VERMILION COUNTY HRA
HEALTH REIMBURSEMENT ACCOUNT
SUMMARY PLAN DESCRIPTION

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INTRODUCTION

THE EMPLOYER IDENTIFIED IN THE PLAN INFORMATION APPENDIX TO THIS HRA (the "Employer") has established the HEALTH REIMBURSEMENT ACCOUNT (the "HRA"). The purpose of this HRA is to reimburse Participants for certain unreimbursed medical expenses ("Eligible Medical Expenses") incurred by the Participant and their Covered 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 (e.g. the name of the sponsoring employer and plan administrator, the plan number, 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 in the plan. 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 You may contact the Employer if you have concerns that the Plan Information Appendix that you have is outdated.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 the 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 in accordance with 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 SPD will control if there is a conflict between this SPD and the official plan document.

This HRA is considered a component of the Employer's medical plan (Component Medical Plan) identified in the Plan Information Appendix. Both the HRA and the Component Medical Plan should be considered a single employee benefit plan even though they are described in separate documents. 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 Component Medical Plan and this HRA are collectively 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.*

Q-1. What is the HRA?

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

- The Employer establishes a Health Reimbursement Account ("Reimbursement Account") for each Participant (see Q-2 for more information on how to become a Participant). This is a notional bookkeeping account established in your name; the Employer does not actually establish a bank account in your name.

- Each Plan Year, the Employer allocates a specified amount of employer contributions, called "HRA Dollars", to each Participant's Reimbursement Account for reimbursement of Eligible Medical Expenses.

- Unlike Health FSA amounts, you may not forfeit some or all of the HRA dollars that you do not use during a Plan Year (see below for a more detailed description of the rollover rules).

Q-2. Who can participate in the HRA?

You are eligible to participate in this HRA if you are an Employee of the Employer (including any Adopting Employer) *and* you also elect to participate in the Component Medical Plan. 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. Eligible employees who become covered under this HRA are called "Participants".

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 Covered Dependents. A "Covered Dependent" is any individual who is enrolled under the Component Medical Plan as your legal spouse or a dependent except as otherwise set forth herein. Notwithstanding the previous sentence, all Covered Dependents must at least be considered a "dependent" of yours as defined in Code Section 105(b) and/or your legal spouse under the Internal Revenue Code. An individual qualifies as a "dependent" of yours for purposes of Code Section 105(b) if they are i) your child as defined under section 152(f) of the code (i.e., a natural, adopted, step, or eligible foster child) who is age 26 or younger at the end of the calendar year; or ii) if you are able to claim the individual as a "dependent" on your federal income tax return or, you would be able to claim the individual as a dependent but for the fact that (a) you are a dependent of another tax payer (b) the individual is married and files a joint tax return with his/her spouse or (c) the individual would otherwise qualify as a "qualifying relative" as defined in Code Section 152(d)(1)(B) but the individual has gross income in excess of the exemption amount. In addition, a child to whom Code Section 152(e) applies (i.e. a child of divorced or "separated"

parents as defined in Code Section 152(e) is considered a "dependent" of both parents for purposes of Code Section 105(b) without regard to who actually claims the child as a dependent on his or her tax return. 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. You may be required to provide proof of dependent status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in coverage under this HRA.

In addition, this HRA will cover a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under this HRA. The plan administrator of the Component Health Plan (or its designee) will notify you if a medical child support order has been received. The plan administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan's QMCSO procedures. The plan administrator will notify both you and the affected child once a determination has been made. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting either the plan administrator of the Component Health Plan or the Plan Administrator of this HRA (as identified in the Plan Information Appendix).

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

Coverage under this HRA for a Participant and/or Covered Dependent(s) begins on the applicable effective 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 effective date of this HRA, as identified in the Plan Information Appendix.

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

Coverage for a Participant and/or Covered Dependent ends on the same date that coverage under the Component Medical Plan ends. However, you, your covered spouse, and/or your covered child(ren) may be eligible to continue coverage under this HRA 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-18 below. All HRA dollars that are not applied towards Eligible Medical Expenses incurred before your termination date are forfeited.

Q-6. What happens to my HRA coverage if I take a leave of absence from the Employer?

