dollars* is allocated to each *Participant's Reimbursement Account* for reimbursement of *Eligible Medical Expenses*.
- You do not necessarily forfeit any *HRA Dollars* that you do not use for expenses incurred during the *Plan Year*.
- You do not have to pay for your HRA coverage (except as otherwise required by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ["COBRA"]).

Q-2. What are the key definitions that affect this SPD?

- *Applicable Coverage Period* means the period identified in the Plan Information Appendix during which ***Eligible Medical Expenses*** must be incurred to be reimbursed.
- *Dependent* means a Medicare-entitled (i.e., enrolled in Medicare) individual who qualifies as a dependent under Code § 105(b), as amended from time to time.
- *Eligible Dependent* means a Medicare-entitled (i.e., enrolled in Medicare) individual that satisfies the eligibility requirements set forth in Q-4 of this SPD.
- *Eligible Medical Expense* means the Medicare premium contributions for a Participant or Covered Dependent as determined by the Participant's former Employer.
- *Eligible Retiree* means a former active employee of the Employer, who is enrolled in Medicare Parts A and B and has remained continuously covered under the Employer's medical plan up until becoming a Participant in this Plan, and who is eligible for Participating Employer Medicare contributions as determined by the Participant's former Employer.
- *HRA Dollars* means the *Employer* contributions allocated to your *Reimbursement Account* in accordance with this SPD.
- *Participant* means an *Eligible Retiree* who satisfies the requirements set forth in Q-3 of the SPD.
- *Plan Administrator* means Sacramento City Unified School District. The *Plan Administrator* has the authority and discretion to administer this HRA as set forth in the Plan Information Appendix.
- *Reimbursement Account* means the notional account established on your behalf by the *Plan Administrator* for purposes of monitoring *HRA Dollars* and reimbursements made to you.
- *Run-out Period* means the period during which requests for reimbursements must be filed.

- *Spouse* means a person to whom you are married in accordance with applicable law.

Q-3. Who is a Participant in this HRA and when does coverage begin?

If, the *Employer* determines that you are an *Eligible Retiree*, you are a *Participant*. Coverage under this HRA for a *Participant* begins on the effective date of coverage set forth in the Plan Information Appendix.

Q-4. Are my dependents eligible for coverage under the HRA?

If you are *Participant*, you may also be reimbursed for *Eligible Medical Expenses* incurred by your *Eligible Dependents*. An *Eligible Dependent* is any individual who meets the following conditions:

- Your legal *Spouse*;
- You die;
- Within 6 months of the end of the plan year; and
- You provide all information regarding the *Eligible Dependent* necessary to satisfy reporting requirements under applicable law.

Coverage for an *Eligible Dependent* is effective on the date identified in the Plan Information Appendix. NOTE: Your *Eligible Dependent* will need to be enrolled in a plan in order for coverage for *Eligible Dependents* to become effective. The applicable enrollment requirements and the effective date of coverage following your request for enrollment of an *Eligible Dependent* will be identified in the Plan Information Appendix.

Q-5. When does coverage under this HRA end?

Your coverage under this HRA ends on the earliest of the following to occur:

- The date you are no longer an *Eligible Retiree*;
- The date the HRA is either terminated or amended to exclude you or the class of *Retirees* of which you are a member, or
- The date the *Eligible Retiree's Employer's* Medicare Contribution ceases.

Your *Eligible Dependents'* HRA coverage ends on the earliest of the following to occur:

- The date your coverage ends;
- The date your covered dependent ceases to be an *Eligible Dependent*; or
- The date the HRA is either terminated or amended to exclude your *Eligible Dependents*.

If you or your *Eligible Dependents* lose coverage as a result of a "Qualifying Event," you may be eligible to continue your coverage under COBRA. See Q-15 for more information on your rights and obligations under COBRA.

Q-6. What is an "Eligible Medical Expense?"

Eligible Medical Expenses are expenses that incurred by you or your *Eligible Dependents* that qualify as "medical care" under Code § 213(d). The only medical expenses which will be reimbursed by this Plan are contributions made by a Participant's former Employer for Medicare premiums. In addition, an

otherwise *Eligible Medical Expense* will not be reimbursed unless the requirements described in Q-12 below have been satisfied.

