Vermilion Valley Bank
Health Reimbursement Arrangement Plan

Document and Summary Plan Description

September 1, 2016

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ADOPTION OF THE PLAN DOCUMENT AND SUMMARY DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Vermilion Valley Bank (the "Sponsor") as of September 1, 2016 hereby sets forth the provisions of the Vermilion Valley Bank Health Reimbursement Arrangement Plan (the "Plan" or "HRA").

Effective Date

The Plan Document is effective as of the date first set forth above, and any amendment is effective as of the date set forth in the amendment.

Adoption of the Plan Document

Vermilion Valley Bank, as the settler of the Plan, hereby adopts this Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1 et seq. ("ERISA").

IN WITNESS WHEREOF, the Plan Sponsor has caused this Document to be executed.

Vermilion Valley Bank

By: Paula Boundy

Name: Paula Boundy

Title: Cashier

ARTICLE I – GENERAL INFORMATION

Introduction and Purpose

This Vermilion Valley Bank Health Reimbursement Arrangement Plan has been established to reimburse the eligible Employees of the Employer for the cost of providing reimbursement for medical expenses incurred by them, their Spouse and Dependents in accordance with the terms of this Document and Summary Plan Description, which has been incorporated into and made a part of this document. The Plan Document is maintained by Vermilion Valley Bank and may be inspected at any time during normal working hours by any Participant.

General Information

Name of Plan:	**Vermilion Valley Bank Health Reimbursement Arrangement Plan**
Plan Sponsor:	**Vermilion Valley Bank**
Plan Administrator: (Named Fiduciary)	**Vermilion Valley Bank 4E Peoria PO Box 128 Piper City, IL 60959 (815) 686-2258**
Plan Sponsor ID No.	**37-0532910**
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**ERISA**
Calendar/Plan Year:	**January 1 through December 31**
Plan Number:	**504**
Plan Type:	**Welfare benefit plan providing medical benefits**

EFFECTIVE DATE:	**September 1, 2016**
Third Party Administrator:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 309-478-2912** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**
Participating Employer:	**None**
Agent for Service of Process:	**Vermilion Valley Bank** **4E Peoria** **PO Box 128** **Piper City, IL 60959**

Legal Entity and Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time.

Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

ARTICLE II – SCHEDULE OF BENEFITS

Vermilion Valley Bank
Health Reimbursement Arrangement Plan
Schedule of Benefits
Effective September 1, 2016

The Employer has established the Vermilion Valley Bank Health Reimbursement Arrangement Plan ("HRA" or "Plan") for the benefit of Participants to coordinate with the Employer's Health Plan.

Participants with Individual (Employee Only) coverage are responsible for 25% of the Health Plan's $5,000 Individual In-Network Deductible. Participants with Family coverage are responsible for 25% of the Health Plan's $10,000 Family In-Network Deductible. The Employer's HRA will reimburse 75% of the Health Plan In-Network Deductible up to the maximum benefit of:

In-Network Deductible Benefit

Individual - Employee Only Coverage	$3,750	Maximum benefit
Family Coverage	$7,500	Maximum benefit

Generally, amounts payable for prescription drug expenses will be paid to the Participant and all other amounts payable from the HRA Plan will be paid to the service provider.

Benefits will be administered using the plan language in the Employer's Health Plan. Copays, In-Network Coinsurance, Out-of-Network Deductible and Out-of-Network Coinsurance are not Eligible Medical Expense under the HRA Plan.

ARTICLE III - PREAMBLE

3.1 Establishment of Plan

Vermilion Valley Bank (the "Sponsor" and "Employer") hereby establishes the Vermilion Valley Bank Health Reimbursement Arrangement Plan (the "HRA" or "Plan") effective September 1, 2016. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article III.

This Plan is intended to permit an Eligible Employee to obtain reimbursement of Eligible Medical Expenses on a nontaxable basis from his or her HRA account.

