Plan Document
and
Summary Plan Description

Grace Cottage
HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Group No: 006B16

Effective: January 1, 2016

INDEX

I. ESTABLISHMENT OF PLAN

Establishment of Plan
Grace Cottage (the "Employer") hereby establishes the Grace Cottage Health Reimbursement Arrangement Plan ("HRA" or the "Plan") for the exclusive benefit of its Employees. The Plan is intended to qualify as an employer-provided medical reimbursement plan under §§105 and 106 of the Internal Revenue Code ("the Code"), and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b). This Plan is not and is not intended to be a Code §125 cafeteria plan. Benefits under this Plan are in the form of reimbursements only for Qualifying Medical Care Expenses as defined by the Plan. In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Qualifying Medical Care Expenses.

Effective Date
This Plan is effective January 1, 2016.

Applicable Law
This Plan shall be governed and construed in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) as amended. Consistent with the terms of ERISA, federal law will preempt state law where applicable.

This document, together with any duly executed amendments, constitutes the Plan in its entirety.

II. GENERAL INFORMATION

Plan Name:	Grace Cottage Health Reimbursement Arrangement Plan (the "Plan")
Type of Plan:	Welfare plan providing medical benefits
Effective Date:	January 1, 2016
Employer:	Carlos G. Otis Health Care Center, Inc. d/b/a Grace Cottage (the "Employer") 185 Grafton Road Townsend, VT 05353 (802) 365-7357
Plan Number:	501
Employer Identification Number:	03-0177161
Group Number:	006B16
Plan Administrator:	Employer (see above)
Claims Administrator:	Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 www.healthplansinc.com (877) 734-7004
COBRA Administrator:	Please refer to your Human Resources Department for additional information
Agent for Service of Legal Process:	Employer (see above)
Plan Cost:	Non-contributory
Plan Year Ends:	December 31st
Fiscal Year Ends:	September 30th
Loss of Benefits:	The Employer may terminate the Plan at any time or change the provisions of the Plan by a written instrument signed by a duly authorized Officer of the Employer. Your consent is not required to terminate or change the Plan.

III. DEFINITIONS

Account(s) – a Health Reimbursement Arrangement Account

Claim Administrator – the person, persons, entity or entities appointed by the Employer, who shall process all or some of the claims under this Plan in accordance with the Plan's terms

Code – the Internal Revenue Code of 1986 as now in effect and as may be amended, together with any governing regulations

Covered Person – a Participant or an Eligible Dependent

Eligible Dependent – a Participant's dependent who is covered under the Grace Cottage Employee Group Medical Plan

Eligible Employee – an Employee who meets the eligibility requirements under Section V of this Plan

Employee – any individual who is considered to be in an employer-employee relationship with the Employer for purposes of federal withholding taxes

Employer Contributions – the amount credited to a Participant's HRA Account as described in Section V

ERISA – Employee Retirement Income Security Act of 1974, as amended

Health Reimbursement Arrangement (HRA) Account – an account established under the terms of this Plan to enable a Participant to receive reimbursement that is not subject to federal income taxes for Qualifying Medical Care Expenses as defined by this Plan

Highly Compensated Employee – one of the 5 highest paid officers, a shareholder who owns (with the application of § 318) more than 10 percent in value of the stock of the employer, or among the highest paid 25 percent of all employees (other than employees excluded under § 105(h)(3)(b)

HIPAA – the Health Insurance Portability and Accountability Act of 1996, as amended from time to time

Key Employee – an Employee who is a five percent shareholder, or an officer with income above a certain threshold as defined as such in § 4l6(i)(l) of the Code, or a one percent shareholder with income above certain thresholds as defined in § 416(j)(l)

Open Enrollment Period – the period of time during which Participants and Eligible Employees may make changes to their benefit elections which take effect on the first day of the following Plan Year and may affect eligibility to participate in this Plan

Participant – an Eligible Employee for whom the Plan Administrator has established an HRA Account

Plan Administrator – the Employer or its successor or successors, which shall have authority to administer the Plan as provided in this document under the section titled "Administration"

Plan Year – the First Plan Year is the period commencing January 1, 2016 and ending December 31, 2016. Each subsequent Plan Year is the 12-month period commencing on January 1st and ending December 31st

Qualifying Change in Status – a Participant's or a Participant's Eligible Dependent's change in family or employment status as defined by IRC § 125 that permits a change in election which results in enrollment in the Grace Cottage Employee Group Medical Plan

Qualifying Event – an event that causes a loss of eligibility to participate in this Plan (see Section V, *COBRA Coverage*). Divorce or separation from a same-sex spouse, dissolution of a civil union or termination of a domestic partnership will not be an eligible Qualifying Event for the purposes of COBRA unless the same-sex spouse, civil union/domestic partner qualifies as a tax dependent

Qualifying Medical Care Expenses – costs incurred by a Covered Person for expenses as defined in Section IV, *Reimbursement of Qualifying Medical Care Expenses*

IV. HOW THE PLAN WORKS

This is a brief summary of how this Plan works. Please refer to the applicable sections of this document for details.

Under this Plan, the Employer establishes an HRA Account for eligible Employees funded solely by Employer contributions. Participants in the Plan may then receive reimbursement of Qualifying Medical Care Expenses incurred by the Participant and the Participant's Eligible Dependents.

Employer Contributions – *Described in detail in Section V, Eligibility, Enrollment and Participation*

The Employer funds the total amount of the HRA Account, crediting contributions on an annual basis. There are no Participant contributions permitted under this Plan and under no circumstances will the Account be funded with salary reduction contributions.

Any unused Account balance remaining after the end of the Plan Year is forfeited.

