Illinois Wesleyan University Notional Account Health Reimbursement Arrangement Plan Document

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Plan Purpose

The name of this Plan is Illinois Wesleyan University Notional Account Health Reimbursement Arrangement (HRA Plan), established by the Employer, Illinois Wesleyan University, whose address is 1312 North Park Street, Bloomington, IL 61701. The effective date of this Plan is August 1, 2009.

The purpose of the Plan is to reimburse Retired Employees, up to certain limits, for their own and their covered Spouses' and Dependents' Qualified Medical Expenses. Qualified Medical Expenses are Expenses not otherwise reimbursed or reimbursable in full by any other accident or health plan. Reimbursements for Qualified Medical Expenses paid by the HRA Plan generally are excludable from taxable income. The Employer intends that the Plan qualify as an employer-provided medical reimbursement plan under Code sections 105 and 106 and regulations issued hereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Expenses reimbursed under the Plan are intended to be eligible for exclusion from the participating Employee's gross income for Federal Income Tax purposes under Code Section 105 (b).

Section I

Definitions

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following rules of interpretation shall apply in reading this instrument:

"Affiliated Employer" means:

a any corporation which is a member of a controlled group of corporations including those within the meaning of section 1563(a) and 414(b) of the Code, determined without regard to sections 1563(a)(4) and (e)(3)(C), including the Employer;
b. any organization under common control with the Employer within the meaning of section 414(c) of the Code;
c. any organization which is included with the Employer in an affiliated service group within the meaning of section 414(m) of the Code; or
d. any other entity required to be aggregated with the Employer pursuant to regulations under section 414(o) of the Code.

"Benefit Credits" means the amounts set aside for Benefits under Section 3 and credited to the Participant's Health Reimbursement Arrangement account.

"Benefits" means the reimbursements for Qualified Medical Expenses available from time to time under the Plan, as set forth on this Plan.

"Board" means the Board of Directors of Illinois Wesleyan University.

"Change in Status" means:

a. A change in a Participant's legal marital status, including marriage, divorce, legal separation, annulment, or death of the Participant's spouse.
b. An event affecting the number of the Participant's Dependents, including birth, death, adoption, and placement for adoption.

c. A change in employment status of the Participant, his spouse or Dependents, including termination or commencement of employment (as determined under the Code Section 125 regulations); a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; or a change in the employment status of the Participant, his spouse or dependent (e.g., hourly to salary, union to non-union, or full-time to part-time), that affects that person's rights under this Plan or an underlying benefit program (e.g., changing from salaried to hourly-paid, union to non-union or part-time from full-time).

d. An event that causes a Participant's Dependent to satisfy or cease to satisfy the eligibility requirements for a particular benefit, such as attaining a specified age or the Dependent's status as a student.

e. A change in the residence of the Participant, his spouse or Dependent.

f. If a Participant or his or her eligible Dependent (1) loses coverage under Medicaid or a state child health program, or (2) becomes eligible for state assistance with respect to paying his or her contributions to the Plan, the Plan allows special enrollment rights as follows:

A Participant may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

g. Any other events included under Code Section 125, or regulations or other guidance promulgated there under relating to changes in family status. The determination of whether there is a Change in Status shall be determined by the Plan Administrator in its sole discretion, consistent with the regulations under Code Section 125.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985.

"Code" means the Internal Revenue Code of 1986, and the same as may be amended from time to time.

"Committee" means the individuals who may be appointed by the Plan Administrator to administer the process of claims review for the Plan in accordance with Section 4.

"Dependent" means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

"Effective Date" means August 1, 2009.

"Eligible Employee" means any Employee who works at least 30 hours per week for a minimum of nine months per year, are at least 45 years of age and are not classified as an adjunct faculty member or as a temporary or part-time employee.

The following Employees are not eligible to participate in the Plan:

- Employees who are under age 45
- Employees who work less than 30 hours per week for a minimum of nine months per year (including employees contracted to teach less than 4.5 course units for a minimum of nine months per year).
- Employees classified as adjunct faculty or are temporary or part-time employees
- Employees who elect, upon retirement, to participate in the Employer's Defined Benefit Plan providing retiree health insurance benefits

"Employee" means any person employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

"Employer" means Illinois Wesleyan University and any other business organization, which succeeds to its business and elects to continue this Plan, which adopts this Plan with the consent of the Board.

