CITY OF KNOXVILLE

HEALTH REIMBURSEMENT ACCOUNT

FOR RETIREES

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE: JANUARY 1, 2008

TABLE OF CONTENTS

INTRODUCTION

The Employer identified in the Plan Information Appendix (the "Employer") has established the Health Reimbursement Account for Retirees (the "HRA"). The purpose of this HRA is to reimburse Participants for certain unreimbursed medical expenses ("Eligible Medical Expenses") incurred by the Participant or their Eligible Dependents. This HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Section 105 and 106 of the Internal Revenue Code ("Code").

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 You may contact the Employer if you have concerns that the Plan Information Appendix that you have is outdated.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

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

The ability of a Participant to earn HRA Dollars is contingent on enrollment in the Component Medical Plan and additional criteria defined by the Employer. If the Participant is not enrolled in the Component Medical Plan, the HRA has a defined time period during which the remaining HRA funds can be spent for Eligible Medical Expenses. The governing documents for this HRA are not intended to replace, supersede, modify, or revise the governing documents of the Component Medical Plan. For purposes of this SPD, the HRA is referred to as the "Plan."

PART I:
General Information about the Plan

***You will notice that certain terms and/or phrases are capitalized throughout this SPD. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined either in this SPD or in the official Plan Document into which this SPD is incorporated.*

Q-1. What is the HRA?

Generally, the HRA is an Employer-provided reimbursement account. The HRA works as follows:

- The Employer establishes a notional account called a Health Reimbursement Account ("Reimbursement Account") for each Participant to keep a record of HRA Dollars allocated to your account and reimbursements made to you under this HRA. You have no property rights in the Reimbursement Account (see Q-2 for more information on how to become a Participant).

- Annually, or more frequently as needed, the Employer may allocate a specified amount of Employer contributions, called "HRA Dollars," to each Participant's Reimbursement Account for reimbursement of Eligible Medical Expenses if the Participant is enrolled in the Component Medical Plan and meets additional criteria defined by the Employer. You do not contribute to the Reimbursement Account.

- You do not necessarily forfeit HRA Dollars that you do not use during a Plan Year.

Q-2. Who can participate in the HRA?

You are eligible to participate in the HRA if you retire from the Employer and have funds remaining in your Active HRA and/or you elect to participate in the Employer's Component Medical Plan upon retirement and meet additional criteria and earn HRA Dollars. Eligible Retirees who become covered under this HRA are called "Participants."

You may be permitted to enroll in the Component Medical Plan during the Component Medical Plan's initial enrollment period or during a special enrollment period. You must generally request enrollment within at least 60 days of losing the other coverage in order to be eligible for this special enrollment. Coverage will be effective as of the date of the change.

In addition, the Component Medical Plan must allow you to enroll yourself (and your eligible Dependents), if you are otherwise eligible, if you request enrollment within at least 60 days of gaining a new dependent through marriage, birth, adoption or placement for adoption. In the case of coverage resulting from a newborn or adopted child, coverage is effective as of the date of the birth. In the case of coverage resulting from gaining a new Dependent through marriage, coverage will be effective as of the date of the change.

For a detailed description of the eligibility and enrollment rules of the Component Medical Plan, please refer to the governing documents for the Component Medical Plan (i.e., the certificate of coverage, SPD, and/or insurance contract).

Q-3. Are my dependents covered under the HRA?

If you become a Participant, you may also be reimbursed for Eligible Medical Expenses incurred by your Eligible Dependents. An Eligible Dependent means any eligible individual who is a Dependent of the Participant, as your legal Spouse or a Dependent and who also satisfies the following requirements: 1) is a

Spouse for purposes of federal income tax law or 2) is a Dependent for health plan purposes as defined in Code Section 105(b) and Code Section 106.

For a detailed description of Dependent eligibility and enrollment rules (including special enrollment rules) under the Component Medical Plan, please refer to the governing documents for the Component Medical Plan (i.e., the Component Medical Plan SPD). You may be required to provide proof of Dependent status upon request by the Plan Administrator (or its designated third party administrator). Failure to provide such proof may result in a delay in coverage under this HRA.