Qualifying Medical Care Expenses – *Described in detail in Section VI, Reimbursement of Qualifying Medical Care Expenses*

The Qualifying Medical Care Expenses available for reimbursement under this Plan are those which:

- Are incurred for medical care, as defined by Code §213, by the Participant and Eligible Dependents,
- Are incurred while the Employee was a Participant in this Plan, and
- Have not been reimbursed under any other health or accident plan, including a Health FSA

The HRA Account will reimburse the following:

Platinum Plan Option – the first $4,000 per individual (for single plan) and $8,000 per family (for family plan) in expenses

Gold Plan Option – the first $3,000 per individual (for single plan) and $6,000 per family (for family plan) in expenses

Silver Plan Option – the first $1,400 per individual (for single plan) and $2,800 per family (for family plan) in expenses

Examples of Qualifying Medical Care Expenses eligible for reimbursement under this Plan are included in Section VI.

Reimbursements – *Described in detail in Section VI, Reimbursement of Qualifying Medical Care Expenses*

Qualifying Medical Care Expenses incurred by a Covered Person may be reimbursed from the Plan, up to the account balance in the Participant's HRA Account on the date the claim is received.

Reimbursements Not Taxable

It is intended that the reimbursements under this Plan will be eligible for exclusion from the Participant's adjusted gross income as provided in Code §105.

Maximum Reimbursements

The maximum amount which a Participant may receive under this Plan in the form of reimbursements for Qualifying Medical Care Expenses incurred in any Plan Year will be regulated as required according to the applicable sections of the Code. The Plan Administrator will reduce or adjust contributions to a Participant's HRA Account as necessary to assure that in the judgment of the Plan Administrator, participation in this Plan will not discriminate in favor of Highly Compensated or Key Employees.

V. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

A. ELIGIBILITY

Employees who are enrolled in the Platinum Plan Option, Gold Plan Option or Silver Plan Option under the Grace Cottage Employee Group Medical Plan are eligible to participate in this Plan.

1. Change in Eligibility during Plan Year

If a Participant or Employee experiences a Qualifying Change in Status during the Plan Year which results in a corresponding change in eligibility for this Plan, eligibility status for this Plan will change automatically. For example, if, as the result of a Qualifying Change in Status, an Employee enrolls in the Platinum Plan Option, Gold Plan Option or Silver Plan Option under the Grace Cottage Employee Group Medical Plan, the Employee automatically will be eligible to participate in this Plan.

B. ENROLLMENT

Enrollment in this Plan is automatic for Eligible Employees. When an Employee becomes eligible for this Plan, the Employer will establish an HRA Account for him or her. No separate enrollment form is required. The effective date of enrollment depends on the reason for enrollment, as shown in the chart below.

Enrollment during:	**Enrollment effective:**
Initial eligibility	The date enrollment in the Grace Cottage Employee Group Medical Plan is effective
Open Enrollment Period	The first day of the Plan Year following the Open Enrollment Period
Enrollment Period following Qualifying Change in Status	The date enrollment in the Grace Cottage Employee Group Medical Plan is effective

C. PARTICIPATION

Participation begins on the date enrollment in the Platinum Plan Option, Gold Plan Option or Silver Plan Option under the Grace Cottage Employee Group Medical Plan is effective. Reimbursements are available from the Account for Qualifying Medical Care Expenses incurred on and after that date.

1. Participation during Periods of Leave

If a Participant goes on a qualifying leave under the FMLA or USERRA, participation in this Plan will continue on as described below.

If a Participant goes on a non-FMLA or non-USERRA leave of absence, participation in this Plan will be based on whether the Participant continues to participate in the Platinum Plan Option, Gold Plan Option or Silver Plan Option during the leave.

2. Participation during FMLA Leave

An Employee who is entitled to and takes a family or medical leave under the terms of the FMLA (Family and Medical Leave Act of 1993, as amended), and the Employee's covered Eligible Dependents, may continue to participate in this Plan during the FMLA leave until the earlier of the expiration of the leave or the date the Employee gives notice to the Employer that the Employee does not intend to return to work at the end of the FMLA leave. If participation is maintained during the leave, the Employee must continue to make any required contributions for coverage in the Platinum Plan Option, Gold Plan Option or Silver Plan Option.

If the Employee chooses not to participate in the Grace Cottage Employee Group Medical Plan while on an FMLA leave, but subsequently returns to Actively at Work status upon or before the expiration of the leave, the Employee and all Eligible Dependents who were covered under the Plan when the leave began shall immediately become covered under the Plan.

The Employer's obligation to provide ongoing coverage under this Plan for an Employee on FMLA ceases if the Employee is more than thirty (30) days late making a required minimum payment for participation in the Platinum Plan Option, Gold Plan Option or Silver Plan Option.

3. Participation during Periods of Military Leave

An Employee who is entitled to and takes a military leave under the terms of the USERRA (Uniformed Services Employment and Reemployment Rights Act (as amended), and the Employee's covered Eligible Dependents, may continue to participate in this Plan during the military leave under the terms of COBRA continuation coverage (see *COBRA Coverage*, below).

Participation in the Plan will begin immediately for an Employee absent from work due to military service on the first day the Employee returns to Actively at Work status, whether or not an Employee elects COBRA continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), provided the Employee returns to Actively at Work status:

- On the first full business day following completion of the military service for a leave of thirty (30) days or less; or
- Within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or
- Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days

In each case, a reasonable amount of travel time or recovery time for an Illness or Injury determined by the Veterans' Administration to be service connected will be allowed.

When participation in this Plan is reinstated, all provisions and limitations in this Plan will apply to the extent that they would have applied if the military leave had not been taken and coverage had been continuous under this Plan.

4. Participation upon Reemployment

If a Participant terminates employment, is rehired and is otherwise eligible to participate in the Platinum Plan Option, Gold Plan Option or Silver Plan Option, he or she may resume participation on the terms described under *Eligibility* at the beginning of this section.

5. Employer Credits to HRA Accounts

Employer contributions are made to an HRA Account annually.

For the Platinum Plan Option, the annual contribution amount is $4,000 per individual (for single plan) and $8,000 per family (for family plan), and is divided equally among the remaining periods in the Plan Year.