Your coverage under this HRA during a paid or unpaid leave of absence will be treated in the same manner that coverage under the Component Medical Plan is treated during a leave of absence. For a detailed summary of the continuation rights under the Component Medical Plan during a leave of absence, please refer to the governing documents of the Component Medical Plan and/or your Employee Handbook.

Generally, if you go on a qualifying unpaid leave under the FMLA, to the extent required by the FMLA, Employer will continue to maintain your group health plan coverage on the same terms and conditions as though you were still active.

Q-7. What is an "Eligible Medical Expense"?

"Eligible Medical Expenses" are medical care expenses *incurred* by you or your Covered Dependents that satisfy all of the conditions described in the "Eligible Medical Expense" section of the Plan Information Appendix. 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 (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided. Also, an otherwise Eligible Medical Expense will not be reimbursed unless the requirements described in Q-15 below have been satisfied.

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

- any expense that is not for "medical care" as defined in Code Section 213(d)
- over the counter medicines or drugs unless they are prescribed
- any expenses incurred for qualified long term care services,
- expenses incurred *prior to the date* that coverage under this HRA becomes effective
- expenses incurred *after the date* that coverage under this HRA ends.
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Limited Purpose Option:

Generally, participation in this HRA will disqualify you from establishing a Health Savings Account (as defined in Code Section 223). To the extent identified as an option offered under this Plan, you may elect, prior to the beginning of the Plan Year, to prospectively "suspend" reimbursement of all otherwise Eligible Medical Expenses except expenses that fall into any of the following three categories (to the extent such expenses qualify as "medical care" under Code Section 213(d):

- Dental expenses
- Vision expenses
- Preventive care (as defined in IRS Notice 2004-23 and Notice 2004-50).

You may choose to revoke this suspension in the future by notifying the Third Party Administrator prior to the first day of the Plan Year in which you wish the suspension revoked. Revocation of the suspension will disqualify you from making tax advantaged contributions to an HSA.

Q-8. What is a Health Reimbursement Account?

Once you become a Participant, the Employer establishes a Reimbursement Account for you. The Reimbursement Account is a notional bookkeeping account that keeps a record of HRA dollars allocated to your account and reimbursements made to you under this HRA. Except as otherwise set forth in the Plan Information Appendix, no trust is established to hold Employer contributions. All reimbursements are made from the Employer's general assets. You have no property rights in the Reimbursement Account.

Q-9. Who contributes to my Reimbursement Account?

While you are an active employee, only the Employer allocates contributions to your Reimbursement Account ("HRA Dollars"). Federal laws prohibit you from contributing to your Reimbursement Account with any portion of a pre-tax salary reduction made under a Code Section 125 cafeteria plan. You may, however, be required to pay the "applicable premium" for continuation of HRA coverage under COBRA (please refer to Q-18 below for more information regarding COBRA continuation coverage).

Q-10. How are HRA dollars allocated to my Reimbursement Account?

Each Plan Year, the Employer allocates a specified amount of HRA Dollars to your Reimbursement Account. The maximum annual HRA Dollar amount is identified in the "HRA Dollar" section of the Plan Information Appendix. The amount of HRA Dollars allocated to your Reimbursement Account is determined in the sole discretion of the Employer and may vary depending on circumstances such as family status. Nevertheless, the annual HRA Dollar amount will be determined in a uniform and non-discriminatory manner.

In addition, HRA Dollars will be allocated to your Reimbursement Account in accordance with the "HRA Dollar" section of the Plan Information Appendix (e.g. all at once at the beginning of the Plan Year or periodically throughout the year on a pro-rata basis, as set forth in the Plan Information Appendix).

Q-11. What happens if I do not use all of the HRA Dollars allocated to my Reimbursement during the Plan Year?

Unlike Health FSA dollars, if you do not use all of the HRA Dollars allocated to your Reimbursement Account in accordance with Q-10 of this SPD, all or a portion 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 "rollover" is described in the "Rollover" section of the Plan Information Appendix. Any funds that you are not permitted to rollover in accordance with this Q-11 will be forfeited and returned to the employer.

Q-12. Is there a limit on how much can be allocated to my Reimbursement Account?