3.2 Legal Status

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45. It is intended that the HRA meet the requirements for qualification under Code Sec. 106, so that the Employer's contributions on behalf of participating Employees will be excludable from gross income for federal income tax purposes, and Code Sec. 105(b), so that benefits paid Employees hereunder will be excludible from their gross incomes.

ARTICLE IV - DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

"Benefits" means any amounts paid to a Participant in the HRA as reimbursement for Eligible Medical Expenses incurred by the Participant during a Plan Year by him, his Spouse, or his Dependents.

"Code" means the Internal Revenue Code of 1986, as amended.

"Coverage Period" means the Plan Year, during which period the benefits provided by this HRA shall be available to a Participant hereunder.

"Dependent" means any Spouse or child of the Participant who is a dependent of the Participant within the meaning of the Health Plan and who is participating in the Health Plan.

"Effective Date" means September 1, 2016.

"Eligible Medical Expenses" means those expenses described on the Schedule which are incurred by the Employee or the Employee's Dependents after the effective date of the Employee's participation herein and during the Plan Year for medical care as defined by Code Sec. 213(d). Eligible Medical Expenses shall not include an expense incurred for:

(a) health insurance premiums for any other plan (including a plan sponsored by the Employer)

(b) long-term care services or;

(c) an illness or injury (or aggravation of an illness or injury) incurred by an Employee during a period of duty with the Uniformed Services.

For purposes of this HRA, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

"Employee" means any individual who is considered to be in a legal employer-employee relationship with the Employer for federal withholding tax purposes. Employee does not include a sole proprietor, any partner in a partnership, any more-than-2% shareholder in a Subchapter S corporation or member of an LLC of the Employer or Participating Employer.

"Employer" means Vermilion Valley Bank.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993 (29 USC §2601 et seq.).

"FMLA Leave" means a leave of absence that the Employer is required to extend to an Employee under the provisions of the FMLA.

"Health Plan" means the high deductible group medical plan of the Employer. A "Health Plan" shall not include a plan which is a plan qualified under Code Sec. 125.

"Highly Compensated Individual" means an individual defined under the Code Section 105(h), as amended, as a "highly compensated individuals" or a highly compensated employee."

"HRA Account" means the funding mechanism by which HRA Dollars are allocated to each Participant to be used for reimbursement of Eligible Medical Expenses. No money will actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Plan Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. Interest will not be credited to or paid on amounts credited to the Participant Account(s).

"Participant" means any Employee who has met the eligibility requirements set forth in Article V who is participating in the Health Plan.

"Plan Administrator" means the entity or person appointed by the Employer who has the authority and responsibility to manage and direct the operation and administration of the HRA. The Employer has appointed itself the Plan Administrator.

"Plan Year" means the period that begins on January 1 and ends on December 31 except the first Plan Year which is a short Plan Year that begins on EFFECTIVE DATE and ends on December 31, 2016.

"Spouse" means an individual who is legally married to a Participant and is treated as a Spouse under the Code.

"Uniformed Services" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-

time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

All other defined terms in this HRA shall have the meanings specified in the various Articles of the HRA in which they appear.

ARTICLE V - ELIGIBILITY

5.1 General Eligibility Requirements

Each Employee is eligible to participate in the HRA on or after the EFFECTIVE DATE and during the time period the Employee is covered by the Health Plan. An Employee is automatically enrolled for coverage on the date he is eligible to participate in the HRA.

5.2 Qualified Medical Child Support Order

The plan administrator will enroll for immediate coverage under this Plan any alternate recipient who is the subject of a Medical Child Support Order that is a Qualified Medical Child Support Order ("QMCSO") if such an individual is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Alternate Recipient means any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a participant.

Medical Child Support Order means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:
Provides for child support with respect to a Participant's child or directs the participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

National Medical Support Notice or "NMSN" means a notice that contains the following information:

- Name of an issuing State agency
- Name and mailing address (if any) of an employee who is a Participant under the Plan
- Name and mailing address of one or more alternate recipients, and
- Identity of an underlying child support order.