For the Gold Plan Option, the annual contribution amount is $3,000 per individual (for single plan), and $6,000 per family (for family plan), and is divided equally among the remaining period in the Plan Year.

For the Silver Plan Option, the annual contribution amount is $1,400 per individual (for single plan), and $2,800 per family (for family plan), and is divided equally among the remaining period in the Plan Year.

6. Debits to Accounts

A Participant's HRA Account will be debited from time to time in the amount of any eligible claim for reimbursement, up to the Participant's Account balance as of the date the claim is submitted, as described in Section VI, *Reimbursement of Qualifying Medical Care Expenses*.

7. Carryover Provisions

Any unused Employer Contributions remaining in the Account after the end of the Plan Year are forfeited by the Participant and credited back to the Employer.

8. When Participation Ends

Participation in this Plan ends on the earliest of the following dates:

- The date the Participant no longer participates in the Platinum Plan Option, Gold Plan Option or Silver Plan Option.
- The date the Participant terminates employment by death, disability, retirement or other separation from service.
- The date on which this Plan terminates.

When participation ends, Participants may be eligible to elect continuation coverage under COBRA, as described below.

9. COBRA Coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act, as amended).

During any Plan Year during which the Employer has more than 20 Employees (as defined under COBRA for this purpose), each person who is a Qualified Beneficiary, as defined below, may elect to continue coverage under this Plan upon the occurrence of a Qualifying Event, as defined below, that would otherwise result in a loss of coverage under the Plan, provided the Qualified Beneficiary has elected to continue coverage under the Platinum Plan Option, Gold Plan Option or Silver Plan Option. Extended coverage under the Plan is known as "COBRA continuation coverage" or "COBRA coverage."

COBRA coverage is group health insurance coverage that an employer must offer to certain Plan participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of certain events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage will be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage will

be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

a. Qualified Beneficiaries. In general, a Qualified Beneficiary is:

- Any Employee who, on the day before a Qualifying Event, is covered under the Plan, or the spouse of a covered Employee, civil union/domestic partner, or an Eligible Dependent child of a covered Employee. If, however, an Employee is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the Employee will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that Employee experiences a Qualifying Event.

- Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an Employee is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the Employee will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that Employee experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any Employee who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed Employees, independent contractor, or corporate director).

An Employee is not a Qualified Beneficiary if the Employee's status as a covered Employee is attributable to a period in which the Employee was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. Nor are such Employee's spouse, civil union/domestic partner, or Eligible Dependent children considered Qualified Beneficiaries.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

b. **Qualifying Events.** A Qualifying Event is any of the following if the Plan provides that the Qualified Beneficiary would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- The death of a covered Employee.
- The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- The divorce or legal separation or dissolution of civil union, or termination of domestic partnership of a covered Employee from the Employee's spouse.
- A covered Employee's entitlement to Medicare.
- An Eligible Dependent child's ceasing to satisfy the Plan's definition of an Eligible Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the spouse, civil union/domestic partner or an Eligible Dependent child of the covered Employee to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under the FMLA does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). The covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

A voluntary waiver of coverage by an Employee on behalf of the Employee or an Eligible Dependent, such as during an Open Enrollment Period, is not a Qualifying Event.

c. **Election Periods.** To be eligible for COBRA coverage, a Qualified Beneficiary must make a timely election for COBRA coverage under the Grace Cottage Employee Group Medical Plan. An election is timely if it is made during the election period. The election period begins no later than the date the Qualified Beneficiary loses the medical coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary loses coverage on account of the Qualifying Event or the date the Qualified Beneficiary is notified of the right to elect COBRA continuation coverage.

d. **Informing the Plan Administrator of the Occurrence of a Qualifying Event.** In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- An Eligible Dependent child ceasing to be an Eligible Dependent child under the generally applicable requirements of the Grace Cottage Employee Group Medical Plan.

- The divorce or legal separation, or dissolution of civil union, or termination of domestic partnership of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

e. **Revoking a Waiver of Coverage during the Election Period.** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

f. **Termination of COBRA continuation coverage.** Except for an interruption of coverage in connection with the revocation of a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum COBRA coverage period.

(ii) The first day for which Timely Payment (as defined below) is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(v) The date, after the date of the election, that the Qualified Beneficiary is entitled to Medicare benefits (either part A or part B, whichever occurs earlier).

(vi) In the case of a Qualified Beneficiary entitled to a disability extension (as described below), the later of:

- 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

- the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

In the case of an Employee who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the Employee's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the Employee who is not a Qualified Beneficiary.

g. Maximum COBRA coverage periods. The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is no disability extension and 29 months after the Qualifying Event if there is a disability extension.

(ii) In the case of a covered Employee's entitlement in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

- 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
- 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(iv) In the case of any Qualifying Event other than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

h. **Limited circumstances under which the maximum coverage period can be expanded.** If an Employee experiences a second Qualifying Event while receiving 18 months of COBRA continuation coverage, the Employee's spouse, surviving spouse, civil union/domestic partner or Eligible Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator. This extension is available to the spouse, civil union/domestic partner and any Eligible Dependent children receiving continuation coverage if the Employee or former Employee dies, or gets divorced or legally separated, or if the Employee or former Employee's civil union is dissolved, or domestic partnership is terminated, or if the Eligible Dependent child stops being eligible under the Plan as an Eligible Dependent child, but only if the event would have caused the spouse or Eligible Dependent children to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, the Qualified Beneficiary must notify the Plan Administrator of the second Qualifying Event with 60 days of the Qualifying Event.

i. **Disability extensions of coverage.** A disability extension will be granted in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, if a Qualified Beneficiary (whether or not a covered Employee) is determined under Title II or XVI of the Social Security Act to have been disabled at some time before the 60th day of COBRA continuation coverage. The disability must last at least until the end of the 18-month period of continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage period.

j. **Payment for COBRA Continuation Coverage.** For any period of COBRA continuation coverage, the Plan requires the payment of an amount that equals 102% of the applicable premium for the Grace Cottage Employee Group Medical Plan, unless the Plan requires the payment of an amount that equals 150% of the applicable premium for any period of COBRA continuation coverage based on a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that Qualified Beneficiary.

