American Health Resources, Inc.

SUMMARY PLAN DESCRIPTION

For all 2013 and 2014
Health Reimbursement Arrangement (HRA) Plans

2013 and 2014 PLAN YEARS
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLANS
SUMMARY PLAN DESCRIPTION
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INTRODUCTION

Your employer, (the "Employer"), is pleased to provide the Health Reimbursement Arrangement (HRA) Plan ("the HRA Plan") for eligible employees. Under federal tax law, the HRA Plan is known as a "Health Reimbursement Arrangement" or "HRA" plan.

This Summary Plan Description (SPD) and the Adoption Agreement (AA) signed by your Employer, herein incorporated by reference in its entirety, describe the basic features of the HRA Plan, how it operates and how you can get the maximum advantage from it. This is only a summary of the key parts of the HRA Plan and a brief description of your rights as a Participant. If there is a conflict between the official, complete plan document and this Summary Plan Description, the official HRA Plan Document will control. Definitions of capitalized terms used in this SPD are contained in Part IV.

PART I. GENERAL INFORMATION ABOUT THE PLAN

I-1. What is the purpose of the HRA Plan?

The purpose of the HRA Plan is to reimburse Eligible Employees, up to certain limits, for their own, their spouse's and their covered Dependents' Health Care Expenses. Reimbursements for Health Care Expenses paid by the Plan generally are excludable from taxable income.

I -2. When did the HRA Plan take effect?

Your HRA Plan took effect as of the date stipulated in the Adoption Agreement. This Summary Plan Description describes plans in effect from January 1, 2013 through December 31, 2013.

I -3. Who can participate in the HRA Plan?

Employees enrolled in the Employer's major medical health insurance plan are eligible to receive a HRA contribution. If Dependent coverage is allowed by the Adoption Agreement signed by your Employer, you can also be reimbursed for eligible Health Care Expenses incurred by your Spouse and Dependents.

I-4. What dependents are covered under the HRA?

If allowed by the Adoption Agreement signed by your Employer, your HRA may cover eligible dependent expenses, if he or she qualifies as a dependent under Section 152 of the Internal Revenue Code by meeting *one of* the criteria listed below, OR is a child who has not attained age 27 by the end of the year. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

Note: This expanded age definition income tax exclusion applies to federal taxes, but may or may not have been adopted in your state. If you have a child who is under age 27 as of the end of the calendar year and who is not a dependent under the definition used by your state taxing authority, and you have paid expenses for that child by using this HRA, you may have additional taxable income for purposes of state income taxes.

To be considered as a dependent under Section 152, the individual must be either a "**qualifying child**" or a "**qualifying relative**."

1. A **qualifying child** is an individual who meets one of the following criteria:
   - Will be less than 19 years of age during the entire calendar year(s) in which coverage is provided; or
   - Will be less than 24 years of age during the entire calendar year(s) in which coverage is provided and is a regular full-time student; or
   - Is permanently and totally disabled.

In addition,

- The individual must reside with you.
- The individual must provide 50% or less of his/her own support.
- The individual must be one of the following:
  - your child (natural, stepchild, adopted child, or child placed for adoption); or
  - your sibling (brother, sister, stepbrother, or stepsister); or
  - a descendent of your child or sibling (e.g., grandchild, great grandchild, niece, nephew)
- The individual must be a citizen, national, or resident of the United States, or a resident of Canada or Mexico. (Special rules apply to adopted children.)
- The individual must be younger than you.

In the case of divorced parents, the child is the qualifying child of the parent with whom the child resides for the longest period during the year. If the child resides with both parents for the same amount of time during the year, the child is the qualifying child of the parent with the highest income.

2. A **Qualifying Relative** is an individual who meets at least one of the following criteria:

- Resides with you and is part of your household; or,
- Is related to you as your child, descendent of a child, sibling, parent, parent's ancestor (e.g., grandparent), step parent, niece, nephew, uncle, aunt, or in-law (son, daughter, father, mother, brother, sister).