Q-7. What is the Reimbursement Account?

Once you become a *Participant*, the *Employer* establishes a *Reimbursement Account* for you. The *Reimbursement Account* is a notional bookkeeping account that keeps a record of *HRA Dollars* allocated to your account and reimbursements made to you under this HRA. You have no property rights in the *Reimbursement Account*.

Q-8. Who contributes to my Reimbursement Account?

Only the *Employer* contributes *HRA Dollars* to your *Reimbursement Account*. The maximum amount of *HRA Dollars* allocated to your *Reimbursement Account* during the *Plan Year* is the sum total of monthly contributions as determined by the Participant's former Participating Employer.

You may, however, be required to pay the "applicable premium" for continuation of HRA coverage under COBRA (please refer to Q-15 below for more information regarding COBRA continuation coverage).

Q-9. When are HRA Dollars allocated to my Reimbursement Account?

HRA Dollars are allocated to your *Reimbursement Account* at the intervals (e.g., monthly, quarterly, or annually) identified in the Plan Information Appendix.

Q-10. What happens if I do not use all of the HRA Dollars allocated to my Reimbursement Account during the Plan Year (Applicable Coverage Period)?

All *Eligible Medical Expenses* must be incurred during the *Applicable Coverage Period* and timely submitted for reimbursement. If you do not use all of the *HRA Dollars* allocated to your *Reimbursement Account* in accordance with Q-9 of this SPD for *Eligible Medical Expenses* incurred during the *Plan Year*, you generally forfeit the balance of the unused *HRA Dollars* allocated to your *Reimbursement Account* during that *Plan Year*.

You must file all requests for reimbursement of expenses incurred during the *Applicable Coverage Period* by the end of the *Run-Out Period (if Applicable)*.

Q-11. What is the maximum amount of reimbursement that I can receive under the HRA?

The maximum reimbursement amount that you can receive under the HRA is equal to your *Reimbursement Account* balance for the *Applicable Coverage Period* at the time the request for reimbursement is processed. Any portion of a claim for reimbursement that exceeds the *Reimbursement Account Maximum* will be pended and processed if and when the *Reimbursement Account* balance for the *Applicable Coverage Period* becomes sufficient.

Your *Reimbursement Account* balance may never exceed the *Reimbursement Account Maximum* identified in the Plan Information Appendix.

Q-12. How do I receive reimbursement under the HRA?

You may request reimbursement by completing and submitting the designated reimbursement and certification form (on which you certify that the expense has not been reimbursed and you will not seek reimbursement for it elsewhere) and submitting it to the Third Party Administrator with documentation from the service provider that identifies the following:

- The date the service was provided;
- The nature of the service;

- The amount of the expense;
- The individuals for whom the service was provided; and

You may submit requests for reimbursement of *Eligible Medical Expenses* at any time prior to the end of the *Run-out Period or Applicable Coverage Period*. Requests for reimbursements submitted after the *Run-out Period or Applicable Coverage Period* will not be reimbursed.

The HRA only reimburse expense(s) that exceed the minimum reimbursement amount set forth in the Plan Information Appendix.

Your claim is deemed filed when it is received by the Third Party Administrator in accordance with the methods designated by the Third Party Administrator. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Any unclaimed reimbursement amounts (i.e., failing to cash a reimbursement check) will be forfeited and returned to the *Employer* if not claimed (or cashed) thirteen months after the applicable coverage period. If your claim for reimbursement is denied, in whole or in part, you will be notified in accordance with the HRA's claims review procedures described in Q-13 below.

You may also pay for claims with your debit card through the debit card program ("Program"). Here is how the debit card works.