Payments for COBRA continuation coverage may be made in monthly installments or may be made for multiple months in advance.

k. **Timely Payment for COBRA Continuation Coverage.** Timely Payment for a period of COBRA coverage means payment that is made to the Plan by 30 days after the first day of that period. Notwithstanding the above, a Qualified Beneficiary has 45 days after the date of the election of COBRA continuation coverage to make the initial payment for coverage. The initial payment for coverage must include payment for the entire period that begins on the date of the Qualifying Event (or revocation of waiver) and ends on the last day of the month in which the initial payment is submitted. Payment is considered made on the date on which it is sent to the Plan.

l. **COBRA Coverage for Employees in the Uniformed Services.** For purposes of this Article V, an Employee who is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services will experience a Qualifying Event as of the first day of the Employee's absence for such duty. Such an Employee and any of the Employee's covered Eligible Dependents will be treated as any other Qualified Beneficiary under subsection 9.a. for all purposes of COBRA. However, to the extent that the Uniformed Services Employment and Reemployment Rights Act ("USERRA") provides greater continuing coverage rights, the provisions of USERRA will apply. The Plan Administrator will furnish the Employee and the Employee's covered Eligible Dependents a notice of the right to elect COBRA continuation coverage for the Grace Cottage Employee Group Medical Plan (as provided above) and shall afford the Employee the opportunity to elect such coverage. However, the maximum period of coverage available to the Employee and the Employee's Eligible Dependents under USERRA is the lesser of (a) 24 months beginning on the date of the Employee's absence or (b) the day after the date on which the Employee fails to apply for or return to active employment from active duty under USERRA with the Employer. If the leave is thirty (30) days or less, the contribution rate will be the same as for active Employees. If the leave is longer than thirty (30) days, the required contribution is 102% of the cost of coverage.

VI. REIMBURSEMENT OF QUALIFYING MEDICAL CARE EXPENSES

This section describes the expenses eligible for reimbursement and how claims for reimbursement are processed.

Reimbursements under this Plan are available for Qualifying Medical Care Expenses only to the extent that these expenses have not been reimbursed through any other health or accident plan, including a Health FSA.

A. ELIGIBLE EXPENSES

The Qualifying Medical Care Expenses that are eligible for reimbursement under this Plan are any permitted under the Internal Revenue Code. Examples of expenses eligible for reimbursement under this Plan include those listed below which:

- Were incurred for a Covered Person, and
- Have not been reimbursed under any other benefit or insurance plan.

IRS Publications 502 and 969 contain additional information about specific eligible expenses.

- Abortion
- Acupuncture
- Alcoholism, treatment of
- Ambulance service
- Artificial limb
- Artificial teeth
- Birth control pills
- Braille books and magazines
- Certain capital expenses/home improvements related to medical care
- Chiropractor
- Christian Science practitioner
- Coinsurance and Deducible amounts
- Contact lenses
- Crutches
- Dental treatment
- Drug addiction treatment
- Drugs
- Eyeglasses
- Fertility enhancement
- Guide dog or specially trained animal
- Hearing aids
- Home health care
- Hospital services
- Laboratory fees
- Laser eye surgery
- Lead-based paint removal
- Medical services provided by medical practitioners
- Nursing home
- Nursing services
- Optometrist
- Organ donors, transplants
- Orthodontic treatment
- Osteopath
- Over-the-counter drugs , with prescription
- Oxygen
- Prescription medicines
- Psychiatric care
- Psychoanalysis
- Psychologist
- Smoking cessation programs
- Special telephone for hearing impaired person
- Sterilization
- Surgery
- Television used for audio/visual aid
- Therapy as medical treatment
- Transplants
- Transportation primarily for and essential to medical care
- Tuition for certain special education services
- Vaccines
- Vasectomy

- Learning disability tuition & tutoring
- Legal fees related to medical expenses
- Meals during hospital/health care institution stay
- Medical aids (such as false teeth, hearing aids, orthopedic shoes and elastic hosiery
- Vision care (eye exams, eyeglasses, contact lenses, contact lens solutions)
- Weight-loss program at physician's direction
- Wheelchair
- X-rays

Expenses which generally are ***not eligible*** for reimbursement include:

- Expenses for cosmetic procedures and services
- Expenses claimed on a Covered Person's income tax return
- Expenses not eligible to be claimed as an income tax deduction
- Expenses reimbursed by other sources, such as insurance companies
- Fees for exercise/athletic/health clubs where there is no specific medical reason for membership
- Hair transplants
- Illegal treatments, operations, or drugs
- Nicotine patches and gum
- Over-the-counter medications without prescription
- Postage/handling fees
- Weight reduction programs for general well being

B. HOW REIMBURSEMENTS ARE PROCESSED

When a claim for Qualifying Medical Care Expenses is submitted by a provider to the Grace Cottage Employee Group Medical Plan, a claim for reimbursement will automatically be processed through the HRA Account for any amounts not fully covered by the medical plan. A check will be issued to the provider who submitted the claim, up to the available balance in the HRA Account when the claim is processed. If the claim exceeds the available Account balance, subsequent reimbursements automatically will be made if additional Employer Contributions are credited to the Account, until the claim has been fully reimbursed, or until all available funds for the Plan Year have been exhausted, whichever happens first.

If the debit card was used to purchase a prescription or other covered service, payment will be transferred automatically to the pharmacy or other provider if the HRA Account balance is sufficient to cover the entire cost. If the Account balance is less than the total eligible charge, the entire transaction will be declined.