In addition,

- The individual must receive more than 50% of his/her support from you.
- The individual does not satisfy the requirements of qualifying child with respect to any individual.
- The individual must be a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

If during the year your dependent ceases to be a dependent, you must immediately discontinue submitting claims for reimbursement under the HRA for your dependent.

Special rule for divorced parents: If both parents together provide more than 50% of his or her support, the individual can qualify as a dependent.

I -5. What benefits are offered through the HRA Plan?

While you are a Participant, the HRA Plan will maintain an "HRA Account" in your name to keep a record of the amount available to you for the reimbursement of eligible Health Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Eligible Health Care Expenses must first be submitted to and, if covered, be reimbursed by any health insurance plan you participate in.

Additionally, if you participate in an employer-sponsored Medical Dental Expense Account (MDEA), you must submit your eligible Health Care Expenses for reimbursement by the MDEA plan before any benefits are payable from the HRA Plan. If you participate in a spouses' HRA Plan, you will be reimbursed for your expenses after you have first exhausted your spouses' (if available) or other HRA balances. To the extent that your Health Care Expenses have been previously reimbursed by **any** other source, they are not reimbursable through this Plan.

The initial credit to your HRA account will be made on a one time basis on the first day of your Plan Year, until such time that it is determined that it will continue beyond that date.

The amount available for reimbursement of Health Care Expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements or payments made to you or on your behalf as of that date.

I -6. How will the HRA Plan Work?

The HRA Plan will reimburse you for eligible Health Care Expenses to the extent that you have a positive balance in your HRA Account. You may submit a paper claim for

reimbursement via a reimbursement request form, completing the form in its entirety, making sure to sign and date it. Send the claim form and documentation (described below) to the Claims Processing Administrator by regular US mail. You may also fax completed claim forms and supporting documentation toll free to AHR at 1-888-815-3921.

Here are the basic rules that apply to all HRA Plans:

- A request for payment must relate to Health Care Expenses incurred during the time you were covered under this Plan.
- A request for payment must be submitted by within the time limit specified in the Adoption Agreement signed by your group for expenses incurred in a prior Plan Year

Any claim for reimbursement must include documentation as follows:

- The name of the person or persons who incurred the Health Care Expenses that you seek to be covered by your HRA;
- The nature and date of the Health Care Expenses so incurred;
- The amount of the requested reimbursement or payment;
- A signed statement from you, certifying that the expenses for which you seek reimbursement have not been reimbursed and are not reimbursable through any other source.

The Adoption Agreement signed by your Employer may stipulate additional requirements for submitting a claim. You may obtain a copy of that Adoption Agreement stipulating these requirements from your Employer or your Claims Processing Administrator, free of charge. In general, however, each claim must be accompanied by an Explanation of Benefits (EOB) from the Group Health Plan of your Employer showing that the Health Care Expenses have been incurred and showing the amounts of such Health Care Expenses, along with any additional documentation that the Claims Processing Administrator may request.

I-7. What happens if I have money left in my HRA account at the end of the year, will it carry forward into the next year?

If the Adoption Agreement signed by your Employer allows it, some or all of any balance remaining in the Participant's HRA Account for a period of coverage after all reimbursements or payments have been made for the period of coverage, may be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent period of coverage.

I -8. Are there any limitations on benefits available from the HRA Plan?

Only Health Care Expenses are covered by the HRA Plan. A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible expenses are doctor office visits, hospitalization, tests, prescriptions and so forth. The HRA is specifically designed to pay only those Health Care Expenses that

are allowable by the U.S. Internal Revenue Service and the Adoption Agreement signed by your Employer. It cannot be used to cover any other expense.

The HRA will not reimburse for OTC medicine (except insulin) without a prescription. The Claims Processing Administrator can provide you with more information about which expenses are eligible for reimbursement.

