Health Reimbursement Arrangement Plan
Summary Plan Description

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INTRODUCTION TO THE PLAN

Your Employer has established a Health Reimbursement Arrangement Plan ("HRA") where by the Employee can be reimbursed for eligible out of pocket expenses that have been incurred because of limitations in their Healthcare Plans. Your Employer funds the HRA for all eligible Employees.

Your Employer has established specific limits per Plan Year for all eligible Enrollees. You can submit claims for eligible health care related expenses incurred by you or your covered dependents to be reimbursed up to the maximum allowed for the plan year.

In exchange for the favorable tax treatment of covered expenses paid through Health Reimbursement Arrangement Plans, the Internal Revenue Service imposes some requirements on the use of your accounts. These guidelines, along with other information about the operation of Health Reimbursement Arrangement Plans, are explained in the following pages.

Benefits are effective the same date as your benefit plan year. The terms and conditions of Your Employer Health Reimbursement Arrangement Plan are governed by the provisions in this document and any and all other written or oral communication regarding the plan or the benefits provided under the plan are superseded and are of no force or effect.

RIGHTS OF PLAN PARTICIPANTS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to specific information and actions.

Information about Your Plan and Benefits:

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan. You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan.

Prudent Actions 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 Health Reimbursement Arrangement Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Some of Your Rights under the HIPAA Privacy Rule:

You have the following rights regarding medical information we maintain about you:

- Right to Inspect and Copy.
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Confidential Communications
- Right to Request Restrictions
- Right to a Paper Copy of this Notice

Enforcement of Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know the reasons. You have the right to obtain copies of documents relating to the decision without charge, and to appeal any denial within established timeframes.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 31 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from

the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. Likewise, the court may order you to pay these costs and fees if you lose, or, for example, if it finds your claim is frivolous.

Assistance with Questions:

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER IMPORTANT PLAN PROVISIONS

Non-Discrimination Requirements

This Plan will comply with all Federal tax law requirements necessary to obtain tax benefits available under the Internal Revenue Code, including the requirement that the plan does not discriminate in favor of certain "key Employees" or "highly compensated Employees." A plan discriminates as to eligibility unless it benefits:

- 70% or more of all Employees, or
- 80% or more of all Employees eligible to benefit under the plan, if 70% or more of all Employees are eligible to benefit under the plan, or
- A group of employees described in IRS Section 410(b)(2)(A)(I) that is found to be a nondiscriminatory classification in accordance with Prop. Treas. Reg. 1.410(b)-For these purposes, there may be excluded from consideration any Employees who have not completed three years of service, part-time Employees whose customary weekly employment is less than 20 hours and nonresident aliens.

A Health Reimbursement Arrangement Plan will not discriminate as to benefits if the type and amount of benefits available to highly compensated participants are also available on the same basis for all other participants. This test is applied by looking at available benefits rather than actual benefit payments under the plan.

Note: If the Plan is discriminatory, then all or part of the medical benefits paid for the benefit of a highly compensated Employee will be taxable to that Employee.

Non-Discrimination and Health Benefits

The following information is from the IRC (Internal Revenue Code) - Section 105(h)

IRC Sec. 105 and Sec. 106 permit employers to offer certain health benefits on a tax-free basis. However, these rules can be different for highly compensated employees (HCEs) if the health plan is self-insured. An HCE is defined as:

- One of the five highest-paid officers
- A shareholder owning (actually or constructively) more than 10% of the company's stock
- Amount the highest paid 25% of all employees

There are two (2) tests under this Section of the IRC that employers need to be aware of while planning the funded benefits.

1. **Eligibility Test** – for a plan to be considered nondiscriminatory with respect to eligibility to participate, it must pass one of the three coverage tests:

    - 70% of all employees benefit under the plan
    - The plan benefits 80% of eligible participants and 70% of all employees are eligible
    - The plan benefits a nondiscriminatory classification of employees (not HCEs)

2. **Benefits Test** – the IRS regulations indicate that the plan must provide the same benefits for both HCEs and non-HCEs.

    A self-insured health plan discriminates as to benefits unless all benefits provided for participants who are

HCEs are also provided to all other participants. All benefits for dependents of HCEs must also be available on the same basis for the dependents of all other employees. The self-insured health plan will also be considered discriminatory as to benefits if it covers HCEs and the type or amount of benefits subject to reimbursement is offered in proportion to compensation.