- *You must make an election to use the card.* In order to be eligible for the debit card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the debit cardholder Agreement (the "Debit Cardholder Agreement"). You must agree to abide by the terms of the Program annually thereafter. A Debit Cardholder Agreement will be provided to you. The debit card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program annually.
- *The card will be turned off when coverage terminates.* The card will be turned off when your coverage under the Plan ends.
- *You must certify proper use of the card.* As specified in the debit cardholder Agreement, you certify when you use the debit card that you will only use the debit card for *Eligible Medical Expenses* and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.
- *The debit card is limited to merchants with health care related merchant category codes except in certain situations. The Plan Administrator has sole discretion to determine whether the merchant has a health care related merchant category code.*
- *You provide your card number to the merchant like you do any other credit or debit card. When you incur an Eligible Medical Expense at an eligible merchant.* Every time you use the card, you certify to the Plan that the expense for which payment under the HRA is being made is an *Eligible Medical Expense* and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.
- *You must obtain and retain a receipt/third party statement each time you use the card.* You must obtain a third party statement from the health care provider (e.g., receipt, invoice, etc.) that includes the following information each time you use the card:

- (i) The nature of the expense (e.g., what type of coverage does the premium cover).
- (ii) The date the expense was incurred.
- (iii) The amount of the expense.

You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement is required to be submitted (except as otherwise provided in the debit cardholder Agreement). You will receive a notification from the Third Party Administrator if a third party statement is needed. You must provide the third party statement to the Third Party Administrator within the time period provided in the notification from the Third Party Administrator.

- *There are situations where the third party statement will not be required to be provided to the Third Party Administrator.* There may be situations in which you will not be required to provide the written statement to the claims administrator. More detail as to which situations apply under your Plan can be obtained by contacting the *Plan Administrator* or Third Party Administrator:

Previously Approved Claim Match (i.e., Recurring Expense): Written statement may not be required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the claims administrator approves a monthly premium payment to a carrier. Each time the card is used for subsequent premium payments to the same carrier the receipt may not need to be provided to the Third Party Administrator if the expense incurred is the same amount and for the same duration.

- *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Third Party Administrator, you must repay the Plan for the unsubstantiated expense as set forth below. In addition, your usage of the card may be terminated by the *Employer* until such time as you have repaid the expense. See Q-14 for more information.

Q-13. What happens if my claim for benefits is denied?

If you are denied a benefit under the Plan, you should proceed in accordance with the following claims review procedures:

Step 1: *Notice is received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- Information identifying the claim;
- The reasons for the denial;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim; and
- Any other information required by applicable law.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Third Party Administrator, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. The Plan has established two levels of appeal; therefore, you should file your appeal with the Third Party Administrator. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first Notice of Denial provided by the Third Party Administrator.

Step 6: *If you still disagree with the Third Party Administrator's decision, file a Second Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the *Plan Administrator* within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim. You will be notified in writing of the *Plan Administrator's* decision as soon as possible but no later than 30 days after receipt of the appeal.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Q-14. What happens if I fail to substantiate a debit card claim or I receive an overpayment?

All debit card transactions will be automatically substantiated for *eligible expenses*. Any purchases that are not an eligible expense will be declined at point of sale.

What is "Continuation Coverage" and how does it work?

The Public Health Services Act requires most non-federal governmental plan sponsors, such as Sacramento City Unified School District, to offer Participants and certain covered family members the opportunity for a temporary extension of health care coverage (called “COBRA” Continuation Coverage”) in certain instances where coverage under the group health plan would otherwise end. Below is a description of your rights and responsibilities under COBRA.

NOTE: To the extent set forth in the Plan Information Appendix, you may be entitled to elect COBRA continuation coverage or a “spend down” option (but not both). See the Plan Information Appendix to determine whether a “spend down” option is offered and the terms of any such “spend down” option.

When Coverage May Be Continued Under COBRA

If you are a *Participant* or a covered *Dependent* under the HRA, then you may continue your coverage under the HRA if you lose coverage as a result of a “qualifying event” and you properly elect continuation coverage. Only active employees of the Employer have the right to COBRA continuation coverage if they lose coverage under the Plan as a result of a termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment. If you are a *Participating Retiree*, this means that you are not eligible for COBRA continuation coverage.

Your *Spouse* has the right to COBRA continuation coverage under the Plan if your *Spouse* loses coverage under the Plan as a result of any one of the following events:

- You die (depending on the terms of the applicable collective bargaining agreement); or
- You become entitled to Medicare.

