Summary Plan Description for the
North Wasco County School District 21
Synergy Health Reimbursement Arrangement Plan

General Benefit Information

Eligible Expenses
The plan provides benefits for the following Eligible Expenses:

Deductible Reimbursement*

Employee Responsibility (core deductible)	First $400 of deductible expenses
Reimbursement Plan	80% of the remaining $1,200 deductible expenses
Total Reimbursement Available	$960.00 per Participant
Total Health Plan Deductible	$1,600 per Participant

*All amounts are per participant, up to three participants

Coinsurance/Copay Reimbursement – Single Coverage

Employee Responsibility	20% ($2,360) of first $11,800 of coinsurance/copay expenses
Reimbursement Plan	20% of next $14,450 of coinsurance/copay expenses
Total Reimbursement Available	$2,890 Maximum
Insurance Coverage Pays	80% ($21,000) of the full $26,250 of coinsurance/copay expenses

Coinsurance/Copay Reimbursement – Employee + Family**

Employee Responsibility	20% of coinsurance/copay expenses / $2,360 per participant
Reimbursement Plan	20% of coinsurance/copay expenses
Total Reimbursement Available	$2,890 per Participant to a Maximum of $5,780

**The maximum payout available for an Employee and Family will vary depending upon how many family members meet the deductible, which is counted toward the family out of pocket maximum.

Expenses are considered eligible only if (1) they are incurred while the individual is covered by this plan and (2) they are considered "qualifying expenses" under the Health Plan, as described in the certificate of coverage or summary plan description for that plan, and which are applied to the health plan's maximum out of pocket limit including deductible, coinsurance and medical copays.

Any expenses incurred after participation in the Plan ends are not eligible for reimbursement

Plan Year
The Plan Year is the 12 month period beginning on October 1st and ending on the following September 30th

Health Plan
The Health Plan is the group health benefit plan sponsored by the Employer, which the employer has identified as including this Health Reimbursement Arrangement.

Eligibility Requirements
Employees who are eligible for and who have elected to participate in the Health Plan (Plan G) are eligible for coverage under this Plan. Coverage will become effective on the first day of the month following date of hire.

Dependents are only eligible if they are covered by the Health Plan. Employees must work the numbers hours required for eligibility for the health plan.

Eligibility of employees covered under a Collective Bargaining Agreement
Employees who are covered by a collective bargaining agreement are only eligible for this Plan if the collective bargaining agreement specifies that medical benefits include the coverage provided by this Plan.

Enrollment
Employees must enroll in this Plan by completing the Enrollment Form that has been provided by the Employer. An open enrollment period is held each year.

Funding
The Employer pays for the coverage under this Plan out of its general assets. Participants are not required to contribute to the cost of coverage.

Carryover of Funds
Under the Plan, unused amounts in your HRA Account, at the end of the claims submission deadline will not carryover from plan year to plan year.

Claims Submission Deadline
Claims must be submitted by December 31st following the end of any Plan Year
Claims must be submitted within 90 days after termination of coverage under this Plan

Claims Administrator
IntegraFlex
2402 W. Jefferson Street
Boise, ID 83702
(208) 287-0310
https://integra-flex.com

Eligibility and Coverage

Who is eligible for coverage under this Plan?

Any employee of the Employer who meets the eligibility requirements (shown under General Benefit Information) is eligible for coverage under this Plan. Coverage under the Health Plan is required for coverage under this Plan.

An employee who participates in this plan can also enroll his/her legal spouse and/or children. Children include the biological children, step children, adopted children and foster children of the Participant. Adopted children include children who are placed for adoption with the Participant. Foster children include children who are placed with the Participant for adoption by a qualified foster agency or court. Coverage is available for children until they reach age 26. Any spouse or child who is eligible for coverage under the Health Plan will be eligible for coverage under this Plan, notwithstanding any provision in this Plan that would limit that eligibility.

How do I enroll for coverage?

Eligible employees must enroll for coverage by filling out, signing and returning an enrollment form. New employees must enroll within 30 days of eligibility or they will not be permitted to enroll until the open enrollment period that is held each year, or as provided below. Any Eligible Employee that enrolls will be a Participant in the Plan.