Qualified Medical Child Support Order or "QMCSO" is a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or eligible dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

- The name and last known mailing address (if any) of the Participant and the name and mailing address of each such alternate recipient covered by the order
- A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined
- The period of coverage to which the order pertains, and
- The name of this Plan.

In addition, a NMSM shall be deemed a QMCSO if it:

- Contains the information outlined in the definition of National Medical Support Notice
- Identifies either the specific type of coverage or all available group health coverage. If the employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and Plan Administrator will assume that all are designated
- Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any)
- Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as qualified if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible plan participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1098 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

- Notify the Participant and each alternate recipient covered by the Order in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO, and
- Make an administrative determination if the order is a QMCSO and notify the Participant and each alternate recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
    - Whether the child is covered under the Plan, and
    - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage, and
- Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

- Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice, and
- Permit any alternate recipient to designate a representative for receipt of copies of the notices that are sent to the alternate recipient with respect to the Order.

5.3 Election to Suspend HRA Account

A Participant may elect to suspend his or her HRA Account for any future Plan Year by submitting a Suspension Election Form to the Administrator before the beginning of that Plan Year. The Participant's suspension election will remain in effect for the entire Plan Year to which it applies, and the Participant may not modify or revoke the election during that Plan Year. The Participant will not receive any Employer Contribution to the HRA Account and will not receive any reimbursements for any Medical Expenses incurred during the Plan Year to which the suspension election applies. Medical Expenses incurred before the beginning of the suspended Plan Year will be reimbursed during the suspended Plan Year, subject to the reimbursement procedures contained in Article 7.2. A Participant may also elect to permanently opt-out of and waive any future reimbursements from the HRA at any time by submitting a properly completed Suspension Election Form to the Plan Administrator. Any such permanent opt-out shall also result in the forfeiture of all HRA payments other than those properly incurred prior to the effective date of the opt-out.

5.4 Reentry after Uniformed Service Duty

No reentry eligibility requirements will be imposed on any Employee who returns to active employment within 90 days of completing a period of absence from employment for duty in the Uniformed Services.

5.5 Termination of a Participant's Coverage

Coverage of a Participant shall terminate automatically on the date:

(a) the Participant is no longer employed by the Employer;

(b) the Participant is no longer in a class of Employees that is eligible for HRA coverage;

(c) the Participant is no longer covered by the Health Plan;

(d) the Participant provides the Plan Administrator notice in writing that the Participant elects to terminate coverage under the HRA (such election shall be permanent and irrevocable and cause the Participant to forfeit any future reimbursements under the HRA); or

(e) the HRA Plan terminates.

5.6 Termination of Coverage of a Dependent

A Dependent's coverage shall terminate on the date:

(a) the Dependent is no longer covered by the Health Plan;

(b) the Participant's HRA coverage terminates; or

(c) the HRA terminates.

5.7 Participation Following Loss of Eligibility

If a Participant terminates his or her participation in the HRA due to the termination of the Employee's employment with the Employer and then again becomes a Participant in the HRA within the same Plan Year the Employee will be reinstated with the same HRA Account balance that such individual had before termination.

5.8 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.

5.9 Non-FMLA and Non-USERRA Leaves of Absence

If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described above under Section 5.5.

ARTICLE VI - AMOUNT OF BENEFITS

6.1 Annual Benefits Provided by the HRA

Each Participant shall be entitled to reimbursement for his documented Eligible Medical Expenses incurred during the Plan Year in an amount equal to the applicable maximum dollar limit for the Plan Year for the Health Plan coverage elected as shown by the amounts set forth on the Health Reimbursement Arrangement Schedule of Benefits and as may be revised by the Employer from time to time. The Participants deductible incurred under the Employer's Health Plan during the first calendar year this HRA is in effect will be considered in determining HRA benefits payable during that Plan Year.