Q-4. What is the effective date of coverage under this HRA?

Coverage under this HRA for an eligible Employee and eligible Dependent(s) begins on the date identified in the "Effective Date of Coverage" section of the Plan Information Appendix. In no event will the coverage under this HRA begin before the earlier of the effective date of this HRA or the effective date of coverage under this HRA. The effective date of this HRA is identified in the Plan Information Appendix.

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

A Participant and/or Eligible Dependent(s) is no longer eligible to earn HRA dollars upon termination from the Component Medical Plan. However, the HRA has a "spend down" period that ends on the last day of the Plan Year following the Plan Year in which coverage under the Employer's Component Medical Plan was terminated. During this time you may be reimbursed for Eligible Medical Expenses for yourself and/or your Eligible Dependent(s) from the remaining HRA funds in your account. However, you, your covered Spouse, and/or your covered child(ren) may be eligible for continued coverage under this HRA and the Component Medical Plan, according to federal law, beyond the date that coverage would otherwise end if coverage is lost for certain reasons. Your continuation of coverage rights and responsibilities are described in Q-16 below. All HRA Dollars that are not applied towards Eligible Medical Expenses incurred before your coverage termination date or during the "spend down" period are forfeited.

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

"Eligible Medical Expenses" are medical care expenses ***incurred*** by you or your Eligible Dependents that satisfy all of the conditions described in the "Eligible Medical Expense" section of the Plan Information Appendix and are for "medical care" as defined in Code Section 213(d). All expenses that are not within the scope of "Eligible Medical Expenses" described in the Plan Information Appendix are excluded. "Incurred" means the date the service or treatment is provided; not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (i.e., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided. Also, an Eligible Medical Expense will not be reimbursed unless the requirements described in Q-13 below have been satisfied.

In no event will the following expenses be eligible for reimbursement:

a) Any expense that is not a Code Section 213(d) expense.

b) Any expenses incurred for qualified long-term care services (as defined in Code Section 106).

c) Expenses incurred prior to the date that coverage under this HRA becomes effective.

d) Expenses incurred after the date that coverage under this HRA ends.

e) Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Whether an Expense is an "Eligible Medical Expense" is within the sole discretion of the Plan Administrator.

Q-7. Who contributes to my Reimbursement Account?

While you are a Participant, the Employer may allocate HRA Dollars to your Reimbursement Account if you are enrolled in the Component Medical Plan and meet additional criteria defined by the Employer. You do not pay a premium for the Reimbursement Account. In fact, federal laws prohibit you from contributing to your Reimbursement Account. You may, however, be required to pay the "applicable premium" for continuation of HRA coverage.

Q-8. How are HRA dollars allocated to my Reimbursement Account?

Annually, or more frequently as needed, the Employer may allocate a specified amount of HRA Dollars to your Reimbursement Account. The maximum annual HRA Dollar amount you can earn is identified in the "HRA Dollars" section of the Plan Information Appendix. The amount of HRA Dollars allocated to your Reimbursement Account is determined solely by the Employer and may vary depending on circumstances, such as family status. In addition, HRA Dollars will be allocated to your Reimbursement Account according to the "HRA Dollars" section of the Plan Information Appendix.

Q-9. What happens if I do not use all of the HRA Dollars allocated to my Reimbursement Account during the Plan Year?

If you do not use all of the HRA Dollars allocated to your Reimbursement Account according to Q-8 of this SPD, all of the HRA Dollars remain in your Reimbursement Account for reimbursement of Eligible Medical Expenses during a subsequent Plan Year. The amount of unused HRA Dollars that you may "carry over" is described in the "Carry Over" section of the Plan Information Appendix.

Q-10. Is there a limit on how much can be allocated to my Reimbursement Account?