Some examples of expenses that are not eligible include the following:

- Premiums that a participant pays under any employer sponsored group plan.
- COBRA or benefit continuation premiums that a Participant pays under any employee group plan.
- Premiums that a participant pays for disability insurance
- Parental fees such as TEFRA
- Pregnancy testing kits.
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Massage therapy (unless prescribed by a doctor to treat a medical condition).
- Home or automobile improvements.
- Custodial care.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, unless prescribed by a physician for a specific medical condition.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

- Any item that does not constitute "medical care" as defined under IRS Code § 213(d).

I-9. How do I become a Participant?

If you meet the eligibility requirements described in Section I-3, you will automatically become a Participant.

I-10. What if I terminate my employment during the Plan Year?

If you terminate employment or retire, your participation in this Plan will terminate unless you elect HRA coverage under COBRA. If you have family coverage through the Plan and you die, your spouse and dependents may be eligible for coverage under COBRA. If you have family coverage through the Group Health Insurance Plan provided by the Employer and you get a divorce or have dependents that are no longer eligible, your ex-spouse or dependents may elect COBRA coverage as described in Section 1-12 below.

I-11. What is COBRA? If my spouse or dependent have a COBRA Qualifying Event, can they continue to participate in the HRA Plan?

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If your spouse or your children incur an event known as a "Qualifying Event," and if such person is covered under the HRA Plan, then the person incurring such event will be entitled under COBRA to elect to continue their coverage under the HRA Plan if they pay the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except under the application of COBRA rules, an individual to lose his or her health insurance coverage. A Qualifying Event in this HRA plan includes the following events:

- Your divorce or legal separation from your spouse;
- Your dependent child's ceasing to qualify as a dependent.

A Participant's termination of employment, reduction of hours, or death are qualifying events because the Participant, spouses and dependents will not have access to the account following such events.

The length of COBRA continuation depends upon the qualifying event:

- When the qualifying event is divorce or legal separation, or a dependent child losing eligibility as a dependent child, continuation lasts for up to 36 months. Your ex-spouse or dependents are responsible for informing the Plan Administrator of the COBRA qualifying event within 60 days after the qualifying event.

- A Qualified Beneficiary is someone who will lose coverage because of a qualifying event.If your ex-spouse or dependents who are qualified beneficiaries elect COBRA continuation they will be charged a monthly premium to maintain your HRA benefit.
- A 2 percent surcharge may be added to each monthly contribution to help defray the administrative expenses.
- If the Adoption Agreement signed by your Employment stipulates that the HRA is a one-time benefit, there is no COBRA continuation other than in limited situations involving divorce or legal separation from your spouse; or if your dependent child ceases to qualify as a dependent.
- If Qualified Beneficiaries fail to make a required monthly payment, their COBRA continuation coverage will terminate and they will cease to be a Participant in the Plan.

I-12. Will I have any administrative costs under the HRA Plan?

No. The Employer will pay the administrative costs for the HRA.

I-13. How long will the HRA Plan remain in effect?

The future of the Plan depends to a certain extent upon the terms of the Employer's applicable Group Health Insurance policy or other coverage choices. The Employer reserves the right to amend the HRA Plan at any time and in any manner that it deems reasonable, in its sole discretion.

I-14. Are my benefits taxable?

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the HRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

I-15. My spouse has a High Deductible Health Plan (HDHP) and wants to contribute to a HSA. Is that allowable?

The HRA is considered a Low Deductible Health Plan (LDHP). HSA rules require that in order to be eligible to contribute to an HSA, the individual cannot have any LDHP, including an HRA or MDEA. If your spouse has a HDHP, you must elect to have your HRA or MDEA account be limited to dental, vision and preventative care expenses. This Limited HRA or Limited MDEA allows your spouse to maintain HSA eligibility. If you want to change your HRA to a Limited HRA or your MDEA to a Limited MDEA, contact AHR and complete the form to make this change. You can change your limited HRA or limited MDEA back to general purpose any time during the year.