6.2 Cost of Coverage

The Employer shall bear the entire expense of providing the benefits set out in Section 6.1.

6.3 Establishment of Account

The Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. All of the amounts payable from the HRA Accounts shall be paid from the

general assets of the Employer. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

A. **Crediting of Accounts:** A Participant's HRA Account will be credited at the beginning of each Plan Year with an amount equal to the applicable maximum dollar limit for the Plan Year as shown by the amounts set forth on the Health Reimbursement Arrangement Schedule of Benefits and as may be revised by the Employer from time to time.

   Newly Eligible Employees - The Employer's annual contribution to the Participant's HRA Account will not be prorated when an Employee becomes a Participant in the HRA Account portion of this Plan coincident with their enrollment in Health Plan even if the entry date is other than the beginning of the Plan Year.

   Permitted HRA Account Election Changes - If a Participant changes coverage under the Health Plan, other than during the Open Enrollment Period, the HRA Account amount will be adjusted to the annual amount for the Plan Year listed on the Health Reimbursement Arrangement Schedule of Benefits for the new level of coverage less any reimbursements made from the Participant's HRA Account for Eligible Medical Expenses incurred during the current Plan Year.

B. **Debiting of Accounts:** A Participant's HRA Account will be debited during each Plan Year for any reimbursement of Eligible Medical Expenses incurred during the Plan Year.

C. **Available Amount**: The amount available for reimbursement of Eligible Medical Expenses is the amount credited to the Participant's HRA Account under subsection A reduced by prior reimbursements debited under subsection B.

6.4 Nondiscrimination Requirements

It is the intent of this Health Reimbursement Arrangement not to discriminate in violation of the Code and the Treasury Regulations thereunder.

If the Administrator deems it necessary to avoid discrimination under this Health Reimbursement Arrangement, it may, but shall not be required to reduce benefits provided to "highly compensated individuals" (as defined in Code Section 105(h)) in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

ARTICLE VII - PAYMENT OF BENEFITS

7.1 Eligibility for Benefits

Each Participant in the HRA shall be entitled to a benefit hereunder for Eligible Medical Expenses incurred by the Participant on or after the effective date of his participation, (and after the EFFECTIVE DATE of the HRA) subject to the limitations contained herein, regardless whether the mental or physical condition for which the Participant makes application for benefits under this HRA was detected, diagnosed, or treated before the Participant became covered by the HRA.

7.2 Claims for Benefits

No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits to the Plan Administrator on a form specified by the Plan Administrator, and pursuant to the procedures set out in Article IX, below. In some cases, the Participant's claim for reimbursement under the HRA will be automatically filed with the Plan Administrator by the Health Plan (i.e. the amounts not paid by the Health Plan). In that case, the Participant is not required to submit a request for reimbursement; however, he/she may be required by the Plan Administrator to provide additional information necessary to support his/her claim.

Upon receipt of a properly documented claim, the Employer will: (i) reimburse the Claimant, or (ii) at the option of the Plan Administrator, pay the provider directly for any amounts payable from the HRA as soon as is administratively feasible. A Participant my submit a claim for reimbursement for an Eligible Medical Expense arising during the Plan Year at any time during the period that begins when the expense is incurred, and ends 90 days after the close of the Plan Year.

7.3 Coordination with Cafeteria Plan

A Participant shall not be entitled to payment/ reimbursement under a health care reimbursement account in a cafeteria plan (i.e. Medical Flexible Spending Account (FSA)) sponsored by the Employer to the extent the expense is reimbursable under this Plan.

7.4 Carryover Balances

In the event that, at the end of the Plan Year, a Participant's substantiated claims for reimbursement of Eligible Medical Expenses are less than the maximum annual benefit provided by Section 6.1, any remaining amount shall be forfeited.