(**Note:** Access to HRA balances with Debit Cards is not available to COBRA participants. COBRA claims can be submitted using the paper form process described above.)

If any expense reimbursed under the Plan is later determined not to be an eligible expense under the Plan, the Employee will be required to reimburse the Plan.

1. Deadline for Submitting Claims

Any claim for reimbursement under this Plan must be submitted no later than 180 days following the close of the Plan Year in which the qualifying expenses were incurred or 90 days after participation in the Plan ends, whichever happens first.

VII. PLAN ADMINISTRATION

A. ALLOCATION OF AUTHORITY

Except as to those functions reserved by the Plan to the Employer or the Board of Directors of the Employer, the Plan Administrator will control and manage the operation and administration of the Plan. The Plan Administrator shall (except as to matters reserved to the Board of Directors by the Plan or that the Board may reserve to itself) have the sole and exclusive right and discretion:

- To interpret the Plan, the Summary Plan Description, and any other writings affecting the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.

- To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan.

All determinations of the Plan Administrator or the Board of Directors with respect to any matter relating to the administration of the Plan will be conclusive and binding on all persons.

B. POWERS AND DUTIES OF PLAN ADMINISTRATOR

The Plan Administrator will have the following powers and duties:

- To require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan as a condition to receiving any benefits under the Plan.

- To make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the Plan.

- To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan.

- To determine the amount of benefits that will be payable to any person in accordance with the provisions of the Plan; to inform the Employer, as appropriate, of the amount of such benefits; and to provide a full and fair review to any covered individual whose claim for benefits has been denied in whole or in part.

- To designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the Plan; and to retain such actuaries, accountants (including Employees who are actuaries or accountants), consultants, third-party administration service providers, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the Plan's effective administration.

C. DELEGATION BY THE PLAN ADMINISTRATOR

The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the Plan. The Plan Administrator may also appoint a benefit committee to assist the Plan Administrator either generally or specifically in reviewing claims for benefits, subject to the right of the Board of Directors to replace any or all of the members of the committee, or to eliminate the committee entirely.

The Plan Administrator, the Employer (and any person to whom any duty or power in connection with the operation of the Plan is delegated), may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including Employees who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist, and the Plan Administrator, Employer, or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

D. FIDUCIARY LIABILITY

To the extent permitted by law, the Plan Administrator will not incur any liability for any acts or for failure to act.

E. INDEMNIFICATION AND EXCULPATION

The Plan Administrator and the members of any committee appointed by the Plan Administrator to assist in administering the Plan, its agents, and officers, directors, and Employees of the Employer will be indemnified and held harmless by the Employer against and from any and all loss, cost, liability, or expense that may be imposed upon or reasonably incurred by them in connection with or resulting from any claim, action, suit, or proceeding to which they may be a party or in which they may be involved by reason of any action taken or failure to act under this Plan and against and from any and all amounts paid by them in settlement (with the Employer's written approval) or paid by them in satisfaction of a judgment in any such action, suit, or proceeding. Indemnification under this Section will not be applicable to any person if the loss, cost, liability, or expense is due to the person's failure to act in good faith or misconduct.

F. COMPENSATION OF PLAN ADMINISTRATOR

Unless otherwise agreed to by the Board of Directors, the Plan Administrator will serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Plan Administrator's duties will be paid by the Employer.

G. BONDING

Unless required by ERISA, by the Board of Directors, or by any other federal or state law, neither the Plan Administrator nor any of the Plan Administrator's delegates will be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

H. PAYMENT OF ADMINISTRATIVE EXPENSES

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third-party administrative service provider, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the Employer unless the Employer directs the Plan to pay such expenses and such payment by the Plan is permitted by law.

VIII. HIPAA PRIVACY AND SECURITY PROVISIONS

A. PRIVACY PROVISIONS

There are three circumstances under which the Plan may disclose an individual's protected health information to the Plan Sponsor.

First, the Plan may inform the Plan Sponsor whether an individual is enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying the individual.

Third, the Plan may disclose an individual's protected health information to the Plan Sponsor for Plan administrative purposes. This is because Employees of the Plan Sponsor perform many of the administrative functions necessary for the management and operation of the Plan. The Plan Sponsor has certified to the Plan that the Plan's terms have been amended to incorporate the terms of this summary. The Plan Sponsor has agreed to abide by the terms of this summary. The Plan's privacy notice also permits the Plan to disclose an individual's protected health information to the Plan Sponsor as described in this summary.

Here are the restrictions that apply to the Plan Sponsor's use and disclosure of an individual's protected health information.

- The Plan Sponsor will only use or disclose an individual's protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.

- If the Plan Sponsor discloses any of an individual's protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep an individual's protected health information as required by the HIPAA regulations.

- The Plan Sponsor will not use or disclose an individual's protected health information for employment related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA.

- The Plan Sponsor will promptly report to the Plan any use or disclosure of an individual's protected health information that is inconsistent with the uses or disclosures allowed in this summary.

- The Plan Sponsor will allow an individual or the Plan to inspect and copy any protected health information about the individual that is in the Plan Sponsor's custody and control. The HIPAA Regulations set forth the rules that an individual and the Plan must follow in this regard. There are some exceptions.

- The Plan Sponsor will amend, or allow the Plan to amend, any portion of an individual's protected health information to the extent permitted or required under the HIPAA Regulations.

- With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log. The disclosure log will go back for six years. An individual has a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.

- The Plan Sponsor will make its internal practices, books and records relating to its use and disclosure of an individual's protected health information available to the Plan and to the U.S. Department of Health and Human Services.