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

If your claim for benefits is denied, 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.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Claims Processing Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Claims Processing Administrator. The Claims Processing Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Claims Processing Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Claims Processing Administrator will make the decision based on the information that it has. This extended period of time to provide additional information on a claim does not apply to claims submitted during the run out period at the end of the plan year.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Claims Processing Administrator will include the following information:

- The specific reason for the denial;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the HRA Plan's review procedures and the time limits applicable to such procedures; and
- If the Claims Processing 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. A copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to appeal the Claims Processing Administrator's denial of your claim.

D. What are the requirements of my appeal?

Your appeal must be in writing to the Plan Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Claims Processing Administrator's act or omission;
- The date of the notice that the Claims Processing Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Claims Processing Administrator's act or omission. You should also include any documentation that you have not already provided to the Claims Processing Administrator.

E. Is there a deadline for filing my appeal?

Yes. Your appeal must be delivered to the Plan Administrator within 180 days after the date of the denial notice or the Claims Processing Administrator's act or omission. *If you do not file your appeal within this 180-day period, you lose your right to appeal.* Your appeal will be heard and decided by the independent Reviewer ("Reviewer") appointed by the Administrator.

F. How will my appeal be reviewed?

Anytime before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and other information to the Plan Administrator. 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 appeal, the Plan 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. The appeal determination will not afford deference to the initial determination made by the Claims Processing Administrator and will be conducted by a fiduciary of the HRA Plan who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination.

G. When will I be notified of the decision on my appeal?

The Reviewer must notify you of the decision on your appeal within 60 days after receipt of your request for review.

H. What information is included in the notice of the denial of my appeal?

If your appeal is denied, the notice that you receive from the Reviewer will include the following information:

- The specific reason for the denial upon review;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- 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 claim 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 a rule, guideline, protocol, or similar criterion was relied upon in making the review determination. A copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

No action may be brought against the Plan, the Employer, the Plan Administrator, or the Claims Processing Administrator until you first follow the above claim procedures and receive a final determination from the Plan Administrator.

I-17. Who is the Administrator?

American Health Resources, Inc. is the Administrator for the HRA Plan.

PART II. ADMINISTRATIVE INFORMATION

The Plan Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits. The Plan Administrator's failure to enforce any provision of this Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties to agents.

The Name of Plan is "The (Employer) HRA Plan". Information about the Sponsoring Employer and other details are contained in the Adoption Agreement signed by the Participants' Employer and available for free from the Employer or the Plan Administrator.

- Plan Administrator: American Health Resources, Inc.
- Contact Person: American Health Resources, Inc.
- Plan Administrator's Telephone Number: 630-762-1717
- Plan Year: As stipulated in the Adoption Agreement signed by the Employer
- Agent for Service of Process: Service may be made on the Administrator at this address: 11 N. 2nd Avenue, St. Charles, IL 60174
- The financial records of the HRA Plan are kept on a Plan Year basis. The PlanYear ends on the date stipulated by the Adoption Agreement signed by the Employer.

Type of Plan: This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code § 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45.

Type of Administration: The Administrator pays applicable benefits from the general assets of the Employer.

Funding: The HRA Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which benefits are paid. **The Administrator is not an insurance company and is under no obligation to pay any claim from the assets of the Administrator.**

PART III. HIPAA PRIVACY RIGHTS

Use and Disclosure of Protected Health Information

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the HRA Plan from using or disclosing certain health information about you that is created or received by the HRA Plan without your written authorization (see the definition of "PHI" in Part V). For additional information about your privacy rights, please either refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official: American Health Resources, Inc. If you wish to authorize the HRA Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from American Health Resources, Inc.

Permitted Uses and Disclosures

The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- Health care treatment;
- Payment for health care;
- Health care operations; and
- Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

For a complete list of permitted exceptions, please refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official.