The amount in your Reimbursement Account can never exceed the Reimbursement Account Maximum identified in the "Reimbursement Account" section of the Plan Information Appendix, if any. Any HRA Dollars that you would otherwise be entitled to under the terms of this HRA will be forfeited to the extent your Reimbursement Account has reached its Reimbursement Account Maximum. If your Reimbursement Account has reached the Reimbursement Account Maximum, your Reimbursement Account will receive no more HRA Dollars until the Reimbursement Account amount has gone below the Reimbursement Account Maximum. At that time you will be entitled to receive your share of HRA Dollars, not to exceed the Reimbursement Account Maximum, at the next regularly scheduled allocation. For example, if HRA Dollars are allocated monthly and your Reimbursement Account balance goes below the Reimbursement Account Maximum in June, you will be entitled to receive an HRA allocation in July. If HRA Dollars are allocated each January 1, and your Reimbursement Account balance goes below the Reimbursement Account maximum in July, you will receive an HRA Dollar allocation the following January 1.

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

The maximum reimbursement amount that you can receive is equal to your Reimbursement Account balance at the time the request for reimbursement is processed. Any portion of a claim for reimbursement that exceeds the maximum reimbursement amount will be pended and processed when the Reimbursement Account becomes sufficient. Pended claims will be processed and, if appropriate, paid before any new claims are processed and paid.

Q-12. Can I qualify for additional HRA funds during the Plan Year?

If you qualify for additional HRA funds during the Plan Year, your annual HRA Dollar allocation may be adjusted as described in the "Changing Coverage" section of the Plan Information Appendix.

Q-13. How do I receive reimbursement under the HRA?

Under this HRA, you have three types of reimbursement options. **First,** you may use your WageWorks Health Care Card to pay for eligible items at the point of sale and funds are deducted automatically from your HRA. Substantiation for certain card transactions may be requested for a purchase. **Second,** you can use the "Pay My Provider" option on the WageWorks' website which allows you to request that a check be issued directly to your provider with funds taken from your HRA. **Third,** you can request the "Pay Me Back" option on the WageWorks' website, for which you will be reimbursed directly from your HRA. A direct deposit feature is available. You must complete the form and submit it to the Third Party Administrator with an EOB or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: a) the name of the patient, b) the date service or treatment was provided, c) a description of the service or treatment; and d) the amount incurred. **You may submit requests for reimbursement of Eligible Expenses at any time.**

Your claim is deemed filed when it is received by the Third Party Administrator. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Any unclaimed reimbursement amounts (i.e., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) by the "Payment Claim Date" identified in the Plan Information Appendix. If your claim for reimbursement is denied, in whole or in part, you will be notified according to the HRA's claims review procedures described in Q-16 below.

Q-14. What happens if my claim for benefits is denied?

If you are denied a benefit under the Plan, you should proceed according to the following claims review procedures:

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

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

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;

- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and

- a right to request all documentation relevant to your claim.

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

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

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

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

Important Information

Other important information regarding your appeals:

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

Q-15. What happens if I receive overpayments or reimbursements are made in error from this HRA?

If it is later determined that you and/or your Eligible Dependent(s) received an overpayment or a payment was made in error (i.e., you were reimbursed for an expense under the HRA that is later paid for by the Component Medical Plan or some other medical plan), you will be required to refund the overpayment or erroneous reimbursement to the HRA.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment; or if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may include the amount on your W-2 as gross income. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this HRA (and to the extent permissible, under the Component Medical Plan).

Q-16. What is "Continuation Coverage" and how does it work?

Continuation coverage under "COBRA" and/or the Public Health Safety Act (PHSA) requires most Employers sponsoring group health plans to offer covered Employees and certain covered family members the opportunity for a temporary extension of health care coverage (called "Continuation Coverage") in certain instances where coverage under the group health plan would otherwise end. However, you may continue coverage under the Component Medical Plan without the HRA. These rules apply to coverage under the Component Medical Plan and the HRA unless the Employer is a small Employer as defined under applicable law (generally less than 20 employees during the current year). The Plan Administrator will tell you whether the Plan is subject to these rules. Below is a description of your rights and responsibilities under the federal COBRA rules and regulations.

Who May Continue Coverage Under COBRA?