"Enrollment Form" means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan.

"Enrollment Period" means the period upon becoming an eligible employee. In addition, with respect to a Plan Year, it means the month prior to the beginning of the Plan Year, or such other period as may be prescribed by the Plan Administrator in a nondiscriminatory manner.

"Entry Date" means the date the conditions for eligibility requirements were met.

"ERISA" means the Employee Retirement Income Security Act of 1974, and the same as may be amended from time to time.

"Expense" (See "Qualified Medical Expense" below.).

"Group Health Plan" means the health plan(s) that the Employer maintains for it's Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies.

"Health FSA" means a health flexible spending arrangement as defined in Prop, Treas. Reg. Section 1.125-2, Q/A-7(a).

"Highly Compensated Employee" means any Employee defined as such in section 105(h) of the Code.

"HRA Account" means the HRA Account described in Section 3.

"Incurred" means a Qualified Medical Expense is incurred at the time the medical care or service giving rise to the Expense is furnished, and not when the individual incurring the Expense is formally billed for, is charged for, or pays for medical care.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section 2, below.

"Participating Employer" means the Employer and any affiliated company which adopts this Plan with the consent of the Board.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employee who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section II; and (b) for employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section II. A different Period of Coverage (e.g. monthly) may be established by the Administrator and communicated to the Participants.

"Plan" means the Health Reimbursement Arrangement Plan described herein.

"Plan Year" means the 12 month period commencing August 1 and ending July 31.

"Qualified Benefits" means each reimbursement for Qualified Medical Expenses as described in the document.

"Qualified Medical Expense" means Expenses Incurred by the Participant, his spouse or dependents(s) after he retires. Qualified Medical Expenses means Expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by any insurance or Medicare. The Health Reimbursement Arrangement Plan allows you to be reimbursed by the Plan for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents. Drug costs, including "over-the-counter" drugs may be reimbursed. You may also be reimbursed for the cost of premiums for insurance coverage for medical care such as health, dental, vision, cancer, Medicare, Medicare supplement and qualified long-term care insurance policies that you pay for with after tax dollars up to the Participant's HRA Account balance.

Qualified Medical Expenses can only be reimbursed to the extent that the participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Employer's Group Health Plan, other insurance, or any accident or health plan a Health FSA. If only a portion of the Qualified Medical Expenses has been reimbursed elsewhere (e.g. because the health insurance plan imposes deductible limitations), the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of the Plan.

The cost of such eligible Expenses must be supported by adequate evidence of the incurring or payment of such cost, and submitted to the Employer by the Participant or his legal representative. The determination of the qualification of the deductible expenses and the determination of the completeness of submitted request for reimbursement will rest solely on the Employer or person or persons appointed to review all claims. The consequent Employer's decision will be final.

"Reimbursement" means the actual transfer of Benefit Credits available to a Plan Participant in the Health Reimbursement Arrangement account, by the Employer, for payment of Qualified Medical Expenses. The

reimbursement will be in the form of a check drawn on the funds of the Employer, or in any other form as determined by the Employer.

"Spouse" means the legally married husband or wife of a Participant, unless legally separated by court decree. Spouse means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

Section II

Participation in the Plan

Eligibility to Participate. Any Eligible Employee shall be eligible to participate hereunder as of the date he becomes an Eligible Employee.

Effective Date of Participation. Each Eligible Employee shall be eligible to become a Participant effective as of the date he meets the Eligibility to Participate requirements above.

Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by providing such data as are reasonably required by the Employer as a condition of such participation. Each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

Cessation of Participation. A Participant will cease to be a Participant as of the earlier of:

a. the date on which the Plan terminates;
b. the date on which he ceases to be an Eligible Employee or the date the Participation ceases according to other provisions of this Plan, if his Participation is extended by other provisions of this Plan.
c. the date on which a Participating Employer terminates its participation in the Plan.