Disclosures to the Employer

After the Employer has certified to the HRA Plan that it is in compliance with the Privacy Rule, the HRA Plan may disclose PHI to the Employer without your authorization to the extent that the PHI is necessary for the Employer to perform HRA Plan administration functions. The HRA Plan may not disclose any more PHI to the Employer than is necessary for the Employer to fulfill its administration functions, and the HRA Plan may not disclose PHI to the Employer for purposes of any employment related actions or in connection with any other employee benefit provided by the Employer.

To the extent that your PHI is disclosed to the Employer, the Employer will:

- Not use or further disclose PHI other than as permitted or required by the official HRA Plan document or as required by law;

- Ensure that any agents to whom the Employer provides PHI received from the HRA Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- Not use or disclose PHI in connection with any other benefit provided by the Employer unless authorized by you;
- Report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI;
- Make PHI available to you in accordance with the requirements of the Privacy Rule;
- Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- Make internal practices, books, and records relating to the Employer's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the HRA Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the HRA Plan that the Employer still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

The Employer may only disclose your PHI to the following:

- Employer employees and may only do so to the extent that the Employer employees perform HRA Plan administration functions:
- The Privacy Official;
- Employees in the Employer's Human Resources Department;
- Employees in the Employer's Office of Attorney General; and
- Any other class of employees designated in writing by the Privacy Official.

If an Employer employee does not comply with the requirements of the Privacy Rule, then the Employer may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Official immediately.

PART IV. DEFINITIONS

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

- **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.
- **Claims Processing Administrator** means American Health Resources, Inc.
- **Claim** means those documents you submit to receive payment from your HRA account.
- **Dependent** means any individual who qualifies as an eligible dependent under the IRS Code 152 definition of dependent, or is a child who has not attained age 27 by the end of the year. Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent." **To be considered as a dependent under Section 152, the individual must be either a"qualifying child" or a "qualifying relative."**
    - **A "Qualifying Child" is an individual who:**
        - will be less than 19 years of age during the entire calendar year(s) in which coverage is provided; or
        - Will be less than 24 years of age during the entire calendar year(s) in which coverage is provided and is a regular full-time student (for more information on full-time student status, see the attached page); **or**
        - **Is permanently and totally disabled, and;**
        - The individual resides with you.
        - The individual provides 50% or less of his/her own support.
        - The individual is one of the following:
        - your child (natural, stepchild, adopted child, child placed for adoption) or;
        - your sibling (brother, sister, stepbrother, or stepsister); or
        - a descendent of your child or sibling (e.g., grandchild, great grandchild, niece, nephew).
        - The individual is a citizen, national, or resident of the United States, or a resident of Canada or Mexico. (Special rules apply to adopted children.)
        - The individual is younger than you.
    - **A "Qualifying Relative"** is an individual who meets at least one of the following criteria:
        - Resides with you and is part of your household; orI
        - is related to you as your
            - descendent of a child, sibling, parent, parent's ancestor (e.g., grandparent), stepparent, niece, nephew, uncle, aunt, or in-law (son, daughter, father, mother, brother, or sister).
        - The individual receives more than 50% of his/her support from you.
        - The individual does not satisfy the requirements of Qualifying child with respect to any individual.

- The individual is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

If during the year your dependent ceases to be a dependent, you must immediately discontinue requesting HRA reimbursement for your dependent.