Yes, there may be a limit. The amount in your Reimbursement Account can never exceed the Reimbursement Account Maximum identified in the "Reimbursement Account" section of the Plan Information Appendix. Any HRA Dollars that you would otherwise be entitled to under the terms of this HRA will be forfeited to the extent they will cause your Reimbursement Account to exceed the Reimbursement Account Maximum. If your Reimbursement Account has reached the Reimbursement Account Maximum, you will receive no more HRA Dollars until the Reimbursement Account balance is less than the Reimbursement Account Maximum. At such time you will be entitled to receive your share of HRA Dollars not already forfeited, 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 (to the extent that you are still a Participant).

Q-13. 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-14. Can I change my level of coverage under the HRA during the Plan Year?

If you change your level of coverage under the Component Medical Plan during the Plan Year (e.g. single to family/family to single or part-time to full-time/full-time to part-time) and there is a different HRA Dollar allocation associated with the new level of coverage, your annual HRA Dollar allocation may be adjusted to the extent described in the "Changing Coverage" section of the Plan Information Appendix. All adjustments (if any) will be applied prospectively only.

Q-15. How do I receive reimbursement under the HRA?

You can obtain a reimbursement form from the Third Party Administrator (identified in the Plan Information Appendix). You must complete the reimbursement form and submit it to the Third Party Administrator in conjunction with an invoice, receipt or other documentation from the third party service provider that identifies (i) the date the service was provided (ii) the nature of the service (iii) the amount of the expense and (iv) the individuals for whom the service was provided. **You may submit requests for reimbursement of Eligible Expenses at any time prior to the end of the Claims Filing Period described in the Plan Information Appendix**. **Requests for reimbursements submitted after the Claims Filing Period will not be reimbursed**.

In some cases, your claim for reimbursement under this HRA will be automatically filed with the Third Party Administrator by the Component Medical Plan Administrator (i.e. for the amounts not paid by the Component Medical Plan). It works like this. You receive treatment from a health care provider and either you or the health care provider files a claim ("Component Medical Plan Claim") with the Component Medical Plan Administrator. Once the Component Medical Plan Administrator processes the Component Medical Plan Claim, the Component Medical Plan Administrator provides you and the health care provider with an Explanation of Benefits ("EOB") that shows the amount of Component Medical Plan Claim that is paid by the Component Medical Plan. At the same time, the Component Medical Plan Administrator submits an EOB to the Third Party Administrator. The Third Party Administrator determines whether any amounts not paid by the Component Medical Plan are payable under this HRA. In that case, you are not required to submit a request for reimbursement form; however, you may be asked by the Third Party Administrator to provide additional information necessary to support your claim.

Your HRA 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 (e.g., 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 in accordance with the HRA's claims review procedures described in Q-16 below.

Q-16. What happens if my claim for benefits is denied?

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the HRA plan are discussed below:

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:

- information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information relevant to the claim and available;
- 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 review procedures and the time limits applicable to such procedures; and
- If the Third Party Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

You have the right to an internal appeal and, if applicable, a review to an independent review organization (i.e., for decisions related to medical judgment and/or rescission of coverage).

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 must file your appeal with the Administrator no later than 180 days after receipt of the notice described in Step 1. The appeal must include the following information:

- Your name and address;

- The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- The date of the notice that the Third Party Administrator informed you of the denied claims; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

If you do not file your appeal within this 180-day period, you lose your right to appeal.

Anytime before the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information. The HRA Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Administrator receives new or additional evidence that is considered, relied upon, or generated in connection with the claims, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Administrator's notice of final internal adverse benefit determination. Similarly, if the Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Administrator's notice of final internal adverse benefit determination.

The internal appeal determination will not afford deference to the internal determination and will be conducted by a fiduciary of the HRA plan who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

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 60 days after the Administrator receives the appeal.

Step 5: *Review your notice carefully.* If your internal appeal is denied, the notice that you receive will include the following information:

- Information about your claim, including the date of service, health care provider, and claim amount;
- The specific reason for the denial upon review;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claims;

- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claims for benefits;

- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and

- If the denial is based on medical judgment or relates to a rescission decision, a statement of your right to bring an external appeal or a civil action under ERISA § 502(a)

Step 6: *Right to seek a review of a denied claim to an external third party for certain claims*. If your denial was based on a medical judgment decision or relates to a rescission of coverage, you may have the right to an external review of the Administrator's denial of your internal appeal.