When applying nondiscrimination test, all employees of a controlled group or affiliated service group, as defined in the IRC Sec. 414, are treated as employed by a single employer.

Benefits Received and Taxable Income under Non-Discrimination Guidelines

If a benefit under the self-insured plan is available to HCEs but not to other employees, the total amount of reimbursement to the HCE with respect to that benefit is an 'excess reimbursement' and must be included in the HCE's income taxes an imputed income.

Employers and benefit consultants should always discuss these issues with Tax Accountants while designing health plans for employees.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. You will give this Plan the information it asks for about other Plans and their payments of allowable charges.

Method of Funding Benefits

Health Reimbursement Arrangement Plans are fully funded by your Employer through their general assets account and are used exclusively for the benefit of plan participants and, as such, are used to pay benefits available under the terms and conditions of the plan. However, unused balances in the Health Reimbursement Arrangement Plans are forfeited by the participants.

Severability

The provisions of this Plan will be considered severable; therefore, if a provision is deemed invalid or unenforceable, that decision will not affect the validity and enforceability of the other provisions of the plan.

Interpretation of the Plan

The Plan Administrator, who is a fiduciary of the plan, has the sole and absolute discretion to construe and interpret the provisions and terms of the plan, to resolve any disputes that may arise under the plan and otherwise determine the operation and administration of the plan. In making such interpretations and determinations, the Plan Administrator shall take into account the interpretation of the provisions and terms of the plan.

Any and all such decisions and determinations made by the Plan Administrator shall be final and binding upon all parties.

Amending and Terminating the Plan

Your Employer reserves the rights, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

Status of Employment Relations

The adoption and maintenance of the plan shall not be deemed to constitute a contract between you and the Plan Sponsor, or to be considered an inducement or condition of the employment of any person. Nothing herein contained shall be deemed (i) to give you the right to be retained in the employ of the Plan Sponsor; (ii) to affect the right of the Plan Sponsor to discipline or discharge you at any time; (iii) to give the Plan Sponsor the right to require you to remain in its employ; or (iv) to affect your right to terminate your employment with the Plan Sponsor at any time.

Conformity with the Law

Except to the extent preempted by federal law, the Plan will provide any coverage required to be provided by any applicable state or federal law. If any provision of the Plan is contrary to any applicable law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

Things to Consider

Unused Health Reimbursement Arrangement Plan Balances - it is important for you to be aware of and understand restrictions placed by the Internal Review Service on any of those funds that have not been used by the end of any particular plan year. To comply with these restrictions:

All claims for Health Reimbursement Arrangement Plan funds must be received by SISCO no later than 90 days after the end of the plan year. The Plan does not allow for the payment of late claims.

Assignment of Plan Benefits and Claims of Creditors

Plan benefits are not subject to the claims of your creditors to the extent the law permits. The Plan does not permit assignment of transfer of Plan benefits. Ask the Plan Administrator to clarify any part of this Plan you do not understand. Only the Plan Administrator can interpret this Plan. Do not rely on interpretations from any other source.

PRIVACY OF PROTECTED HEALTH INFORMATION

The Plan Sponsor agrees to the following:

1. The Plan will not disclose PHI to your Employer in its capacity as the Plan Sponsor, unless it receives a certification by the Plan Sponsor that the plan documents have been amended to incorporate the required provisions.

2. PHI may be disclosed from the Plan to members of your Employer workforce, as necessary, for the members of the workforce to carry out the Plan Administration functions with your Employer as the Plan Sponsor. The disclosure may be made without the authorization of the individual to whom the information pertains if the plan document meets the requirements of the Policy and the Standards of Privacy of Protected Information policy. The following disclosures are NOT permitted without the individual's authorization:

   Disclosures by a health insurance company or health maintenance organization that provides benefits to your Employer employees through its Group Health Plan, if the disclosures do not comply with the provisions of the plan documents;

   Disclosures to the Plan Sponsor for purposes of employment related actions, or for decisions in connection with any other benefit or employee benefit plan offered by your Employer.

3. The Plan Sponsor agrees it will not use or further disclose PHI received from the Plan other than as permitted or required by the plan documents or as required by law.