7.5 Reimbursement of Excess Reimbursements

If it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses that have been substantiated by such Participant during the Plan Year, the Administrator shall give the Participant written notice of any such excess amount, and the Participant shall repay the amount in excess to the Employer within the time frame established by the Administrator. If repayment is not made, the Administrator may offset future benefits by an amount equal to the excess reimbursement. If all attempts to recover the excess reimbursement are unsuccessful, the Administrator may direct the Employer to include such amounts in the gross income of the Employee.

ARTICLE VIII - PLAN ADMINISTRATION

8.1 Allocation of Authority

The Plan Administrator shall control and manage the operation and Administration of the HRA. The Plan Administrator shall have the exclusive right to interpret the HRA and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting

the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as it may request for the purpose of the proper administration of the HRA as a condition to receiving any benefits under the HRA;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the HRA;

(c) To decide on questions concerning the HRA and the eligibility of any Employee to participate in the HRA, in accordance with the provisions of the HRA;

(d) To determine the amount of benefits that shall be payable to any person in accordance with the provisions of the HRA; to inform the Employer, as appropriate, of the amount of such Benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part; and

(e) To designate other persons to carry out any duty or power that would otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the HRA.

8.2 Provision for Third Party Administrative Service Providers

The Plan Administrator may employ the services of such persons as it may deem necessary or desirable in connection operation of the HRA. The Plan Administrator, the Employer (and any person to whom it may delegate any duty or power in connection with the administration of the HRA), and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant, (including Employees who are actuaries or accountants), consultant, third party administration service provider, legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive and binding as to all persons.

The Plan Administrator has assigned ministerial claims processing duties to the Third Party Administrator. "Ministerial claims processing duties" for this purpose means the receipt and routine processing of claims for benefits under the Plan.

8.3 Several Fiduciary Liability

To the extent permitted by law, neither the Plan Administrator nor any other person shall incur any liability for any acts or for failure to act except for his own willful misconduct or willful breach of this HRA.

8.4 Compensation of Plan Administrator

The Plan Administrator shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of his duties shall be paid by the Employer.

8.5 Bonding

Unless required by any Federal or State law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this HRA.

8.6 Payment of Administrative Expenses

All reasonable expenses incurred in administering the HRA, including but not limited to administrative fees and expenses owing to any third party administrative service provider, actuary, consultant, accountant, attorney, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, shall be paid by the Employer.

8.7 Funding Policy

The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the HRA and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the HRA but shall be the property of, and shall be retained by, the Employer.

8.8 Source of Benefit Payments

The Employer shall self-fund any non-insurance benefits to which a Participant is entitled under this HRA.

8.9 Disbursement Reports

The Plan Administrator shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the HRA.

8.10 Timeliness of Benefit Payments

Payments shall be made as soon as administratively feasible after the required forms and documentation have been received by the Plan Administrator, subject to the Claims Procedure requirements set out in Article IX.

8.11 Limit on Coverage

Any coverage elected by a Participant under this HRA shall cease if the Participant fails to make any required contributions toward such coverage.

ARTICLE IX - CLAIM PROCEDURES

9.1 Claims for Benefits

Any Participant (who, for purposes of obtaining benefits under this Plan is called a "Claimant"), or his authorized representative, may file a claim for a HRA benefit to which

the Claimant believes that he is entitled. Such claim must be in writing, and delivered to the Plan Administrator, in person or by mail, postage prepaid. No plan benefit will be paid unless a Claimant has first submitted a written claim for benefits to the R. Upon receipt of a properly documented claim, the Plan Administrator shall adjudicate the claim as soon as is administratively feasible. In some cases, the Participant's claim for reimbursement under the HRA will be automatically filed with the Plan Administrator by the Health Plan (i.e. the amounts not paid by the Health Plan). In that case, the Participant is not required to submit a request for reimbursement; however, he/she may be required by the Plan Administrator to provide additional information necessary to support your claim.

To the extent the claim is approved, the Employer will: (i) reimburse the Claimant, or (ii) at the option of the Plan Administrator, pay the provider directly for any amounts payable from the HRA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for payment of claims. The Plan Administrator may provide that payment/reimbursements of less than certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payment/ reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.