Since this HRA and the Component Medical Plan are considered a single Plan, you cannot continue coverage under this HRA unless you elect coverage under the Component Medical Plan. Nevertheless we have generally described your rights to continue coverage under the Plan pursuant to federal COBRA. You should also refer to the governing documents for the Component Medical Plan for additional continuation of coverage information.

Federal COBRA requires group health plans to provide "Qualified Beneficiaries" an opportunity to temporarily continue group health coverage when that coverage is lost as a result of certain "Qualifying Events." A "Qualified Beneficiary" is the Employee, Spouse, or Dependent Child covered under the Plan immediately preceding the Qualifying Event. A child born to or adopted by (including a child placed for adoption with) a covered Employee during the covered Employee's COBRA period is also considered a "Qualified Beneficiary" if properly enrolled.

When Coverage May Be Continued Under COBRA

Coverage may only be continued if coverage is lost as a result of certain Qualifying Events. You have the right to COBRA continuation coverage if you lose coverage under the Plan as a result of a termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment.

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

- You terminate employment (for reasons other than gross misconduct) or have a reduction in your hours of employment (including a military leave of absence).
- You die.
- You and your Spouse divorce or legally separate.
- You become entitled to Medicare.

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

- You terminate employment or have a reduction in your hours of employment.
- You die.
- You and your Spouse divorce or legally separate.

- You become entitled to Medicare.

- Your dependent child ceases to be a covered dependent under the Plan.

A child born to or adopted by (including a child placed for adoption with) a covered Employee during the covered Employee's COBRA period is also considered a "Qualified Beneficiary" if properly enrolled.

Notice and Election Rules

The Plan Administrator must send notice to Qualified Beneficiaries of the right to the continuing participation following the covered Employee's termination of employment, reduction in hours or death.

If the covered Spouse and/or Covered Dependent children lose coverage as a result of a divorce, legal separation, or dependent child ceasing to be a dependent, you or the affected Qualified Beneficiary must send notice to the COBRA Administrator identified in the Plan Information Appendix within 60 days of the latter of:

- The event; or

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

The Qualified Beneficiary will then be sent a notice of this right to continuing participation following receipt of Qualified Beneficiary's notice.

Once you and/or any other Qualified Beneficiary have been provided notice of the right to elect COBRA continuation coverage, an election for continuation coverage under the Plan must be made within 60 days of the later of the date of the notice or the date coverage is lost as a result of the Qualifying Event. If a Qualified Beneficiary fails to provide this notice to the COBRA Administrator identified in the Plan Information Appendix during the 60 day notice period, the Qualified Beneficiary will lose the right to COBRA continuation coverage and coverage under the Plan will cease as of the last date you were eligible for coverage. Each Qualified Beneficiary has a separate and independent right to elect COBRA continuation coverage. A Qualified Beneficiary Employee or Spouse can elect coverage for any other Qualified Beneficiary. On the other hand, you may not decline COBRA continuation coverage for the Qualified Beneficiary Spouse. A parent or guardian can elect coverage for a Qualified Beneficiary child who is a minor.

Duration of Coverage

Qualified Beneficiaries may continue coverage for 18 months if coverage is lost as a result of your termination of employment (for reasons other than gross misconduct), or coverage ends because of your reduction in hours of employment Qualified Beneficiaries other than the covered Employee may continue coverage under the Plan for 36 months if coverage is lost as a result of the covered Employee's death, a divorce or legal separation or a dependent child ceasing to be a Dependent, or you become entitled to Medicare.

If you or a Qualified Beneficiary family member is determined by the Social Security Administration to have been disabled at any time prior to the end of the first 60 days of continuation coverage resulting from a termination or reduction in hours of employment, COBRA may be extended from 18 months up to 29 months. You or a Qualified Beneficiary must notify the Plan Administrator prior to the end of the

original COBRA period (up to 18 months) or the 60 day notice period, whichever comes first. The 60 day notice period ends 60 days after the latter of:

- The date of the determination.
- The date of the Qualifying Event (i.e., termination of employment).
- The date that coverage is lost as a result of the Qualifying Event.