4. The Plan Sponsor agrees that it will ensure that any agents, including any subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

5. The Plan Sponsor will not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

6. The Plan Sponsor will agree to report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.

7. The Plan Sponsor will agree to permit individuals to have access to minimal PHI, which it has received from the Plan, as needed to administer the Plan.

8. The Plan Sponsor will agree to make available protected health information for amendment and incorporate any amendments to protected health information in accordance with Privacy Guidelines.

9. The Plan Sponsor will agree to make available the information required to provide an accounting of disclosures in accordance with HIPAA Privacy guidelines.

10. The Plan Sponsor will agree to make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with Federal privacy regulations regarding PHI.

11. The Plan Sponsor will agree, if feasible, to return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which

disclosure was made; except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

12. In order to provide adequate separation between the Plan Sponsor and the Plan, those employees or classes of employees described below, under the control of the Plan Sponsor may be given access to PHI for disclosure. Any employee or person who receives PHI relating to Payment, Health Care Operations, or other matters pertaining to the Plan in the ordinary course of business are included in this description.

    Those who are assigned to the administration of the Plan. This includes claim processing, maintenance of enrollment and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the Group Health.

    Others who are authorized to have access to PHI on behalf of Your Employer, in its role as the Plan Sponsor, for purposes permitted by the plan documents.

13. The Plan Sponsor will agree to restrict the access to and use of PHI received from the Plan by members of its workforce (as described in item 12 above) to the Plan Administration functions that the Plan Sponsor performs for the Plan.

14. The Plan Sponsor agrees to implement an effective mechanism for resolving any issues of noncompliance in the event any member of the workforce who is authorized to have access to the Plan's PHI violates any of the provisions of the plan documents as set forth in this policy and will include disciplinary action up to and including termination of employment.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Group Health Plan.

2. Shall meet all requirements regarding security for the protection of electronic protected health information as detailed at 45 CFR parts 160, 162 and 164 as well as HITECH Act Subtitle D.

3. Ensure that the adequate separation required by § 164.504(f)(2)(iii) of the Privacy Rule is supported by reasonable and appropriate security measures.

4. Ensure that any agent, including a subcontractor, to whom it provides this information, agrees to implement reasonable and appropriate security measures to protect the information.

5. Report to the Group Health Plan any security incident of which it becomes aware.

ELIGIBILITY AND PARTICIPATION

Who Is Eligible?

You are eligible for coverage under the Plan if you are an Active, full-time Employee of your Employer, enrolled in the Employer's Benefit plan, and residing in the United States. An Active Employee is an Employee who is on the regular payroll of the Employer. If an employee works a partial year, they are entitled to the full amount through the Health Reimbursement Arrangement Plan. If an employee has an enrollment level change (i.e. individual coverage changes to family coverage), funding will be prorated and adjusted accordingly.

When Participation Ends

Your participation in the Health Reimbursement Arrangement Plans ends on the earliest of:

- The date the medical plan terminates after termination of employment;
- The date you transfer to an ineligible class of employee; or
- The date Your Employer discontinues the plan.

If you terminate your employment during the plan year, or your participation in this plan ends for any reason, you will have no more than 90 days following your date of termination to submit expenses for services rendered while you were eligible under the Plan. Any expenses incurred after your termination will not be eligible for payment.

No Guarantee of Payment or Employment

This Plan shall not be interpreted to constitute a contract of employment. No part of this Plan shall give any employee the right to be retained in the employer's service or interfere with the employer's right to terminate his employment at any time, nor shall it give the employer the right to interfere with the employee's right to terminate his employment at any time.

HEALTH REIMBURSEMENT ARRANGEMENT PLAN

How Much Can You Use?

Your Employer will reimburse through the Health Reimbursement Arrangement Plan (HRA) up to the maximums allowed for all eligible out-of-pocket expenses in the plan year.

HOW HEALTH REIMBURSEMENT ARRANGEMENT PLANS WORK

As you or your covered dependents incur expenses that can be reimbursed from a Health Reimbursement Arrangement Plan, you may submit them with a request for reimbursement, and payments are made to you from your account(s) using the tax-free dollars your Employer has set aside.

Payments from Health Reimbursement Arrangement Plans cannot be made to anyone but you (or your survivors in the event of your death).