Nothing in this section shall prohibit the payment of Benefits with respect to claims arising prior to the Participant's termination of participation in accordance with the requirements stated in Section III.

Termination of Employment. If a Participant separates from service with the Employer during the Plan Year he must satisfy the conditions of retirement eligibility before his employment with the Employer ends, or the entire balance of his notional HRA account will be forfeited. He will avoid forfeiture of his account if he is at least age 55 and has completed at least 10 years of continuous service at the time his employment with the Employer ends. Once he has met these requirements and he has retired from his employment with the Employer, he may use his account to pay for Qualified Medical Expenses incurred by himself, his spouse and dependents.

To the extent he does not meet the requirements described above:

- Break In Service: If he ceases to be employed by the Employer, then the balance of his account will be forfeited once he has been absent for one year (a one-year Break In Service), and it will not be restored if he is later rehired. If he returns to service prior to incurring a one-year Break In Service, his years of continuous service going forward will include his service prior to the Break in Service. Otherwise, his prior years of continuous service will not be counted.

- Permanent Disability: If he becomes Permanently Disabled while employed by the Employer, he will be deemed to have met the requirements described above. However, if he is not able to establish that he is Permanently Disabled by the end of a one-year break in service, his account will be forfeited as described above; provided, however, if he establishes that he is Permanently Disabled prior to incurring a three-year break in service, the Employer will restore the amount forfeited to his account (without interest or earnings).

FMLA and USERRA Leaves of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

HRA account after Participant dies. If a Participant dies after he is retired or after he satisfies the requirements for retirement eligibility under the Employer's retirement definition (generally age 55 or older with at least 10 years of continuous service), and he has an eligible Spouse and/or Dependent at the time of his death, the surviving Spouse or Dependent may use the Participant's HRA account for Qualified Medical Expenses provided he did not elect to retire under the Employer's Defined Benefit Plan option. If there is no

surviving Spouse or Dependents then his Plan account balance is forfeited one year after the end of the Plan Year in which the Participant dies. However, a participant is eligible to submit claims for Qualified Medical Expenses that were incurred before your death. Your legal representative must submit claims within 12 months of the last day of the Plan Year in which the claims were incurred.

If a Participant dies while still an Employee and before he satisfies the requirements for retirement eligibility under the Employer's retirement definition (generally age 55 or older with at least 10 years of continuous service) his participation in the Plan will cease, and no further contributions or interest will be contributed on his behalf. The Participant's Plan account balance will be forfeited.

Change in Enrollment.

An Eligible Employee, who is not enrolled, may complete an enrollment form in connection with a change of status:

When a significant coverage is no longer available resulting in a loss of coverage under this Plan, a Participant may change to another benefit option, if available, or cease enrollment.

Participants may make a change in benefit options that corresponds with changes made under an accident and health plan of the spouse's or dependent's employer including changes made under a domestic partner's plan, or the plan of the employee's employer. The change request must be combined with adequate documentation describing the change in coverage for which the Participant, dependent, or domestic partner is covered.

Participants may make a change in coverage to add self or dependent that loses coverage under a health plan maintained or administered by a government or educational institution.

Section III

Benefits

Benefit Credits. There shall be credited to each Participant's Health Reimbursement Arrangement account those Benefit Credits that correspond to the amount of the Employer's funding for the complete Plan Year or for such partial Plan Year, as shown by the amounts set forth below, and as may be revised by the Employer from time to time. The amount of Benefits actually provided to or for the benefit of any Participant shall be a charge to the balance of his Health Reimbursement Arrangement account.

Initial HRA Account balance determined on August 1, 2009. The Employer calculated the amount of each Participant's beginning HRA account balance based on the Participant's age and years of continuous service on July 31, 2009. Each Participant's HRA account was credited $125 per month for each month he had been employed as an Eligible Employee after attaining age 45, up to a maximum of 20 years. In addition, interest in the amount of 6.25% per year was credited to each participant. If a participant had over 20 years of continuous service as of July 31, 2009, a $300 offset was applied to their initial Notional HRA Account balance to reflect a $300 contribution to a funded HRA established in the Participant's name under the Emeriti Retiree Health Plan for Illinois Wesleyan University (Funded Account).