A Claimant may submit a claim for reimbursement for an eligible charge arising during the Plan Year at any time during the period that begins when the expense is incurred, and ends 12 months after the close of the Plan Year. Claims filed late will be denied. Adjudication of claims and related reimbursements of benefits shall be made as soon as administratively feasible after the required claim forms have been received by the Plan Administrator but not later than 30 days after receipt of a complete claim.

9.2 Required Information

Each Claimant's claim for HRA benefits shall contain a written statement containing the following information:

(a) the person or persons on whose behalf Eligible Medical Expenses have been incurred;

(b) the nature of the Eligible Medical Expenses incurred;

(c) the amount of the Eligible Medical Expenses incurred; and

(d) a statement as to the amount of the Eligible Medical Expenses that have been paid through insurance from any other source.

The Claimant also must submit such evidence as the Plan Administrator shall reasonably require to substantiate the nature, the amount, and the timeliness of any Eligible Medical Expenses incurred for which HRA benefits are claimed.

9.3 Notifications of Decisions on Benefit Claims

The Plan Administrator shall notify the Claimant or his authorized representative of the HRA's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim, in accordance with Section 9.1, above. This period may be extended one time by the HRA for up to 15 days, provided that the Plan

Administrator both determines that such an extension is necessary due to matters beyond the control of the HRA and notifies the Claimant or his authorized representative before the end of the initial 30 day period of the circumstances requiring the extension of time and the date by which the HRA expects to render a decision. If such an extension is necessary due to a failure of the Claimant or his authorized representative to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant or his authorized representative shall be given at least 45 days from receipt of the Notice within which to provide the specified information.

For purposes of the various time periods set out in Section 9.1, above, the period of time within which a benefit determination must be made shall begin at the time a claim is filed in accordance with Section 9.1, above, regardless of whether all the information necessary to make a benefit determination is included with the filing. In the event that a period of time is extended as permitted by this Section 9.3 due to the failure of a Claimant or his authorized representative to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Claimant or his authorized representative until the date on which the Claimant or his authorized representative responds to the request for additional information.

9.4 Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request;

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

9.5 Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; ; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

- That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

Requirements for Appeal

The Participant must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the employee/Participant;
- The employee/Participant's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances; but not later than 30 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim; pre-service urgent, pre-service non-urgent or post-service.

- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of

the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

9.6 External Review Process

A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process applies only to:

(a) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and

(b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit

Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
   (d) The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of

the external review decision and unless or until there is a judicial decision otherwise.

C. Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
   (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   (b) A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.
The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.9.7 Coordination with Medicare and Medicaid.

MEDICARE

When Medicare is primary payer, the Plan will coordinate the Plan benefits with Medicare in accordance with the "Coordination of Benefits" provision in this Plan.

If a covered person is eligible for Medicare as primary payer, but does not enroll or apply for it on time, the Plan will estimate what Medicare would have paid if the covered person had made timely application.

The Plan Administrator will determine if Medicare is primary payer based upon Medicare regulations and the status of the Participant on the date a covered expense is incurred.

MEDICAID

Payment for Expenses Incurred with respect to a Covered Person or Covered Dependent under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Covered Persons or Covered Dependent as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling or in determining or making any payments for Expenses Incurred of a Covered Person or Covered Dependent, the fact that the Covered Person or Covered Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person or Covered Dependent to such payment for such Expenses Incurred.

ARTICLE X - CONTINUATION COVERAGE

If the Employer is subject to the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) with respect to this Plan then the following Article X applies

10.1 COBRA Rights

During any Plan Year during which the Employer has more than twenty (20) employees (including persons who are considered to be "employees" within Code Sec. 401(c), directors, and independent contractors to the extent that any of the three categories is eligible to participate in this HRA), under certain circumstances, you have the right to temporarily extend your health coverage under this plan under a federal continuation provision called COBRA. COBRA continuation coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under this plan is lost because of a qualifying event.
The health coverage that will be extended is the same coverage that is provided to active covered employees.