The Advantages of a Health Reimbursement Arrangement Plan

Paying for eligible health-care expenses through a Health Reimbursement Arrangement Plan offers advantages to both the Employer and the Employees. The Medical Expenses that are reimbursed are tax deductible by the Employer and the Employer has flexibility in the design of the plan's provisions, such as establishing maximum amounts for reimbursement and setting eligibility requirements for participation. The biggest advantage to Employees is that the plan's reimbursement payments are not considered to be taxable income to Employees, provided that they have not taken a medical expense deduction for these amounts on their personal income tax return.

IMPORTANT:
If your employer offers a Qualified High Deductible Health Plan (QHDHP) <u>and</u> you are enrolled in the QHDHP <u>and</u> you have decided to open and contribute to a Health Savings Account (HSA) <u>and</u> your employer is offering a Health Reimbursement Arrangement (HRA) to reimburse for eligible medical expenses <u>you will not be able to participate in the HRA plan</u>. You will need to complete an enrollment form indicating that you are <u>opting out</u> of the HRA plan because you are currently participating and contributing to an HSA plan. Please see your HR representative for a copy of this form.

ELIGIBLE EXPENSES

Expenses

You can be reimbursed for eligible out-of-pocket expenses you incur for yourself or your covered dependents.

To qualify for reimbursement from your Health Reimbursement Arrangement Plan, expenses cannot be reimbursable from any health care plan or other insurance.

Your employer may decide to cover Over-the-counter drugs and expenses with the HRA plan. Please refer to the HRA plan's Summary of Benefits and Summary of Benefits & Coverages to see what is covered.

If the plan sponsor does cover Over-the counter drugs and expenses it is important to know that The Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") effective January 1, 2020 amended the requirements to the Health Reimbursement Arrangement to cover or reimburse for Over-the counter drugs and medicines.

Over the Counter (OTC) items listed below (but limited to) are covered by your Health Reimbursement Arrangement plan. Some of the items may also be covered under the Medical Group Health Plan. Plan limitations would apply as documented in your medical benefit summary description.

Acid Controllers
Allergy & Sinus
Antibiotic Products
Anti-Diarrheal Medication
Anti-Gas Medication
Anti-Itch & Insect Bite
Anti-Parasitic Treatments
Baby Rash Ointments/Creams
Band Aids
Birth Control
Braces & Supports
Catheters
Cold Sore Remedies
Contact Lens Supplies & Solutions
Cough, Cold & Flu Medication
Denture Adhesives
Diagnostic Tests & Monitors
Digestive Aids
Elastic Bandages & Wraps
Feminine Anti-Fungal/Anti-Itch Medication
First Aid Supplies
Hemorrhoid Preps
Home Testing for Covid-19
Insulin & Diabetic Supplies
Laxatives
Menstrual Care Products
Motion Sickness Medication
Ostomy Products
Pain Relief
Personal Protective Equipment (PPE)
Reading Glasses
Respiratory Treatments
Sleep Aids & Sedatives
Stomach Remedies
Wheelchairs, Walkers, Canes

EXPENSES NOT COVERED BY HEALTH REIMBURSEMENT ARRANGEMENT PLANS

Out-of-pocket expenses incurred for medical plan benefits that are **NOT COVERED** under the Employer's Benefit Plan would also **NOT** be covered under this Plan. This would include medical plan benefit limitations, medical plan exclusions and any information not noted as covered in the HRA plan's Summary of Benefits.

REQUESTING BENEFITS FROM YOUR HEALTH REIMBURSEMENT ARRANGEMENT PLANS

When you or your covered dependents incur eligible expenses during the year, you must submit them for reimbursement from your Health Reimbursement Arrangement Plan. The procedures for filing benefit requests for each account are explained below.

From the Health Care Health Reimbursement Arrangement Plan

Expenses eligible for reimbursement due to your participation in your Employer Health Reimbursement Arrangement Plan will be considered first under the appropriate plan.