Your covered *Dependent* children may have the right to COBRA continuation coverage under the plan if your *Dependent* children lose coverage as a result of any one of the following five events:

- you die; or
- your *Dependent* child ceases to be an *Eligible Dependent* under the Plan

These events that result in a loss of coverage are called “qualifying events.” Your covered *Spouse*, and your covered dependent children who are covered immediately preceding the qualifying event are called “qualified beneficiaries.” A child born to or adopted by (including a child placed for adoption with) a covered Employee during the covered Employee’s COBRA period is also considered a “qualified beneficiary” if properly enrolled. **A Dependent must be enrolled in Medicare to be eligible for benefits through the HRA.**

Notice and Election Rules

If the covered *Spouse* and/or covered *Dependent* children lose coverage as a result of a divorce, legal separation, or *Dependent* child ceasing to be a *Dependent*, you or the affected qualified beneficiary must send notice to the COBRA Administrator within 60 days of the later of:

- The event, and
- The date coverage is lost as a result of such event.

The qualified beneficiary will then be sent a notice of this right to continuing participation following receipt of your notice. Once you and/or any other qualified beneficiary have been provided notice of the right to elect COBRA continuation coverage, an election for continuation coverage under the Plan must be made within 60 days of the later of the date of the notice or the date coverage is lost as a result of the qualifying event. If a qualified beneficiary fails to provide this notice to the COBRA Administrator during this 60-day notice period, the qualified beneficiary will lose the right to COBRA continuation

coverage and coverage under the Plan will cease as of the last date you were eligible for coverage. Each qualified beneficiary has a separate and independent right to elect COBRA continuation coverage. A qualified beneficiary employee or spouse can elect coverage for any other qualified beneficiary. On the other hand, you may not decline COBRA continuation coverage for the qualified beneficiary spouse. A parent or guardian can elect coverage for a qualified beneficiary child who is a minor.

Duration of Coverage

Qualified beneficiaries other than the covered *Retiree* may continue coverage under the Plan for 36 months if coverage is lost as a result of the covered *Employee's* death.

Note: In all situations in which you or another qualified beneficiary is required to provide notice of a qualifying event (either an initial qualifying event or a subsequent qualifying event), you must identify the qualifying event, the date of the qualifying event, and the qualified beneficiaries impacted by the qualifying event.

Type of Coverage

If a qualified beneficiary chooses continuation coverage, he or she is entitled to the level of coverage under the HRA in effect for you immediately preceding the qualifying event. At the beginning of each Plan Year that COBRA is in effect, the qualified beneficiary will be entitled to an increase in their *Reimbursement Account* balance equal to the sum of the *HRA Dollars* allocated to similarly situated active participants (subject to any restrictions applicable to similarly situated active participants) so long as you continue to pay the applicable premium.

Cost

For the period of continuation coverage, the cost of such coverage will not exceed 102 percent of the “applicable premium,” as determined by the *Plan Administrator*. The *Plan Administrator* will notify you of the applicable premium. The notice you receive will describe the premium payment requirements under the Plan (i.e., who you pay the premium to, etc.), which will be no less frequently than monthly.

Early Termination of Coverage

A qualified beneficiary's continuation coverage will end prior to the expiration of the 36-month period for any of the following reasons:

- The company no longer provides group health coverage to any of its employees.
- The qualified beneficiary does not make the required payments (within the grace period).
- A qualified beneficiary on COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation with respect to any pre-existing condition of the individual.

Q-16. How long will the Plan remain in effect?

Although the *Employer* expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. All modifications/terminations effectuated by the Employer will be applied to all *Participants* and covered *Dependents* except as otherwise stated.

Q-17. Who do I contact if I have questions about the HRA?

If you have any questions about the HRA, you should contact the Third Party Administrator or the *Plan Administrator*. Contact information for the Third Party Administrator and the *Plan Administrator* is provided in the Plan Information Appendix.

PLAN INFORMATION APPENDIX

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

This Appendix provides information specific to the above-named Employer's Health Reimbursement Arrangement.