If the Social Security Administration determines that you or a Qualified Beneficiary is no longer disabled while on COBRA continuation coverage, you or a Qualified Beneficiary must notify the Plan Administrator within 30 days of the date of the Social Security Administration's determination that you are no longer disabled.

If you become entitled to Medicare (and do not lose coverage under the Plan) and then terminate employment or have a reduction in hours of employment within 18 months of your Medicare entitlement, your Qualified Beneficiary Spouse and/or covered children are eligible to receive 36 months of continuation coverage beginning on the Medicare entitlement date.

If COBRA coverage was elected following a termination of employment or reduction in hours of employment, additional Qualifying Events (such as divorce, Medicare entitlement, or death) may occur during the first 18 months (or during the disability extension discussed above) that may result in an extension of the 18 month (or 29 month) continuation period to 36 months for the Qualified Beneficiary Spouse and/or child. In no event will COBRA continuation coverage last longer than 36 months from the date of the termination of employment or reduction in hours of employment. You or your Qualified Beneficiary must notify the COBRA Administrator within 60 days of the event if a second Qualifying Event occurs during your continuation coverage period. NOTE: A second event will not entitle your Qualified Beneficiary Spouse to additional coverage unless the event would have caused a loss of coverage if it was the initial Qualifying Event.

Type of Coverage

If you choose continuation coverage, you are entitled to the level of coverage under the HRA in effect for you immediately preceding the Qualifying Event. At the beginning of each Plan Year that COBRA is in effect, you will be entitled to an increase in your Reimbursement Account Balance equal to the sum of the HRA Dollars allocated to similarly situated active participants (subject to any restrictions applicable to similarly situated active participants) so long as you continue to pay the applicable premium.

Cost

For the period of continuation coverage, the cost of such coverage will not exceed 102% of the "applicable premium," as determined by the Plan Administrator, or 150% of the "applicable premium" during any disability extension to which you may be entitled, as determined by the Social Security Administration. The Plan Administrator will notify you of the applicable premium. The notice you receive will describe the premium payment requirements under the Plan (i.e., who you pay the premium to, etc.).

Early Termination of Coverage

Your continuation coverage will end prior to the expiration of the 18, 29, or 36 month period for any of the following reasons:

- The company no longer provides group health coverage to any of its employees.

- The Qualified Beneficiary does not make the required payments (within the grace period).

- You or a Qualified Beneficiary on COBRA becomes covered–after the date COBRA is elected–under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation with respect to any pre-existing condition of the individual (this does not apply during the first 18 months of continuation coverage due to a military leave of absence).

- You or a Qualified Beneficiary on COBRA becomes entitled to Medicare after the date COBRA is elected.

- Coverage has been extended for up to 29 months due to Qualified Beneficiary's disability and there has been a final determination that the Qualified Beneficiary is no longer disabled and the 29 month period is exhausted. Coverage will end on the first day of the month that begins more than 30 days after the determination that you are no longer disabled.

Q-17. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

Q-18. Does the Plan coordinate benefits with other Component Medical Plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). As such, this HRA does not coordinate benefits with any other group or individual health coverage except as provided herein.

If you are also a Participant in a Health Care Spending Account (commonly referred to as a "HCSA") sponsored by your Employer, that covers the same expenses as this HRA, the expenses covered both by the HRA and the HCSA will be paid as described in the Plan Information Appendix.

Q-19. Who do I contact if I have questions about the HRA?

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

PLAN INFORMATION APPENDIX

CITY OF KNOXVILLE
HEALTH REIMBURSEMENT ACCOUNT
FOR RETIREES

SUMMARY PLAN DESCRIPTION

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

**The effective date of this Plan Information Appendix is January 1, 2008.*

I. GENERAL PLAN INFORMATION

1. Name, Address, and Telephone Number of the Employer/Plan Sponsor:	**City of Knoxville** **400 Main Street** **Room 599** **Knoxville, TN 37902** **865-215-2111**
2. Name, Address, and Telephone Number of the Plan Administrator: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more committees or third parties.	**City of Knoxville** **400 Main Street** **Room 599** **Knoxville, TN 37902** **865-215-2111**
3. Address for Service of Legal Process:	**City of Knoxville** **400 Main Street** **Room 599** **Knoxville, TN 37902**
4. Employer's Federal Tax Identification Number:	**62-6000326**
5. Original Effective Date of the HRA:	**January 1, 2008**
6. Plan Year:	**January 1 through December 31**
7. Affiliated Employers participating in the Plan:	**N/A**