Eligible health care expenses should be submitted with the request form and an EOB (Explanation of Benefits) or an itemized bill with the following information included:

- Provider's name
- Patient's name
- Date of service or purchase
- Diagnosis or condition being treated
- Cost of each service or supply
- Insurance carrier payment
- Insurance carrier adjustment

IMPORTANT:

If another health plan (including Medicare) is responsible to pay benefits before your Employer Health Reimbursement Arrangement Plan, submit expenses to the other plan before submitting them to this plan for consideration. When you do submit them to this plan, attach a copy of the other plan's payment explanation worksheet so that any remaining unpaid health care expense can be paid through your Health Reimbursement Arrangement Plan. This is necessary because in order to qualify for reimbursement from your Health Reimbursement Arrangement Plan.

GUIDANCE ON SUBSTANTIATING CLAIMS PAID WITH HRA DEBIT CARDS

The Internal Revenue Service (IRS) released a Ruling concerning substantiation of medical expenses that are paid using a debit card in connection with Health Reimbursement Arrangements (HRAs). Substantiation of claims is required to ensure the tax-exempt nature of these health care reimbursement accounts.

What Are HRA Debit Cards?

A HRA debit card or "Flex Card" is electronically loaded with a set amount of funds, such as the maximum amount available in an Employee's HRA during a plan year. The card is given to you and age-appropriate Dependents (if requested) to be used by you and covered family members to pay for copayments, coinsurance and other eligible expenses not covered by the medical plan. For example, if you visit a Physician who accepts the card, and incur a $20 copayment, you could use the card to pay the Physician directly from the HRA.

Procedures to Meet Substantiation Requirements:

The following procedures meet the substantiation requirements for electronic reimbursement:

- ❖ You must certify upon enrollment and each plan year thereafter that the card will only be used for eligible medical care expenses of you and your Dependents. They must also certify that any expense paid with the card has not been reimbursed, and that you will not seek reimbursement, under any other plan covering health benefits.

- ❖ Reimbursements for medical expenses may only be processed if they originate with certain vendors having health care-related Merchant Codes (e.g., Physicians, Pharmacies, and Hospitals).

- ❖ Every claim must be reviewed and substantiated, either manually or (for electronic claims) automatically using one of the following methods: (1) the copayment for a service or product matches the amount specified for that type of medical service provider, as indicated by its Merchant Code; (2) recurring claims for which the dollar amount, provider and time period of the claim have been previously approved; and (3) real-time substantiation in which the card links electronically with a medical services provider, such as a Pharmacy Benefit Manager (PBM), that permits substantiation of a claim at the time and point of sale.

- ❖ This plan document includes meaningful correction procedures, later in this section, for claims that are subsequently identified as impermissible, including requiring you to repay the amount.

Key Points in Understanding the IRS requirement:

(1) You and your Dependents are responsible for using the Flex Card correctly and according to the law.

(2) Merchant Category Codes, as identified by MasterCard, will be the primary tracking tool for payment and/or auditing of expenses.

(3) The Claims Processor and the Plan Claims Administrator can select a method to substantiate claims for payment through the Health Reimbursement Arrangements based on their health care plan.

(4) Acceptable substantiation can be:

  - ❖ Copayment matching (using Merchant Category Codes);
  - ❖ Identification of recurring expenses;
  - ❖ Pharmacy Benefit Manager (PBM) matching in or after the fact (retro) or real-time point-of-service match.

(5) You and your Dependents will be able to use the Flex Card to purchase eligible medical expenses and supplies.

(6) If you or your Dependents use the Flex Card illegally, the IRS has established guidelines for the Employer to recover the funds.

(7) You and your Dependents will be held liable for any funds charged against the Flex Card improperly.

The Claims Processor and the Plan Administrator reserve the right to inactivate the Flex Card if requested claim substantiation is not made in a timely manner as defined in the request.

Correction procedures for claims that are subsequently identified as impermissible:

Step 1 – Request Employee Repayment of Ineligible Amount

1) Claims Administrator notifies cardholder that ineligible amount must be repaid to the plan either via email or mailed letter.

2) If cardholder repays the amount: Claims Administrator marks the transactions as "Resolved – Employee Pay."

3) If cardholder does not repay the amount (or provide further substantiation for the claim), Claims Administrator leaves cards at temporarily inactive, and goes to Option A, B, or C of Step 2 as appropriate.

Step 2

Option A – Withholding Amount from Employee Wages

1) Claims Administrator temporarily inactivates all cards attached to your account (including Dependent cards).