- The Plan Sponsor will, if feasible, return or destroy all of an individual's protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the Plan or from any business Employee when the Plan Sponsor no longer needs an individual's protected health information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy an individual's protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

In addition to the Privacy Officer, the following classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to an individual's protected health information for the purposes set forth above:

- Chief Financial Officer
- Director of Human Resources
- Employees and other workforce members at the direction of the above listed classes of employees
- Benefits Coordinator

This list includes every class of Employees or other workforce members under the control of the Plan Sponsor who may receive an individual's protected health information. If any of these Employees or workforce members use or disclose an individual's protected health information in violation of the rules that are set out in this summary, the Employees or workforce members will be subject to disciplinary action and sanctions. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to an individual.

B. SECURITY PROVISIONS

The Plan Sponsor will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Plan Sponsor certifies to the Plan that it agrees to:

- Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

- Require that any agent or subcontractor of the Plan Sponsor agrees to the same requirements that apply to the Plan Sponsor under this provision;

- Report to the Plan any security incident that the Plan Sponsor becomes aware of;

- Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

IX. AMENDMENT AND TERMINATION OF THE PLAN

A. AMENDMENT

The Employer has the right to amend this Plan in any and all respects at any time, and from time to time, without prior notice.

Any such amendment will be by a written instrument signed by a duly authorized Officer of the Employer.

The Plan Administrator will notify all Participants of any amendment modifying the material terms of the Plan as soon as is administratively feasible after its adoption, but in no event later than 210 days after the close of the Plan Year in which the amendment has been adopted. Such notification will be in the form of a Summary of Material Modifications (within the meaning of ERISA §102(a)(1) and Labor Reg. §2520.104b-3) unless incorporated in an updated Summary Plan Description (as described in ERISA § 102(b)).

Notwithstanding the above, to the extent the material change is a material reduction in covered services or benefits (as defined in Labor Reg. §2520.104b-3(d)(3)), such Summary of Material Modifications shall be distributed within 60 days of the date of adoption of such change.

B. TERMINATION OF PLAN

Regardless of any other provision of this Plan, the Employer reserves the right to terminate this Plan at any time without prior notice. Such termination will be evidenced by a written resolution of the Employer. The Plan Administrator will provide notice of the Plan's termination as soon as is administratively feasible, but no more than 210 days after the last day of the final Plan Year.

C. TERMINATION BY DISSOLUTION, INSOLVENCY, BANKRUPTCY, MERGER, ETC.

This Plan will automatically terminate if the Employer (1) is legally dissolved; (2) makes any general assignment for the benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity; (5) sells or transfers substantially all of its assets; or (6) goes out of business, unless the Employer's successor in interest agrees to assume the liabilities under this Plan as to the Participants.

X. GENERAL PROVISIONS

A. COMMUNICATION TO ELIGIBLE EMPLOYEES

The Employer will promptly notify all Eligible Employees of the availability and terms of the Plan.

B. IN GENERAL

Any and all rights provided to any person under this Plan shall be subject to the terms and conditions of the Plan. This Plan shall not constitute a contract between the Employer and any Covered Person, nor shall it be consideration or an inducement for the initial or continued employment of any Employee. Likewise, maintenance of this Plan shall not be construed to give any Employee the right to be retained as an Employee by the Employer or the right to any benefits not specifically provided by the Plan.

C. NO GUARANTEE OF NON-TAXABILITY

The Plan is designed and is intended to be operated as a Health Reimbursement Arrangement Plan under §§105 and 106 of the Internal Revenue Code. Nonetheless, neither the Employer nor any Plan fiduciary shall in any way be liable for any taxes or other liability incurred by a Participant or anyone claiming through him or her by virtue of participation in this Plan.

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's Gross Income for Federal or State Income Tax purposes, or that any other Federal or State Tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan are excludable from the Participant's Gross Income for Federal and State Income Tax purposes, and to notify the Employer if the Participant has reason to believe that any payment is not so excludable.

D. INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements that are not for Qualifying Medical Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or State Income Tax or Social Security Tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and State Income Tax that the Participant would have owed. If the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security Tax that would have been paid on such compensation, less any such additional Income and Social Security Tax actually paid by the Participant.

E. NONDISCRIMINATION

In accordance with §105 of the Code, the Plan is intended not to discriminate in favor of Key Employees and Highly Compensated Employees as to eligibility to participate or as to contributions and benefits, nor to provide more than *25%* of all statutory nontaxable benefits to Highly Compensated Employees. If, in the operation of the Plan, more than 25% of the total nontaxable benefits are found to be provided to Highly Compensated Employees, or the Plan discriminates in any other manner (or is in danger of so discriminating), then notwithstanding any other provision contained herein, the Plan Administrator shall reduce or adjust such contributions and/or benefits under the Plan as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan thereafter will not discriminate. All rules, procedures and decisions of the Plan Administrator shall be adopted, made and/or applied in such fashion that they do not discriminate in favor of Key or Highly Compensated Employees.

F. COVERAGE PURSUANT TO A QUALIFIED MEDICAL CHILD SUPPORT ORDER

Dependents shall be provided benefits in accordance with applicable requirements of any Qualified Medical Child Support Order provided that such order does not require the Plan to provide any type or form of benefit, or any option under the Plan, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in § 1908 of the Social Security Act (as added by § 13822 of the Omnibus Budget Reconciliation Act of 1993).

Any payment of benefits made by the Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

The terms "Qualified Medical Child Support Order" and "Medical Child Support Order" shall have the meanings given to them in § 609 of the Employee Retirement Income Security Act.

An "Alternate Recipient" shall mean any child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enroll under the Plan with respect to such Covered Person.

G. COMPANY FUNDING

All benefits paid under this Plan shall be paid in cash from the general assets of the Employer. No Employees shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Employer may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Employer and an Employee or

any other person. Neither an Employee nor a beneficiary of an Employee shall acquire any interest greater than that of an unsecured creditor.

H. WAIVER AND ESTOPPEL

No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Employee or eligible beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

I. NONVESTED BENEFITS

Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Plan Participant.

J. INTERESTS NOT TRANSFERABLE

The interests of Participants under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, or encumbered without the written consent of the Plan Administrator.