What happens if I don't enroll myself or my spouse or child within 30 days of eligibility?

If an Eligible Employee does not elect coverage within 30 days of initial eligibility or if a Participant does not enroll a spouse or child within 30 days of that individual's eligibility, the Eligible Employee can enroll during any annual open enrollment period and a Participant can enroll any spouse or child during the open enrollment.

In addition, if an event occurs that triggers one of the HIPAA special enrollment rights, the Eligible Employee can enroll or a Participant can enroll any spouse or child within 30 days of the applicable date. HIPAA special enrollment is permitted when:

- the Eligible Employee or his or her spouse or child previously declined coverage that has now been lost because it was exhausted (COBRA) or terminated due to loss of eligibility or loss of employer contributions ;

- A new dependent is acquired as a result of marriage, birth, adoption, placement for adoption or placement by a foster agency or court.

There may be additional election rights contained in the employer's plan. See the Employer for details.

Benefits

How does the health reimbursement account work?

The Health Reimbursement Account works like this:

- The Claims Administrator records the amount that is available in your Health Reimbursement Account, though the account exists only as a paper record;
- When you have an Eligible Expense, you will submit an Explanation of Benefits from the insurance company or a detailed receipt from the provider to the Claims Administrator; and
- If the claim is eligible for reimbursement and there are sufficient funds in your Health Reimbursement Account, the Claims Administrator will direct deposit the funds into your provided bank account and subtract the amount paid from your Reimbursement Account balance.

What expenses are eligible for reimbursement?

Eligible Medical Expenses include expenses that are considered "qualifying expenses" under the Health Plan, as described in the certificate of coverage, and which are applied to the health plan's maximum out of pocket limit including deductible, coinsurance and medical copays.

However, the Reimbursement Account funds cannot be used for deductible or coinsurance expenses until after the Employee and his or her spouse and Dependents (if any) have satisfied their portion.

To be considered "Eligible," the expense must also be incurred during the Plan Year. An expense is incurred when the care is provided rather than when you are billed or when you pay for the service. For employees who enroll in the Plan in the middle of a Plan Year, expenses incurred before coverage becomes effective are not eligible. This is also true for any dependents that enroll during the Plan Year.

Any expenses incurred after participation in the Plan ends are not eligible, though Employees have until the claims submission deadline after termination of coverage to submit any expenses incurred during the period of participation. See the section on COBRA continuation for a discussion of extended coverage.

If I am also enrolled in a health care flexible spending account, which plan pays first?
Benefits under this Plan are intended to pay for Eligible Expenses that are not reimbursed or reimbursable by another plan. However, if an Eligible Expense is covered by both this Plan and a health care flexible spending account, then this Plan would pay before reimbursement under the flexible spending account would be available.

How does Coordination of Benefits work if I am covered under a health plan sponsored by another employer?
This plan is intended to cover only participant out of pocket expenses, that are not reimbursed or reimbursable by another plan. If a participant is covered under two health plans, claims need to be submitted to both plans and an Explanation of Benefits for both carriers need to be submitted with reimbursement requests.

What happens if I receive reimbursement for a qualifying medical expense and I receive reimbursement under this plan?
If you receive a reimbursement under this Plan and reimbursement for the same expense is made under another plan, you will be required to refund the reimbursement to the Employer. Any amount not refunded becomes taxable income to the Participant.

Will I receive coverage for pre-existing conditions under this Plan?
There are no restrictions for pre-existing conditions under this Plan. However, if the Health Plan contains a pre- existing condition exclusion or limitation, any expenses not covered under the Health Plan will not be eligible for coverage under this Plan, unless otherwise stated under General Benefit Provisions.

Claim Submission

How do Participants receive benefits under the Plan?
When you have an Eligible Expense you must submit an Explanation of Benefits to the Claims Administrator. If the claim is eligible for reimbursement, the Claims Administrator will direct deposit the funds into your provided bank account.