Contributions made to Participant's HRA Account Each Year. Beginning August 1, 2009, the Employer will make an annual contribution to the Participant's accounts of $1,500 annually ($125 per month) allocated by the Employer between the Participant's Notional HRA account in this Plan and his Funded Account in the Emeriti Plan. These contributions will be made annually to Participants for up to 20 years of continuous service earned after the age of 45. The annual contribution may be pro-rated to reflect partial years of continuous service. If a new Participant becomes eligible and enters the Plan after August 1, or a participant reaches his full 20 years of Employer contributions in the middle of the next Plan Year, he will receive partial funding of $125 per month for the number of months he is a participant in the initial Plan Year or $125 per month for the number of months needed for him to reach 20 complete years of Employer contributions. This $125 per month will be allocated between the Participant's Notional HRA account in this Plan and his Funded Account in the Emeriti Plan. No additional Employer contributions will be made to his HRA account after he ceases to be an Eligible Employee, whether due to retirement or other termination of employment or change to part-time or other ineligible status.

Interest Earned on the HRA Account Balance. Interest is credited to a Participant's account annually at the beginning of the Plan Year for the following Plan Year. The annual interest rate is 6.25%. Interest is calculated based on the balance that day, including any Employer contribution scheduled to be made for that Plan Year. Interest will continue to be credited to his account at the beginning of each Plan Year after he retires until his account balance is exhausted. No interest will be credited to his account in his initial year of participation if he is a new Participant who enters the Plan after the first day of the Plan Year. He will receive interest for the next Plan Year the following August 1 based on his account balance that day. The Employer contribution for the upcoming Plan Year will be credited to his HRA account balance on August 1 each year before the interest is calculated.

Election of Benefits. An Eligible Employee who meets the eligibility requirements will automatically participate in this Plan.

Nature of Participant Health Reimbursement Arrangement account (HRA Account). No money shall actually be allocated to any Reimbursement Account; any such Reimbursement Account shall be of a memorandum nature, maintained by the Plan Administrator for accounting purposes, and shall not be representative of any identifiable Trust assets. No interest will be credited to or paid on amounts credited to a Health Reimbursement Arrangement account.

Provision of Benefits. The Employer shall provide such Benefits as the Participant has elected under the Plan, in such amounts as do not exceed the amount indicated on the Schedule A of this Plan, and subject to Employer contributions from time to time. Such Benefits shall be subject to the provisions of this Plan, the Summary Plan Description, contract, or other arrangement setting forth the further terms and conditions pursuant to which such Benefits are provided. No amount shall be applied to provide Benefits under this Plan if such amount would exceed the balance of the Participant's Benefit Credits in the Health Reimbursement Arrangement account.

Carryover of Benefits. If any balance remains in the Participant's HRA Account for a Period of Coverage, such balance shall be carried over to reimburse the Participant for Qualified Medical Expenses incurred during a subsequent Period of Coverage. A Participant has one year after the end of the Plan Year to file a claim for any Qualified Medical Expenses Incurred in the prior plan year. However, upon termination of employment before satisfying the condition of retirement eligibility or other loss of eligibility, the Participant's coverage ceases, and the entire balance of his notional HRA account will be forfeited. In addition, any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the year the check was issued shall remain the property of the Employer.

Revocation and Modification of Elections.

a. Once an Eligible Employee has elected Benefits under the Plan and the Plan Year has begun, he may not amend or revoke his election of Benefits, unless there is a Change in Status or as may otherwise be permitted under this Section 3. The revocation of a designation of Benefits and election of new Benefits may be made by an Eligible Employee only if both the revocation of existing designation of Benefits and election of new Benefits are made on account of and consistent with the previously described Change in Status (except for coverage under COBRA as defined in Section 5.)

b. Change in Coverage.

A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the employer of the Participant's spouse, former spouse, or Dependent's employer, if (a) the accident and health plan in which the spouse, former Spouse, or Dependent participates permits its participants to make an election change that would be permitted under Treasury regulation Section 1.125-4(b) through (g); or (b) the Participant's plan year period of coverage is different from the plan year period of coverage under the cafeteria plan or benefit plan of the plan in which the Spouse, former Spouse or Dependent participates.