K. SEVERABILITY

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

L. HEADINGS

The headings of sections and subsections are for ease of reference only and shall not be construed to limit or modify the detailed provisions hereof.

M. APPLICABLE LAW

This Plan shall be governed and construed in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Consistent with the terms of ERISA, federal law will preempt state law where applicable.

XI. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF ERISA RIGHTS

The HRA is subject to the claims and review procedures described under ERISA.

Claims and Appeals Procedures

This section describes a Covered Person's rights and obligations with respect to filing claims, receiving timely notice about whether and the extent to which benefits are payable, and the option to appeal a claim that has been denied in whole or in part.

Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to the Claim Administrator. As directed by the Plan Administrator, the Claim Administrator makes initial claim and initial appeal determinations based on the specific terms of the Plan. The Plan Administrator has authority to determine the amount of benefits that will be paid on any particular benefit claim, and has discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claims.

The steps involved in claims and appeals processing are outlined below. Important details about the required procedures and Covered Persons' rights are included in Sections A-F below.

1. All initial claims must be filed no later than 180 days following the close of the Plan Year in which qualifying expenses were incurred or 90 days after participation in the Plan ends, whichever happens first.

2. As directed by the Plan Administrator, the Claim Administrator will make an initial determination about benefits payable based on the specific terms of the Plan and will notify the Covered Person within the period specified for the type of claim filed (see *D. Initial Claim Determination*, and Chart A, below).

3. If the claim is denied in whole or in part, and the Covered Person disputes the determination, he or she may contact the Claim Administrator to confirm that the claim was properly processed. The Covered Person may also immediately file a formal internal appeal (see *F. Internal Appeals and External Review of Denied Claims,* below).

4. As directed by the Plan Administrator, the Claim Administrator will review the first internal appeal filed, and will make an appeal determination based on the specific terms of the Plan within the period specified for the type of claim that is the subject of the appeal (see *F. Internal Appeals and External Review of Denied Claims*, Chart B below).

5. If the first internal appeal is denied, the Covered Person may file a second internal appeal within the time periods specified in Chart B, below. The appeal will be reviewed by the Plan Administrator, who holds the authority to make the final determination about benefits payable under the Plan. The second appeal is the final internal appeal available under the Plan.

6. If the final internal appeal is denied in whole or in part and the denial is related to a rescission or is based on medical judgment, and the Covered Person disputes the determination, the Covered Person (or authorized representative) has the right to request an external review by an independent review organization (IRO) within the time periods specified in Chart B, below. The IRO will review the denial and issue a final decision within the period specified for the type of claim that is the subject of the review (see *F. Internal Appeals and External Review of Denied Claims*, Chart B below).

A. Who May File a Claim

A claim may be filed by a Covered Person, his or her authorized representative, or his or her health care service provider. To designate an "authorized representative," a Covered Person must submit a request in writing to the Claim Administrator. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the Covered Person through his or her authorized representative. The forms required to authorize a representative are available from the Claim Administrator.

For the purposes of this Article, "claimant" refers to the Covered Person to whom the claim relates or, as applicable, to the Covered Person's authorized representative.

B. Types of Claims

All claims under this Plan are post-service claims, i.e., they are claims for services that have already been provided.

C. When and How to File a Claim

A Covered Person must submit claims by the earlier of 180 days following the close of the calendar year in which the claim was incurred or 90 days after participation in the Plan ends. Claims received after that date will be denied. This time limit does not apply if the Covered Person is legally incapacitated.

Claims to the Grace Cottage Employee Group Medical Plan must be filed either by using the debit card issued upon commencement of participation or by using a written form available from the Claim Administrator. Written claims must be submitted to the Claim Administrator using one of the following methods:

- U.S. Mail
- Hand delivery
- Facsimile (FAX): (508) 329-4812
- Electronic transmission directly from the provider

Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581	**Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581 Attn: FSA/HRA Department

D. Initial Claim Determination

After a claim has been submitted to the Claim Administrator, the Plan is obligated to make a determination within the time limits specified. In some cases, the time limit may be extended if there are circumstances beyond the Claim Administrator's control that require a delay, or if the claim was submitted improperly or lacked information necessary to make a determination. In such cases, the claimant will be notified about the need for a delay or for additional information regarding the claim within a specified period of time.

CHART A – Time Limits Regarding Initial Claims			
Maximum period after receipt of claim for initial benefits determination	**Maximum extension of initial benefits determination for delays beyond the control of Claim Administrator**	**Maximum period to notify Claimant of improperly filed claim or missing information**	**Period for Claimant to provide missing information**
30 days	15 days	30 days	45 days maximum

E. How Claims are Paid

If a claim is approved, in whole or in part, and the debit card was used or the provider submitted the claim, payment is made directly to the provider. Otherwise payment will be made directly to the Covered Person.

F. Internal Appeals and External Review of Denied Claims

If a claim is denied in whole or in part, a claimant may file an internal appeal of the adverse benefit determination. An adverse benefit determination includes a "rescission" (retroactive termination) of an individual's coverage under the Plan due to fraud or intentional misrepresentation. Before filing an appeal, a claimant may first want to contact the Claim Administrator's FSA/HRA Department at (877) 734–7004 to verify that the claim was correctly processed under the terms of the Plan, but is not required to do so.

Initial internal appeals must be filed within 180 days of the initial claim denial; second internal appeals must be filed within 60 days of the initial appeal denial; requests for external review (available for rescissions and claim denials based on medical judgment) must be filed within 4 months of the second internal appeal denial. Any appeal or request for external review received after these deadlines will be denied. Chart B below shows details of the deadlines for filing appeals and making determinations upon review.