**The effective date of this Plan Information Appendix is January 1, 2015.*

I. GENERAL PLAN INFORMATION

1. Name, Address, and Telephone Number of the <i>Employer/Plan Sponsor</i> :	Sacramento City USD 5735 47th Avenue Sacramento, CA 95824
2. Name, Address, and Telephone Number of the <i>Plan Administrator</i> : The <i>Plan Administrator</i> shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The <i>Plan Administrator</i> may delegate one or more of its responsibilities to one or more committees.	CONEXIS 6191 North State Highway 161 Suite 400 Irving, TX 75038
3. Address for Service of Legal Process:	N/A
4. <i>Employer's</i> Federal Tax Identification Number:	94-6002491
5. Plan Number:	501

6. Original Effective Date of the HRA:	January 1, 2015
7. Plan Year:	1/1/2015 through 12/31/2015
8. Third Party Administrator:	CONEXIS
10. COBRA Administrator	N/A
11. How is the HRA funded?	general assets

II. ELIGIBILITY REQUIREMENTS AND EFFECTIVE DATE OF COVERAGE

A. The *Retirees* who satisfy the following requirements are eligible to participate in this HRA:

A former active employee of the *Employer*, who is enrolled in Medicare Parts A and B and who has remained continuously covered under the *Employer's* medical plan up until becoming a Participant in this Plan and who is eligible for Employer Medicare contributions as determined by the Employer.

B. The effective date of coverage under the HRA for *Participants* is:

The effective date of the Participant's coverage under a Medicare plan.

C. The effective date of coverage for *Eligible Dependents* is:

The date that the individual becomes an *Eligible Dependent*.

Initial Enrollment Period: The Employer will notify you the time period that you're *Eligible Dependents* first becomes eligible. If your *Eligible Dependents* enrolls at that time, their coverage will be effective as of the date your coverage is effective. If they do not enroll at that time, you will not have an opportunity to enroll them until the next Special Enrollment Period or Annual Enrollment Period described below.

III. ELIGIBLE MEDICAL EXPENSES

Only Medicare premiums are eligible for reimbursement under this Plan (provided all other terms and conditions of the HRA have been satisfied):

IV. HRA Dollars

A. The annual amount of *HRA Dollars* that may be allocated to a *Reimbursement Account* is:

Variable by Bargaining Unit, Date of Hire, and Years of Service

B. The annual *HRA Dollars* are allocated to your *Reimbursement Account* during the *Plan Year* as follows:

A pro-rata portion of your annual *HRA Dollars* identified above will be allocated to your *Reimbursement Account* on the first day of each month; however, if you become eligible during an allocation period, the Pro-rata portion for that allocation period will be allocated to your *Reimbursement Account* as of your effective date of coverage.

C. The balance of your *Reimbursement Account* during the *Applicable Coverage Period* may not exceed the following amount:

Please see your human resources department for additional information

V. APPLICABLE COVERAGE PERIOD

1/1/2015

VI. MINIMUM REIMBURSEMENT AMOUNT

The minimum amount that may be reimbursed is:

\$10

Requests for reimbursement that are less than the minimum reimbursement amount identified above until all aggregate amount of claims submitted for reimbursement is equal to or greater than the minimum reimbursement amount. The minimum reimbursement amount does not apply to claims filed during the last month of the Plan Year or claims filed during the *Run-Out Period* (if the *Applicable Coverage Period* is the *Plan Year*)

VII. CARRY OVER OF UNUSED HRA DOLLARS

No carry over is permitted

VIII. RUN-OUT PERIOD

Requests for reimbursement of Eligible Medical Expenses must be filed by no later than:

90 days

IX. Spend-Down Option

If the HRA has a Spend-Down Option, the terms and conditions of the Spend-Down Option will be provided below.

Under this HRA, you may elect either COBRA continuation (as described in the SPD) or this Spend-Down Option, but not both. The Spend-Down Option is designed to give you an alternative to COBRA continuation coverage. Under the Spend-Down Option, you may, in lieu of COBRA continuation coverage, elect to spend your unused *HRA Dollars* as of the date you terminate participation as a result of a “qualifying event” for COBRA purposes for Eligible Medical Expenses incurred during the Spend-Down Period by you and/or your *Eligible Dependents*. The Spend-Down Period begins on the date that you lose coverage under the HRA as the result of the Qualifying Event and ends on the earlier of the date you spend all remaining *HRA Dollars* in your *Reimbursement Account*. Any *HRA dollars* not used for expenses incurred during the Spend-Down Period will be forfeited. Unlike COBRA, you will not be eligible for any future employer contributions under the Spend-Down Option of the revocation of the previous waiver-not the date of the Qualifying Event. If you elect COBRA, you forever lose your right to elect the Spend-Down option.