Where there is a judgment, decree, or order (including a qualified medical child support order described in ERISA Section 609) ("Order") resulting from a Participant's divorce, annulment, legal separation, or change in custody, (a) a Participant's election under this Plan may be changed to provide coverage for a Dependent who is the Participant's child if the Order requires such coverage, and (b) coverage of the Dependent who is the Participant's child may be revoked or changed if the Order requires someone other than the Participant to provide such coverage.

If a Participant, his spouse or Dependent is entitled to special enrollment rights under a Group Health Plan, as required by Code Sec. 9801(f) (i.e., HIPAA), then a Participant may revoke a prior election for coverage under

this Plan and make a new election, provided that the election corresponds with such special enrollment rights under the Group Health Plan.

A Participant entitled to make a new election under this Section 3 must do so within 30 days of the event described above. Any such election shall apply for the balance of the Plan Year in which the election is made unless a subsequent event (described in this Section 3) occurs.

Duration of Participation. A Participant shall remain a Participant under the HRA until the earliest of: (i) the Participant's cessation of employment prior to becoming a Retiree-Eligible Individual; (ii) the death of the Participant; (iii) the exhaustion of the Participant's Account Balance; (iv) cancellation of the Participant's Account; (v) the date on which this HRA terminates.

Upon a Participant's death who is a Retiree or a Retiree Eligible individual (under the Employer's retirement definition), the Participant's eligible surviving Spouse and/or Dependents shall be entitled to reimbursement from the HRA Account balance in accordance with the terms of the Plan. If there is no surviving Spouse or Dependents then the Participant's Plan account balance is forfeited. However, the Participant's legal representative is eligible to submit claims for Qualified Medical Expenses that were incurred before the Participant's death. Your legal representative must submit claims within 12 months of the last day of the Plan Year in which the claims were incurred.

If a Participant dies while still an active Employee and before the Participant is eligible for retirement (under the Employer's retirement definition) his participation in the Plan will cease, and no further contributions or interest will be contributed on his behalf. The Participant's Plan account balance will be forfeited.

Reimbursements. Except as otherwise provided in this Plan, reimbursement of expenses shall be made at such time and in such amounts as are evidenced by submitted proof of Qualified Medical Expenses incurred by the Participant, his Spouse or Dependents, provided sufficient Benefit Credits are available in the account of the Participant. Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. No payment may be made for any medical expense incurred by the Participant before the Participant's retirement date or incurred or paid on or after the date of actual termination of participation. Provisions for reimbursement of expenses by the Employer will be determined by the Employer who is the sole source of payment of benefits.

Your claim reimbursements will be processed on a minimum of a monthly basis. A claim must be $25.00 or more to be eligible for payment or reimbursement. If a claim is less than $25.00 it will be pended until the Participant has accumulated at least $25.00 or it is the end of the run-out period. In addition, any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) by 180 days following the close of the Plan Year following the Period of Coverage in which the Qualified Medical Expense was reimbursed shall remain the property of the Employer.

Payment for Incapacitated Participants. Whenever a Participant is under a legal disability or incapacitated in any way so as to be unable to manage his/her personal financial affairs, the Plan may make any Qualified Medical Expense payments to which such Participant is then entitled to the Participant's legal representative or in such other manner according to applicable law as the Plan considers appropriate for the benefit of such Participant. Any such payment shall constitute a complete discharge of any liability of the HRA and the Employer with respect to, and to the extent of, the Qualified Medical Expense payment so made.

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

Section IV

Administration

Enrollment. An Eligible Employee is automatically enrolled in the Plan.

Administrator. The Employer's Retiree Health Insurance Committee shall be the Plan Administrator for the purposes of ERISA.