Requirements of this external review are:

You may file a written request for an external appeal with the Administrator. Your external appeal must be filed with the external reviewer within 120 days of the date you were serviced with the Administrator's response to your internal appeal request. If you do not file your appeal within this 120 day period, you lose your right to appeal.

The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available.

Important Information

Other important information regarding your appeals:

- You will not be allowed to take legal action against the Plan, The Employer, The Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your internal appeal rights. But you do not have to pursue external review in order to preserve your right to file a lawsuit.

Q-17. 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 Covered Dependent(s) received an overpayment or a payment was made in error (e.g., 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 for the current plan year, or a subsequent plan year, 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-18. What is "Continuation Coverage" and how does it work?

If you lose coverage under this HRA and the Component Medical Plan because of certain "Qualifying Events", you may be able to continue your coverage in accordance with a federal law called "COBRA". COBRA 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. Under COBRA, "qualified beneficiaries" may be required to pay the "applicable premium" (102% of the cost to the employer to provide the coverage).

When Coverage May Be Continued

Only "Qualified Beneficiaries" may continue coverage under COBRA and only if the loss is the result of a Qualifying Event. A "Qualified Beneficiary" is an employee, Spouse or Dependent child who has coverage under the Plan immediately preceding a qualifying event. A child born to or adopted by (or placed for adoption with) a covered employee during a continuation period is also a Qualified Beneficiary, if the child is added to the coverage within 60 days of the birth, adoption or placement for adoption.

Generally, you ("the covered employee") have the right to COBRA continuation coverage under the Plan if you lose coverage under the Plan as a result of one of the following "Qualifying Events":

- 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 Qualifying 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 Qualifying 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 an eligible dependent under the Plan

Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered employees and qualified beneficiary spouses may elect COBRA on behalf of all of the other qualified beneficiaries, and parents (whether qualified beneficiaries or not) may elect COBRA on behalf of their minor children who are qualified beneficiaries. If the election doesn't specify whether the coverage is for self-only or not, it will be assumed that the election is for all qualified beneficiaries. Likewise, a qualified beneficiary employee may not decline coverage for a qualified beneficiary spouse or non-minor child. Generally, you have 60 days from the later of the date of the notice or the date coverage is lost as a result of the qualifying event to elect coverage.

NOTE: You must elect to continue coverage under the Component Medical Plan in order to continue coverage under this HRA. If you or your Covered Dependents are not eligible for COBRA under the Component Medical Plan (or you do not choose COBRA continuation of the Component Medical Plan), you are not eligible for COBRA continuation of the HRA coverage.

Notice and Election Rules

NOTE: The notice requirements set forth herein apply only to coverage under this HRA. You may also be required to provide notice to the COBRA administrator of the Component Medical Plan in conjunction with providing notice to the COBRA Administrator of this HRA.

The Plan Administrator (or its authorized designee) 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 within 60 days of the later of:

- the event and
- the date coverage is lost as a result of such event or

The qualified beneficiary will then be sent a notice of this right to continuing participation following receipt of your 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 during this 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

COBRA continuation coverage under this HRA lasts as long as the COBRA continuation coverage under the Component Medical Plan lasts. Generally, 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 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 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 your covered Spouse and Dependents. 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 if a second qualifying event occurs during your continuation coverage period. A second qualifying event will not entitle the qualified beneficiary spouse and or dependent child to additional COBRA coverage unless the qualifying event would have caused a loss of coverage under the HRA if it was the initial qualifying event.

Note: In all situations in which you or another qualified beneficiary is required to provide notice of a qualifying event (either an initial qualifying event or a subsequent qualifying event), you must identify the qualifying event, the date of the qualifying event, and the qualified beneficiaries impacted by the qualifying event.

Type of Coverage

If you choose COBRA 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 COBRA 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 (e.g., who you pay the premium to, etc.).

When Continuation Coverage Ends

COBRA Continuation coverage under this HRA will continue for as long as continuation coverage continues under the Component Medical Plan. 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 (this does not apply during the first 18 months of continuation coverage due to a military leave of absence).

- 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. Coverage will end the first day of the month that begins more than 30 days after the Social Security Administration's determination that you are no longer disabled. You are required to notify the COBRA administrator when there has been a determination that a qualified beneficiary is no longer disabled.