- **Eligible Employee**. An individual is eligible to participate in this Plan if the individual satisfies the definition of an Employee in this Plan, and the eligibility conditions for the Group Health Plan, the provisions of which are specifically incorporated herein by reference. Once an Employee has met the Plan's eligibility requirement, the Employee's coverage will commence on the first day of the Plan Year coinciding with or next following the date on which he or she met the eligibility requirements.
- **Employee.** An individual who is (a) an active employee of the Employer, a member of the Former Employees with Disabilities (FEWD) group, a COBRA participant, an Independent Billing Unit (IBU) employee, or an employee on leave of absence, and (b) enrolled in the Group Health Plan on during open enrollment, or (c) an individual on qualifying leave from a position satisfying clause (a) or (b) of this paragraph.
- **Employer.** The legal entity that employs the Employee and is signatory to the Adoption Agreement.
- **Health Care Expenses.** See Section 1-6 for a description of Health Care Expenses.
- **HRA Account**. The recordkeeping account established in your name by the Employer on the basis of which your eligible Health Care Expenses will be paid or reimbursed.
- **IBU.** This is an independent billing unit of the Employer covered by this plan.
- **Participant.** A person who is an Eligible Employee who becomes a Participant in the Plan in accordance with Section I-7.
- **PHI.** This generally includes all information, whether written or oral, in connection with the HRA Plan that (1) is created or received by the HRA Plan; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present, or future payment for the provision of health care; and (3) identifies you or could be used to identify you.
- **Plan.** The (Employer) Health Reimbursement Arrangement (HRA) Plan set forth herein and as amended or restated from time to time.
- **Plan Administrator.** American Health Resources, Inc.
- **Plan Year.** That period of time set forth in the Adoption Agreement, during which Health Care Expenses incurred may be eligible for reimbursement or payment under this Plan.
- **Privacy Rule**. The regulations that were issued by the Department of Health and Human Services in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- **Spouse.** An individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

PART V. MISCELLANEOUS

EFFECT OF PLAN ON YOUR EMPLOYMENT RIGHTS

The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document. The Plan is not a contract of employment between you and the Employer.

PROHIBITION AGAINST ASSIGNMENT OF BENEFITS

No benefit payable at any time under this Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

OVERPAYMENTS OR ERRORS

If it is later determined that you and/or your Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA Plan.

If you do not refund the overpayment or erroneous payment, the HRA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay, or seek repayment from you in a court of law.

NOTICE OF PRIVACY PRACTICES

ALL AHR 2013 AND 2014 HRA PLANS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE EFFECTIVE DATE OF THIS NOTICE IS JANUARY 1, 2013.

Introduction

Under the federal Medical Data Privacy Regulations, or "Privacy Regulations," the Administrator of your Pre-Tax Plan (the health flexible spending account) is required to give you this NOTICE OF PRIVACY PRACTICES which tells you about how the Plan protects the privacy of your health information and your rights under the new Privacy Regulations. (The Privacy Regulations can be found at 45 *Code of Federal Regulations* Parts 160 and 164.)

The Privacy Regulations govern the use and disclosure of your individually identifiable health information that is transmitted or maintained by the Plan. This is called "Protected Health Information" or "PHI" under the Regulations.

1. When the Plan Uses and Discloses Your PHI

A. Uses and Disclosures Required by the Privacy Regulations

The Plan is required to give you access to certain PHI if you ask so you can inspect and copy it.

The Plan is required to release your PHI to the Secretary of the federal Department of Health and Human Services to review the Plan's compliance with the Privacy Regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations.

The Plan and its "business associates" have the right to and will use PHI without your consent, authorization, or opportunity to agree or object so the Plan can carry out "treatment, payment, and health care operations." **The Plan can also disclose PHI to the Plan Sponsor and to certain agents of the Plan Sponsor (e.g., staff members of the Employee Insurance Division of the Management and Budget Department in the Enrollment and Billing, Benefits Services, or Purchasing Units).** The Plan Document has been amended to protect your PHI as required by federal law.

A health flexible spending account is involved with the reimbursement of plan participants' unreimbursed medical and dental expenses. PHI can be disclosed by the business associate to the Plan Sponsor for such purposes.

C. Uses and Disclosures that Require Your Written Authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist.

Your authorization will also generally be obtained before the Plan will release your PHI to persons not specifically authorized to receive the information under the Privacy Regulations, such as your spouse. When your authorization is required for a release of your PHI, you will also have the right to revoke the authorization at any time.

D. Uses and Disclosures that Require that You Have an Opportunity to Agree or Disagree before the Information is Used or Released.