Qualified beneficiaries who elect COBRA continuation coverage must pay the premiums for COBRA continuation coverage.

10.2 When You Become a Qualified Beneficiary

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under this plan because of one of the following qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct.

If you are the covered spouse of an employee, you will become a qualified beneficiary if you lose your coverage under this plan because any of the following qualifying events happens:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his/her gross misconduct
- Your spouse becomes entitled to Medicare benefits under Part A, Part B, or both
- You become divorced or legally separated from your spouse.

A covered dependent child will become a qualified beneficiary if he/she loses coverage under this plan because any of the following qualifying events happens:

- The covered employee parent dies
- The covered employee parent's hours of employment are reduced
- The covered employee parent's employment ends for any reason other than his/her gross misconduct
- The covered employee parent becomes entitled to Medicare benefits under Part A, Part B, or both
- The parents become divorced or legally separated
- The child no longer meets the definition of a dependent child under this plan.

10.3 When is COBRA Coverage Available?

The Plan Administrator, or the Plans designated representative, will notify you of your right to continue coverage under COBRA once the Plan has been notified that a qualifying event has occurred. The Plan Administrator will be aware when the qualifying event is end of employment or reduction of hours of employment, death of the employee.

10.4 You Must Give Notice of Some Qualifying Events

For all other qualifying events, you must notify the Plan Administrator, or the Plan's designated representative, in writing of the qualifying event within 60 days after the event occurs. If the Plan Administrator, or the Plan's designated representative, is not notified within this time frame, COBRA continuation cannot be offered. In order to take advantage of the disability extension, you must also notify the Plan within sixty days of a determination by Social Security that you or a dependent are disabled. It is important for each covered person and covered dependent to timely provide the Employer with his current mailing address.

10.5 The Plan Administrators Notification Responsibilities

Once the Plan Administrators, or the Plans designated representative, receive notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children.

10.6 COBRA Election Period

You or your dependents have the responsibility to notify the Plan, or the Plan Administrator's designated representative, of your desire to continue coverage within sixty days from the later of the date of notification or loss of coverage. Upon acceptance, you or your dependent will be notified of any enrollment forms that must be completed. Qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the Plan would have occurred.

If a covered person decides to continue this coverage, the first premium payment is due 45 days following the date he/she returns the election form. Coverage is provided only when the full premium for the applicable period is received. The covered person must pay any premiums after that within 30 days of the date the premium is due. Premium payments must be made to the Plan, or the Plan Administrators designated representative. Coverage is not in force for any period for which premium is not paid.

If you or a covered dependent experience a qualifying event and do not receive a qualifying event notification in a timely fashion, you should contact the Plan, or the Plan Administrator's designated representative, immediately.

10.7 Length of Continuation

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation can be extended.

10.8 Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the Plan in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the social security Administration determination must be provided to the Plan Administrator within 60 days of the date of the determination and prior to the end of the 18th month of continuation coverage.

10.9 Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your covered spouse and covered dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

10.10 Persons who cannot Continue

A covered person cannot continue this coverage under the COBRA continuation provision if:

- At the time of his/her termination, the covered person is a nonresident alien with no earned income from sources within the United States, or is the dependent of such person.

10.11 COBRA Termination

Although COBRA continuation coverage has a maximum time frame, you may voluntarily terminate coverage at any time by notifying the Plan, or the Plan Administrator designated representative, in advance. In addition, COBRA states that continuation coverage will end for one or more of the following reasons:

- The date the maximum continuation period has been exhausted
- The date the employer ceases to maintain any group health plan for any employee
- The date the covered person is covered by another group health plan which does not include a preexisting condition clause or which would have the preexisting condition limitation period reduced by qualifying previous coverage
- The date the covered person becomes covered by Medicare Part A and/or Part B
- The date any premium that is due is not paid within the time allowed.
- A covered person’s continuation under this Plan will terminate anytime this Plan is terminated.