1. Appeals or requests for external review must be in writing and must be submitted to the Claim Administrator using one of the following methods:

    - U.S. Mail
    - Hand delivery
    - Facsimile (FAX): (508) 329-4812

Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581	**Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581

Appeals and requests for external review *must* include the following information:

(a) The patient's name.
(b) The patient's Plan identification number.
(c) Sufficient information to identify the claim or claims being appealed, such as the date of service, provider name, procedure (if known) and claim number (if available).
(d) A statement that the Covered Person (or authorized representative on behalf of the Covered Person) is filing an appeal or request for external review.

In making an appeal or request for external review, the Covered Person has the right to:

- Review pertinent documents and submit issues and comments in writing.
- Automatically receive any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim as soon as possible so as to provide the Covered Person with reasonable time to respond before the final internal determination is issued.
- Designate an authorized representative to act on the Covered Person's behalf for the purposes of the appeal or request for external review.
- Submit written comments, documents, records, or any other matter relevant to his or her appeal or request for external review, even if the material was not submitted with the initial claim.
- Have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal or request for external review, upon request and free of charge.

All appeals or requests for external review will be given a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the appeal or request for external review, regardless of whether such information was submitted or considered in the initial benefit determination. In addition, the review will not afford deference to the initial adverse benefit determination, and the review decision will be made by individuals who were not involved in the initial claim denial and who are not subordinates of those who made the initial determination. If the denial was based on a medical judgment, the appeal or request for external review will be reviewed by a health care professional retained by the Plan who did not participate in the initial denial.

If the initial appeal is denied, the claimant will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that an initial appeal is denied, the claimant will have 60 days to request a second appeal. In filing a second appeal, the claimant must follow the procedures specified under (a)-(d) above, and will have the same rights as specified for the initial appeal. The second appeal will be reviewed by the Plan Administrator who holds authority under the Plan to make factual findings and to interpret Plan provisions regarding the payment of benefits.

If the second appeal is denied, the claimant will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that a second appeal is denied, and the denial involved a rescission or was based in whole or in part on medical judgment, the claimant will have 4 months to request an external review. In filing a request for an external review, the claimant must follow the procedures specified under (a)-(d) above, and will have the same rights as specified for the initial and second appeal. The Plan will conduct a preliminary review of the request to determine if the claim is eligible for external review and will provide timely notification to the claimant, in accordance with the requirements of federal law, as to whether the claim is eligible and whether any additional information is needed if the request is incomplete. If the claim is eligible for external review, the Plan will assign the review to an IRO on a random basis, rotating assignments among IROs. The IRO will review the Plan's denial "de novo" and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO's determination will be binding on the Plan and the Covered Person, except to the extent that other remedies are available under state or federal law. If the IRO overturns the Plan's denial, the Plan will provide coverage or payment for the services regardless of whether the Plan intends to seek other remedies available under state or federal law.

For appeals of denials based on reasons other than rescissions or medical judgment, the second internal appeal is the final appeal available to the Covered Person and there is no further review available under the Plan. However, Covered Persons may have other remedies available under state or federal law, such as filing a lawsuit.

CHART B – Time Limits Regarding Initial and Second Internal Appeals and Request for External Review					
Maximum period for Claimant to file initial internal appeal after initial denial	**Maximum period for issuing determination regarding initial appeal**	**Maximum period for Claimant to file second internal appeal following denial of initial appeal in whole or in part**	**Maximum period for issuing determination regarding second appeal**	**Maximum period for Claimant to file request for external review following denial of final appeal***	**Maximum period for issuing determination regarding external review**
180 days	30 days	60 days	30 days	4 months	45 days

*available for rescissions and denials based on medical judgment

Statement of Rights

Participants in this Plan are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan Participants will be entitled to:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents governing the Plans including insurance contracts and collective bargaining agreements (if any) and a copy of the latest annual report (Form 5500 Series) filed, if applicable, by the Plan with the U.S. Department of Labor;

(2) 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), if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies;

(3) Receive a summary of the Plan's annual financial report if the Plan is required to distribute such a summary annual financial report;

(4) Continue health care coverage for himself or herself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a COBRA Qualifying Event. The individual or his or her dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing his or her COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate his or her plan – called "fiduciaries" of the Plan – have a duty to do so prudently and in the interest of the individual and other plan participants and beneficiaries. No one, including a participant's employer, union (if any), or any other person, may fire the individual or otherwise discriminate against the individual in any way to prevent the individual from obtaining benefits under the Plan or exercising his or her rights under ERISA.

If his or her claim for a benefit under this Plan is denied in whole or in part, the individual must receive a written explanation of the reason for the denial. The individual has the right to have the Plan review and reconsider his or her claim. Under ERISA, there are steps the individual can take to enforce the above rights. For instance, if the individual requests materials from the Plan and does not receive them within 30 days, the individual may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the individual up to $110 a day until the individual receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If the individual has a claim for benefits that is denied or ignored, in whole or in part, the individual may file suit in a state or federal court after exhausting the internal appeals and external review process described in this Article. There may be exceptions to the requirements that individuals exhaust the internal appeals process before seeking external review or pursuing legal remedies if the Plan does not adhere to the procedural standards for claims and appeals described under this Article in a manner which is compliant with the Patient Protection and Affordable Care Act. In addition, if the individual disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the individual may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if the individual is discriminated against for asserting his or her rights, the individual may seek assistance from the U.S. Department of Labor, or the individual may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful the court may order the person the individual has sued to pay these costs and fees. If the individual loses, the court may order the individual to pay these costs and fees, for example, if it finds his or her claim is frivolous.

If the individual has any questions about this Plan, the individual should contact the Plan Administrator. If the individual has any questions about this statement or about his or her rights under ERISA, the individual should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his or her telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

IN WITNESS WHEREOF, the Employer has caused this Grace Cottage Health Reimbursement Arrangement Plan Document to be executed by its duly authorized representative.

Grace Cottage

5/22/16
Date

By: _____
Authorized Signature

CHRISTOPHER LACHEY
Print Name

DIRECTOR OF HUMAN RESOURCES
Title