Q-19. What are my continuation rights under this HRA if I take a leave of absence to serve in the U.S. Armed Forces?

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides certain provisions for employees who take a leave of absence from employment to perform service in the "uniformed services" (as defined by USERRA). You may have additional protections under state laws. Under USERRA, if you take a leave of absence to perform services in the uniformed services ("Military Leave"), you will be permitted to continue coverage under the Plan for a particular period of time. Generally, coverage under this HRA during a military leave of absence will be provided in accordance with the Employer's internal policies and procedures. At a minimum, if you take a Military Leave that is less than 31 days, you may continue coverage under the Plan for yourself, your covered legal Spouse and your covered dependent children on the same terms and conditions as before the leave. If you take a Military Leave that is 31 days or longer, you may continue coverage for yourself and your covered dependents until the earlier of the date you are otherwise required to return to work (as required by USERRA), or 24 months after your leave begins to the extent that you pay 102% of the applicable premium (as generally defined in COBRA). The Employer will notify you of the applicable premium. Your rights and obligations regarding premium payments mirror those required by COBRA. Coverage for you and your covered Dependents will end earlier if you fail to pay the applicable premium described herein. Coverage for your covered Dependents will end earlier if they cease to be eligible Dependents (as defined herein). Your USERRA required continued coverage will run concurrent with any COBRA period that would otherwise be available (although any rights you or any other Qualified Beneficiary may have under COBRA end when the COBRA period ends, even if coverage is still being continued in accordance with USERRA). You have the same election rights and obligations that you have under COBRA; however, you may be allowed a longer period of time to elect where, under the applicable facts and circumstances, it is impossible or unreasonable for you to make an election. When you return from military leave, you will immediately be eligible to participate in the same benefits that you had prior to leave, without waiting periods. In addition, USERRA generally prohibits application of pre-existing condition exclusions for employees returning from military leave or for their Dependents (except for conditions incurred during or aggravated by your military service).

Q-20. 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. All modifications/terminations effectuated by

the Employer will be applied to all Participants and Covered Dependents except as otherwise stated.

Q-21. Does the Plan coordinate benefits with other Component Medical Plans?

Only medical care expenses that have not been reimbursed or those for which you will not seek reimbursement from any other source may qualify as 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 Flexible Spending Arrangement (commonly referred to as a Health FSA) sponsored by your Employer, the expenses covered both by the HRA and the Health FSA will be paid as described in the Plan Information Appendix.

Q-22. 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.

PART II:
ERISA RIGHTS

This HRA may be a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA). If it is an employee welfare benefit plan subject to ERISA, ERISA provides that you, as a Plan Participant, will be entitled to:

1. Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply 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.

2. Continue Component Medical Plan Coverage

- Continue health coverage for you, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

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 Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest

of the Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

4. Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a 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 (e.g., if it finds your claim is frivolous).

5. Assistance with Your Questions

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

PLAN INFORMATION APPENDIX
Vermilion County HRA

HEALTH REIMBURSEMENT ACCOUNT

SUMMARY PLAN DESCRIPTION

This Appendix provides information specific to **Vermilion County HRA**.

**The effective date of this Plan Information Appendix is 1/1/2016*

I. GENERAL PLAN INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:	Vermilion County HRA 6 N Vermilion Room 310 Danville, Illinois 61832 (217) 554-6004
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.	Vermilion County HRA 6 N Vermilion Room 310 Danville, Illinois 61832 (217) 554-6004
3. Address for Service of Legal Process:	6 N Vermilion Room 310

	Danville, Illinois 61832 (217) 554-6004
4. Employer's federal tax identification number:	37-6002224
5. Plan Number	501
6. Original Effective Date of the HRA:	1/1/2016
7. Plan Year:	1/1/2016 through 12/31/2016
8. Third Party Administrator:	Coventry Consumer Advantage, Inc. PO BOX 7758 London, KY 40742 1-800-722-1758
9. Identity of Component Medical Plan(s) under which this HRA is a component.	Vermilion County HRA Health Benefit Plan
10. How is the HRA funded? (trust or general assets)	General Assets
11. Who is the COBRA Administrator for the HRA?	As designated by Vermilion County HRA