ARTICLE XI - AMENDMENT OR TERMINATION

It is the intention of the Employer to maintain the HRA indefinitely. However, the Employer may amend or terminate all or any part of this Plan at any time for any reason by any person or persons authorized by the Sponsor to do so, and any such amendment or termination will automatically apply to all Participating Employers.

ARTICLE XII - GENERAL PROVISIONS

12.1 No Employment Rights Conferred

Neither this HRA nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

12.2 Payments to Beneficiary

Any benefits otherwise payable to a Participant following the date of death of such Participant shall be paid to his spouse, or, if there is no surviving spouse, to his estate.

12.3 Nonalienation of Benefits

Benefits payable under this HRA shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse or for any other relative of a Participant, prior to actually being received by the person entitled to the benefit under the terms of the HRA; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable hereunder, shall be void. The HRA shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagement or torts of any person entitled to benefits hereunder.

12.4 Mental or Physical Incompetency

If the Plan Administrator determines that any person entitled to payments under the HRA is incompetent by reason of physical or mental disability, he may cause all payments thereafter becoming due to such person to be made to any other person for his benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Plan Administrator and the Employer.

12.5 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the HRA because he cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identity or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one (1) year after the date such payment first became due.

12.6 Requirement of Proper Forms

All communications in connection with the HRA made by a Participant shall become effective only when duly executed on forms provided by and filed with the Plan Administrator.

12.7 Source of Payments

The Employer shall be the sole source of benefits under the HRA. No Participant or other person 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 HRA, and then only to the extent of the benefits payable under the HRA to such Participant or other person.

12.8 Tax Effects

Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any payments received by a Participant hereunder will be treated as includible in gross income for federal or state income tax purposes.

12.9 Multiple Functions

Any person or group of persons may serve in more than one fiduciary capacity with respect to the HRA.

12.10 Gender and number

Masculine pronouns include the feminine as well as the neuter gender, and the singular shall include the plural, unless indicated otherwise by the context.

12.11 Headings

The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

12.12 Applicable laws

The provisions of the HRA shall be construed, administered and enforced according to applicable Federal law and the laws of the State of Illinois.

12.13 Severability

Should any part of this HRA subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

ARTICLE XIII – YOUR RIGHTS UNDER ERISA

As a participant in the HRA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

13.1 Receive Information about the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and copies 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.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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.

13.2 Continue Group Health Plan Coverage

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. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

13.4 Enforce Your 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 or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which 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 domestic relations order or 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 a federal court. The court will decide who

should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. 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 your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XIV - HIPAA PRIVACY

14.1 Right to Receive and Release Information

The Plan Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator or Third Party Administrator deems necessary to carry out the provisions of the HRA, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, et seq., or other applicable law, the Plan Administrator or Third Party Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any Claimant under the Plan shall furnish to the Plan Administrator or Third Party Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the HRA and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

(a) Not use or further disclose the information other than as permitted or required by the HRA or as required by law;

(b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make available protected health information in accordance with 45 C.F.R. 164.524;

(g) Make health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

(i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.;

(j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the HRA shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

ARTICLE XV – ANNUAL NOTICES TO HEALTH PLAN PARTICIPANTS

15.1 Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies.
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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 amounts applicable to other medical and surgical benefits provided under this health plan.
Please keep this information with your other group health plan documents. If you have any questions about the Plan's coverage of mastectomies and reconstructive surgeries, please call Group Plan Solutions at 888-301-0747.

15.2 The Newborn' and Mother' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group health plans from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth:

- following a normal vaginal delivery to less than 48 hours, and
- following a cesarean section, to less than 96 hours.

The Plan may not require that a provider obtain authorization from us for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, the Plan may not:

- deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage
- provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage
- provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage
- require a mother to give birth in a hospital
- restrict benefits for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description.