Claims incurred during any Plan Year can be submitted until the Claims Submission Deadline after the end of that Plan Year and up to the Claims Submission Deadline after coverage ends for whatever reason. The Deadlines are shown under General Benefit Information.

All claims will be processed and paid (if eligible under the Plan) within 30 days of receipt of a completed Request for Reimbursement Form. However, the Claims Administrator may request a 15-day extension for matters beyond its control.

What happens if a claim is denied?
If a claim is denied because it is incomplete, the Claims Administrator will provide a description of any additional material or information necessary and an explanation of why this material or information is necessary. This notice will be provided within 5 days of receipt of the claim (or immediately for urgent care claims).

After receipt of all the information needed to review a claim, if any claim for benefits under the Plan is wholly or partially denied, the Claims Administrator will give notice in writing of the denial within 30 days after the claim is filed. This notice will include the following information:

- Information that is sufficient to identify the claim involved (including date of service, name of health care provider, claim amount, diagnosis code and its meaning, and the treatment code and its meaning)
- The specific reason or reasons for the denial, including a description of the meaning of any denial code;
- Specific reference to pertinent Plan provision, internal rule, guideline, protocol or similar criteria on which the denial is based.

If you request a review of the claim denial, you may review pertinent documents and submit issues and comments in writing. The appeal will be reviewed by a committee or individual who was not involved in the initial denial. The decision of the Claims Administrator on review will be made promptly, but not later than 30 days after receipt of the request for review, unless special circumstances require an extension of time for processing. The decision on review will be made in writing and will include specific reasons for the denial, written in a manner that you can understand and will include references to the Plan provisions on which the denial is based. The notice of denial will include a discussion of the decision.

The Claims Administrator will provide you with any new or additional information that was considered, relied upon or generated in connection with the claim. This information will be provided in advance of the final determination so that you have a reasonable opportunity to respond prior to that date.

Upon exhaustion of the internal review process, you have the right to initiate an external review of the denial. The Claims Administrator will provide a description of the applicable external appeal process.

Termination of Coverage

When does coverage terminate under this plan?
Coverage for a Participant or any spouse or child will terminate on the earlier of:

- the date of termination of this Plan;
- the date the Participant is no longer actively employed by the Employer;
- the date the Participant number of hours required for coverage drop below the required hours;
- the date the Participant, spouse or child is no longer covered by the Health Plan;
- the date the Participant is absent from employment for more than 31 days for a period of duty in the Uniformed Services;
- the date the Participant is no longer in a class of Employees that is eligible for Plan coverage;
- the date that an Employee or Dependent is determined to have submitted any claim that contains false or fraudulent information under state or federal law

What happens to my coverage if I take a FMLA leave or other leave of absence?
Your coverage (and the coverage of your spouse and children) may continue during a FMLA leave or other leave of absence in accordance with the requirements of the FMLA or the Employer's policies. If you fail to return to active employment with the Employer, your coverage will terminate at the earlier of: (1) the end of the leave of absence, unless the leave resulted from your disability and continued coverage is considered an accommodation under the Americans with Disabilities Act and its regulations (as amended); or (2) the date you tell the Employer that you do not intend to return to active employment at the required number of hours per week.

What happens if I re-enroll after coverage terminates?
If a covered Employee terminates his or her employment for any reason, including disability, retirement, layoff or voluntary resignation, and then is rehired within 30 days or less, the Employee's reimbursement account will be reinstated to the date of termination with the same balance that the individual had before termination, pending reinstatement in the Health Plan.

Continued coverage under this Plan for employees who are on other leaves of absence will be determined in accordance with the policies of the Employer.

Can I elect COBRA if I lose coverage under this plan?

COBRA is available for this Plan only if the Employer is subject to the requirements of federal COBRA laws for the applicable Plan Year.

If an Employee's and/or Dependent's coverage under this Plan terminates because of a "qualifying event," each individual has a right to purchase continued coverage for a temporary period of time. COBRA coverage is available under this Plan, only if the individual also elects COBRA under the Health Plan and if COBRA is elected under the Health Plan, coverage under this Plan will continue under the same terms.