Named Fiduciary. The Employer shall be the named fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration which has been delegated by the Employer and any references to the Employer shall instead apply to the delegate. However if the employer

assigns any of the Employer's responsibility to an Employee, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

Rules of Administration. The Plan Administrator shall have full discretionary authority and power to administer and construe the Program, subject to applicable requirements of law. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary powers and duties: (i) to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Program; (ii) to interpret the Program, its interpretation thereof to be final and conclusive on all persons claiming benefits under the Program; (iii) to decide all questions concerning the Program, including questions of fact respecting Program benefits, the eligibility of any person to participate in the Program and the status and rights of any Participant under the Program; and (iv) to appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Program.

Third Party Administrator. The Plan may from time to time employ the services of a Third Party administrator (TPA) for designated Plan administration, or other Qualified professionals for Plan services, under the direction of the Plan Administrator. A Third Party Administrator (TPA) is under contract to provide administrative services to this Plan. This TPA is:

Benefit Planning Consultants, Inc.
PO Box 7500
Champaign, IL 61826-7500
217-531-9000, 877-272-8880

Funding Policy. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of the Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

Procedure If Benefits Are Denied Under This Plan. If a claim for reimbursement under this Plan is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in the SPD. The Committee acts on behalf of the Administrator with respect to appeals.

Nondiscriminatory Operation. All rules, decisions and designations by the Employer, Claim Administrator, and each Committee under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

Liability of Administrative Personnel. Neither the Employer nor any of its Employees shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

Section V

Miscellaneous

Expenses. All reasonable expenses incurred in administering the Plan are paid by the Employer while the Participant is an active Employee. Once the Participant is retired, his HRA account will be charged a $5.00 per month administrative fee (or the applicable rate agreed to by the Employer at that time) payable to the TPA.

Amendment and Termination. The Employer may amend or terminate all or any portion of this Plan at any time for any reason by resolution of the Employer or by any person authorized by the Employer to take such action.

Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

Alienation of Benefits. No Benefit under this Plan may be voluntarily or involuntarily assigned or alienated.

Facility of Payment. If the Employer deems any person incapable of receiving Benefit to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be a complete release of the Employer and shall be deemed full payment of the Benefit. Such payments shall, to the extent thereof, discharge all liability of the Employer.

Proof of Claim. As a condition of receiving Benefits under the Plan, any person may be required to submit whatever proof the Employer may require either directly to the Employer or to any person delegated by it.

Code and ERISA Compliance. It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

No Guarantee of Tax Consequences. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

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

Applicable Law. The Plan shall be construed, adminitered and enforced according to the laws of the State of Illinois to the extent not superceded by the Code, ERISA, or any other federal law.

Source of Payments. The Employer shall be the sole sources of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or beneficiary.

Sole Proprietors, Partners in a Partnerships, members of Limited Liability Companies, and more than two percent owners of S-Corporations are not eligible to participate in an HRA on a pre-tax basis. If any of these owners or certain relatives as defined in the Code receive distributions through the HRA, the Employer is responsible for determining the amount to be included each plan year as personal taxable income.

Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

Multiple Functions. Any person or a group of persons may serve in more than one fiduciary capacity with respect to the Plan.

Gender and Form. Unless the context clearly indicates otherwise, pronouns shall be interpreted so that the masculine pronoun shall include the feminine, and the singular shall in clude the plural.

Plan Provisions Controlling. In the event that the terms or Provisions of any summary or description of this Plan, or of any other intsrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this plan shall be controlling.

Prior Year Claims. Claims can be submitted up to one year past the end of the plan year.

Health Insurance Portability and Accountability Act (HIPAA). Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

Compliance with HIPAA Privacy Standards.

(a) Application. If the Health Reimbursement Arrangement Plan under this Cafeteria Plan is subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) Disclosure of PHI. The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(c) PHI disclosed for administrative purposes. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care.

(d) PHI disclosed to certain workforce members. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(1) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(2) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(3) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(4) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(5) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(6) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(7) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(8) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer 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; and

(9) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f) (2) (iii) of the Privacy Standards and set out in (d) above.

Compliance With HIPAA Electronic Security Standards. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth above.

Executed this Date: _____/_____/_____

Illinois Wesleyan University

ATTEST: _____ **(Secretary)**

BY: _____ **(Authorized Officer)**