The Plan can disclose your PHI to family members, other relatives and your close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment for that care; and you have either agreed to the disclosures or have been given an opportunity to object and have not objected.

E. Other Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required.

The Plan can use and disclose your PHI without your consent, authorization or request under the following circumstances; however, as a general rule the Plan will release PHI in these situations only when necessary to protect a person's health or safety:

1) When required by law, such as releases to the Secretary of Health and Human Services.
2) When permitted for purposes of public health activities, including when necessary to report if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.
3) To report information about abuse, neglect or domestic violence to public authorities.
4) To a public health oversight agency for oversight activities such as civil, administrative or criminal investigations; inspections; licensing or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5) When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
6) When required for law enforcement purposes (for example, to report certain types of wounds).
7) For other law enforcement purposes, including identifying or locating a suspect, fugitive, material witness or missing person.
8) To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Disclosure is also permitted to funeral directors, as necessary to carry out their duties with respect to the decedent.
9) For research, subject to certain conditions.
10) To prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11) When authorized by and to the extent necessary to comply with workers'compensation or other similar programs established by law.

2. Your Rights

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

These requests should be made to the Plan's "Contact Person" listed at the end of this Notice.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

Designated Record Set includes your medical records and billing records maintained by or for a covered health care provider; enrollment, payment, billing, and claims adjudication; or other information used in whole or in part by or for the Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30- day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan's Contact Person.

If the Plan denies you access, you or your personal representative will be provided with a written denial stating the basis for the denial, a description of how you can exercise those review rights and a description of how you can complain to the Secretary of the U.S. Department of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set as long as the PHI is maintained in the designated record set. The request must be made in writing and must provide your reasons supporting your request.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan cannot comply with the deadline. If the request is denied in whole or part, the Plan will provide you with a written denial that explains the basis for the denial. You or your personal representative can then submit a written statement

disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests to amend your PHI in a designated record set should be made to the Plan's Contact Person at the Plan Administrator's office. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

D. The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also give you an accounting of the Plan's disclosures of your PHI during the six years prior to the date of your request. However, the accounting need not include PHI disclosures made (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Plan gives you a written statement about the reasons for the delay and the date by which accounting will be provided. If you request more than one accounting within a 12- month period, the Plan will charge a reasonable, cost-based fee for each additional accounting.

E. The Right to Receive a Paper Copy of This Notice Upon Request.

Please contact the Plan's Contact Person at the Plan Administrator's office to receive a paper copy of this Notice.

F. Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of this authority may take one of the following forms: (1) a power of attorney for health care purposes notarized by a notary public; (2) a court order of appointment of the person as the conservator or guardian of the individual; or (3) an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2003, and the Plan is required to comply with the terms of this notice. The Plan, however, reserves the right to change its privacy practices and to apply the

changes to any PHI received or maintained by the Plan before that date. If a privacy practice is changed, a revised version of this notice will be provided by mail to all past and present covered persons for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

A. Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

This minimum necessary standard will not apply in the following situations:

1) disclosures to or requests by a health care provider for treatment;
2) disclosures made to the Secretary of the U.S. Department of Health and Human Services;
3) uses or disclosures that are required by law; and
4) uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe the information can be used to identify an individual. In other words, if the information is de-identified, it is not individually identifiable health information and, therefore, not PHI.

The Plan can also use or disclose "summary health information" to the Plan Sponsor for modifying, amending or terminating the Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals and from which identifying information has been deleted in accordance with the Privacy Regulations.

4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan's Contact Person. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

5. Whom to Contact for More Information

If you have any questions, please contact the Plan's Contact Person, Cassandra Johnson, American Health Resources, Inc. The address is 11 N. 2nd Ave., St. Charles, IL 60174, and the telephone number is 630-762-1717.

Conclusion

PHI uses and disclosures by the Plan are regulated by the federal HIPAA law. This notice attempts to summarize the Privacy Regulations. The Privacy Regulations will supersede any discrepancy between the information in this notice and the regulations.