II. EFFECTIVE DATE OF COVERAGE

A. The effective date of coverage for Participants is as follows:

1/1/2016

III. ELIGIBLE MEDICAL EXPENSES

The following Internal Revenue Code Section 213(d) medical expenses are eligible for reimbursement under this Plan (provided all other terms and conditions of the HRA have been satisfied):

- in and out of network
- copay, coinsurance, deductible

And at the following percentage:

50 %

Members are responsible for paying a portion of the deductible before accessing HRA funds (upfront deductible). The upfront deductible (Single/EE-Spouse/EE-Child/Family) is:

$500/$1,000/$1,000/$1,000

The amount of the upfront deductible required to be paid per individual annually before eligible for HRA reimbursement:

No individual limitations

IV. HRA DOLLARS

HRA Dollars will be allocated to your Reimbursement Account during the year as follows:

Single: $2,500

EE/Spouse: $5,000

EE/Child: $5,000

Family: $5,000

If your effective date is after the annual plan effective date, you will receive the following amounts:
The same amounts as listed above.

The amount available for reimbursement per individual annually is: No individual limitations

V. REIMBURSEMENT ACCOUNT

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

EE: $2,500/EE-Spouse: $5,000/EE-Child: $5,000/Family: $5,000

VI. ROLLOVER

A. If the Participant has unused funds in the Reimbursement Account at the end of the Plan Year, and those amounts are less than the amount set forth in Section V above, the following portion of the unused amount will remain in the Reimbursement Account for reimbursement of Eligible Medical Expenses in the next Plan Year: Not Applicable

B. If applicable the Rollover amount will be allocated to your Reimbursement Account on the: 91 days following the end of the plan year.

VII. CLAIMS FILING PERIOD

If a member is still active on the last day of the plan year, all claims must be filed with the Third Party Administrator within 90 days following the end of the plan year.

If a member terminates coverage prior to the last day of the plan year, all claims must be filed with the Third Party Administrator within 90 days following the date of termination.

VIII. CHANGING COVERAGE

If a member changes coverage during the following year, the amounts are calculated based on the following pro-ration: No Pro-ration

No Pro-ration Examples:

Plan Year 01/01 to 12/31. Benefit Amounts $1200 single, $2400 family. Member changes from single to family 07/01. Benefit amount is $1200 from 1/1 – 6/30 and $2400 from 7/1 – 12/31, but total annual amount will not exceed $2400.

Plan Year 01/01 to 12/31. Benefit Amounts $1200 single, $2400 family. Member changes from family to single 07/01. Benefit amount is $2400 from 1/1 – 6/30 and $1200 from 7/1 – 12/31, but total annual amount will not exceed $2400.

Monthly Examples: (1/12)

Plan Year 01/01 to 12/31. Benefit Amounts $1200 single, $2400 family. Member changes from single to family 07/01. Benefit amount is $1800. [1200/12=100 X 6]= 600 + [2400/12=200 X 6] = 1200 [600 + 1200] = $1800.

Plan Year 01/01 to 12/31. Benefit Amounts $1200 single, $2400 family. Member changes from family to single 07/01. Benefit amount for January through June is $2400 and $600 for July through December [1200/12=100 X 6]= $600.

Quarterly Examples: (1/4)

Plan Year 01/01 to 12/31. Benefit Amounts $1200 single, $2400 family. Member changes from single to family 08/01. Benefit amount is $1800. [1200/4 = 300 X 2] = 600 + [2400/4=600 X 2] = 1200 [600 + 1200] = $1800.

Plan Year 01/01 to 12/31. Benefit Amounts $1200 single, $2400 family. Member changes from family to single 08/01. Benefit amount for January through July is $2400 and $600 for August thru December [1200/4 = 300 X 2] = $600.

IX. PAYMENT CLAIM DATE

Any unclaimed reimbursement amounts (e.g., failing to cash a reimbursement check) will forfeit if not claimed (or cashed) by the end of the Plan Year following the Plan Year in which the reimbursement was issued.

X. INTERACTION/COORDINATION WITH HEALTH FSA

To the extent that Eligible Medical Expenses are covered both by this HRA and by an Employer sponsored Health FSA in which the employee participates, the Eligible Medical Expenses will be paid in the following order:

HRA Only