8. Third Party Administrator:	**WageWorks, Inc.**

The Plan Administrator has delegated certain day to day ministerial administrative duties such as claims processing to the Third Party Administrator. The Third Party Administrator processes claims and performs other administrative duties in accordance with the terms of the Plan and/or the Plan Administrator's instructions. In addition, the Third Party Administrator may rely on guidance from applicable regulatory agencies to assist it in administering the Plan in accordance with its terms.	**10375 North Baldev Court Mequon, WI 53092**
9. Continuation Coverage Administrator	**PayFlex Systems USA Inc. PO Box 2239 Omaha, NE 68103-2239 800-284-4885**
10. How is the HRA funded?	**General Assets of the Employer**

II. EFFECTIVE DATE OF COVERAGE

Employees who had a Health Reimbursement Account balance at the point of retirement from the Employer may continue to access their Health Reimbursement Account until the last day of the Plan Year following the Plan Year in which coverage under the Component Medical Plan terminated. New Health Reimbursement Accounts will be effective as of the first date of the quarter in which the Participant satisfies the eligibility. Retiree's Dependents are not eligible separately; Retirees may utilize their available Health Reimbursement Account funds for eligible Dependent health care expenses.

III. ELIGIBLE MEDICAL EXPENSES

The following medical expenses are eligible for reimbursement under this Plan (provided all other terms and conditions of the HRA have been satisfied):

Medical care expenses as defined in Internal Revenue Code Section 213(d), including the following specific Premiums determined by the City: Medicare Part B, Medicare Part D, and Medicare supplement policies.

IV. HRA Dollars

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

Credits will be added upon retirement when balance is rolled from the Active Health Reimbursement Account to the Retiree Health Reimbursement Account and quarterly thereafter if applicable. See the City of Knoxville's communication materials for additional details.

B. HRA Dollars will be allocated to the Participant's Reimbursement Account in the following manner:

Upon Retirement and/or Quarterly

V. REIMBURSEMENT ACCOUNT

The amount in your Reimbursement Account may not exceed the following amount:

Unlimited

VI. CARRY OVERS

A. If the Participant has unused funds in the Reimbursement Account at the end of the Plan Year, the following portion of the unused amount will remain in the Reimbursement Account for reimbursement of Eligible Medical Expenses in the next Plan Year:

Unlimited

B. The Carry Over amount, if any, is allocated to your Reimbursement Account annually in the subsequent year as a lump sum.

VII. RUN-OUT PERIOD

This perpetual plan offers a spend-down feature for Retirees whose medical coverage under the Component Medical Plan terminates. Funds in the Reimbursement Account may be used until the end of the Plan Year following the Plan Year in which coverage under the Component Medical Plan terminated.

VIII. CHANGING COVERAGE

Retirees who had a Health Reimbursement Account balance at the point of retirement may continue to access their Health Reimbursement Account as a Participant. All Retirees, regardless of the Reimbursement Account balance at the time of retirement, may earn Retiree HRA Dollars and become a Participant if: 1) enrolled in the Component Medical Plan, and 2) participating in the Chronic Disease Management Program.

IX. PAYMENT CLAIM DATE

Any unclaimed reimbursement amounts (i.e., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) within twelve (12) months after the check is issued.

X. INTERACTION/COORDINATION WITH HEALTH REIMBURSEMENT ACCOUNT

To the extent that Eligible Medical Expenses are covered both by this HRA and by an Employer sponsored Health Care Spending Account in which the Retiree participates, the Eligible Medical Expenses will be paid as follows:

Employer sponsored HCSA will pay first.
Employer sponsored HRA will pay second.