2) Claims Administrator notifies Employer of failure to provide sufficient documentation to substantiate claim.

3) Employer withholds amount from your wages and provides funds to the Claims Administrator for deposit back to the plan (if allowed under state law).

4) Upon receipt of the funds from Employer, Claims Administrator marks the transaction as "Resolved – Payroll Deduction."

5) Claims Administrator reactivates all cards attached to the account.

Option B – Offset Prior Ineligible Transaction with Eligible Transaction

1) Claims Administrator temporarily inactivates all cards attached to your account (including Dependent cards).

2) Claims Administrator notifies cardholder that subsequent claims must be submitted via a manual process until ineligible amount is repaid, either via email or mailed letter.

3) Cardholder submits claim for eligible expense.

4) Claims Administrator offsets the eligible expense against the amount owed for the ineligible transaction.

   a) If the eligible expense is in excess of the ineligible claim, Claims Administrator reimburses the difference to the cardholder, and reactivates the cards associated with your account.

   b) If the eligible expense is less than the ineligible claim, Claims Administrator notifies the cardholder that additional eligible expenses will need to be submitted to offset the ineligible transaction. Cards are not reactivated.

WHERE TO SEND YOUR CLAIMS

Mail or forward completed claim forms to:

HRA Department, SISCO
P.O. Box 1542
Dubuque, IA 52004-1542
Fax – 563-207-7300
Email RAServices@siscobenefits.com

*****DO NOT SUBMIT CANCELLED CHECKS OR UNITEMIZED RECEIPTS*****

If you believe a request for reimbursement was improperly settled, the following process is available:

1. Within 60 days of receipt of the processed request for reimbursement, you may request, in writing or verbally, that the plan conduct a review of the processed request for reimbursement. The plan will review the processed request according to the provisions of the plan document and inform you whether or not an error was made. Any errors will be corrected promptly.

   All requests for a review of denied reimbursement should include a copy of the initial denial letter and any other pertinent information. Send all information to:

   HRA Department, SISCO
   P.O. Box 1542
   Dubuque, IA 52004-1542

2. If you are not satisfied with the above review, a written request for a second review may be submitted to the plan within 60 days of the first review. The plan will then forward the file to your Plan Administrator. The request should state, in clear and concise terms, the reason for disagreement with the way the request was processed.

Requests for a second review must be in writing with a copy of the original processed request for reimbursement information, first review decision and any other information attached.

When the Plan Administrator receives the written request, the request for reimbursement will be reviewed again and the results of this review furnished in writing to you within 60 days in most cases, but in no case more than 120 days.

Requests for appeals, which do not comply with this procedure, (including failure to provide additional or requested information) will not be considered, except in extraordinary circumstances.

Other Important Information Regarding your Plan:

Newborns’ and Mothers’ Health Protection Act of 1996 (Newborns’ Act)

Employee Benefit Plans offering group health coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Genetic Information Nondiscrimination Act

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

Women’s Health and Cancer Rights Act (WHCRA)

The Women’s Health and Cancer Rights Act (WHCRA) signed into law on October 21, 1998, amended ERISA and the Public Health Service Act by including important protections for mastectomy patients who elect breast reconstruction in connection with a mastectomy. An eligible patient who is receiving benefits in connection with a mastectomy will be eligible for the following benefits in a manner determined in consultation with the attending physician and the patient for:

1) All stages of reconstruction of the breast on which the mastectomy has been performed.
2) Surgery and reconstruction of the other breast to produce symmetrical appearance.
3) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedema.

Such coverage is subject to all plan provisions, limitations and requirements outlined in your Summary Plan Description.

Mental Health Parity and Addition Equity Act

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addition Equity Act and ERISA Section 712.

DEFINITIONS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under previously explained provisions of this Plan.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis. An Employee who is absent due to Illness or Injury will be considered an Active Employee.

Amend adds, deletes or changes the provisions of the Plan and applies to all Covered Persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

Amendment is a formal document signed by the representative of your Employer.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is your Employer.

Forfeiture is the loss to the individual of unused Health Reimbursement Arrangement Plan credits.

Plan Administrator is your Employer.

Plan Sponsor is your Employer.

Plan Year is the twelve (12) month plan period for the Employer Health Reimbursement Arrangement Plan.