Qualifying events include termination of employment, reduction in hours, divorce, death, or a child ceasing to meet the definition of Dependent. A participating Employee or Dependent must notify the Administrator of any divorce, legal separation, or a child ceasing to be considered a Dependent under the Plan within 60 days after the event. This notice must be in writing and addressed to the Administrator. In addition, if a second qualifying event occurs during COBRA continuation coverage or if the former Employee becomes entitled to Medicare or dies during the COBRA coverage, the former Employee or Dependent (as applicable) must notify the Administrator. Finally, an Employee must notify the Administrator of the start or end of any disability that is determined under the Social Security Act to be a covered disability.

Any notice described in the above paragraph must be provided in writing to the Administrator within 60 days of the occurrence of the event (except that if there is a change in the Employee's disability status, notice must be given within 30 days). If the Employee or Dependent fails to provide notice within the required time period, he or she may no longer be eligible for COBRA continuation coverage. In this event, the Administrator may send Notice of Unavailability of COBRA Coverage upon receipt of the late notice.

If you have any questions about your COBRA rights, please read the COBRA notice, which has been provided to you and your spouse (if covered) at the time of your enrollment in the Health Plan. You can contact the Administrator if you need another copy.

You will need to follow the procedures set forth in the Notice that you will receive when your participation ends and you will be required to make premium payments for continued coverage.

Can I continue coverage during a period of active military duty?

Yes, you can continue coverage in accordance with USERRA for yourself and/or your covered spouse and children during a period of absence from employment due to military service. This extended coverage will be administered similar to COBRA coverage in accordance with the Employer's policies and can continue for up to 24 months.

How long will the plan remain in effect?

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

Notices

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 requires group health plans, insurance companies, and HMO's that cover hospital stays following childbirth to provide coverage for a minimum period of time. In general, hospital coverage for the mother and newborn must be provided for a minimum of 48 hours following normal delivery, or 96 hours following a cesarean section. Group health plans may not restrict benefits for a hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following delivery, and less than 96 hours following a caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-pockets costs or to use a certain provider or facility. Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

The Plan provides coverage in compliance with The Newborns' and Mothers' Health Protection Act.

Women's Health and Cancer Rights Protection Act

The benefits of most health plans must include coverage for the following post-mastectomy services and supplies in a manner determined in consultation with the attending physician and the patient:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Health Plan and the terms of this plan.

General Plan Information

Plan Name
North Wasco County School District 21 Health Reimbursement Arrangement

Type of Plan
This Plan is a Health Reimbursement Arrangement that is integrated with major medical coverage that is described in a separate SPD.

Plan Year
October 1st- September 31st

Plan Number
501

Effective Date
October 1, 2016

Employer/Plan Sponsor
North Wasco County School District 21
3632 W. 10th Street
The Dalles, OR 97058
(541) 506-3424

Name of other participating Related Employers
None

Plan Sponsor's Employer Identification Number
75-3154866

Plan Administrator
North Wasco County School District 21
3632 W. 10th Street
The Dalles, OR 97058
(541) 506-3424

Named Fiduciary
North Wasco County School District 21
3632 W. 10th Street
The Dalles, OR 97058
(541) 506-3424

Agent for Service of Legal Process
North Wasco County School District 21
3632 W. 10th Street
The Dalles, OR 97058
(541) 506-3424

Statement of ERISA Rights

As a participant in the 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 are entitled to:

Receive Information about the Plan and its Benefits

You are entitled to examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if there are 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), any updated summary plan description and, if there are 100 or more participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

If there are more than 100 participants in the Plan, you are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

During any Plan Year in which the Employer is subject to COBRA, you are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. You are also entitled to review this summary plan description and the documents governing your COBRA continuation coverage rights.

You are entitled to reduction or elimination of any exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to any plan pre-existing condition exclusion which may be up to 12 months (or 18 months for late enrollees) after your enrollment date in your coverage.

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 Employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union (if any), 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.

Enforce Participant's Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 that 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 federal court. The

court shall decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about the 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 the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.