PLAN DOCUMENT

FOR THE

REFORMED BENEFITS ASSOCIATION HEALTH BENEFIT PLAN
FOR
CHRISTIAN REFORMED CHURCH IN NORTH AMERICA
EMPLOYEES

(Effective as of January 1, 2014)

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REFORMED BENEFITS ASSOCIATION
HEALTH BENEFIT PLAN
FOR
CHRISTIAN REFORMED CHURCH IN NORTH AMERICA EMPLOYEES

Article 1

Establishment of Plan

1.1 Effective Date

The Reformed Benefits Association (the "RBA") established the Reformed Benefits Association Health Benefit Plan for Christian Reformed Church in North America Employees (the "Plan") to provide health and welfare benefits for eligible Participants. The Christian Reformed Church in North America ("CRCNA") is a member of the RBA. The Plan is established effective as of January 1, 2014. Previously the individuals who will be eligible to participate in this Plan were participants in the Christian Reformed Church in North America Consolidated Group Insurance (CGI) Plan. That plan terminated as of the end of business on December 31, 2013.

1.2 Organization of the Plan

The Plan applies to many different groups of CRCNA Employees and Candidates and their eligible Dependents. These groups of Employees or Candidates and their eligible Dependents may be subject to different terms and conditions of the Plan. The provisions of the Plan which apply to a specified group of Employees or Candidates and their eligible Dependents are called a Sub-Plan.

Attached to the initial portion of the Plan, as Appendices, are the terms and conditions which apply to the different groups of Employees or Candidates and their eligible Dependents. A separate Appendix applies to each group of Employees or Candidates and their eligible Dependents. For each group of Employees or Candidates and their eligible Dependents, the Sub-Plan consists of the Plan document and the provisions in the applicable Appendix.

The RBA provides Retiree health benefits pursuant to a separate plan.

1.3 Intent of the Plan

It is intended that the health and accident benefits provided to Participants be eligible for exclusion from the Participants' income under Section 105 of the Code.

The self-insured health benefits under the Plan are subject to the nondiscrimination requirements of Section 105(h) of the Code. The self-insured health benefit portion of each Sub-Plan shall be considered a separate plan for purposes of these nondiscrimination requirements. However, to the extent Participants in the Sub-Plan are not eligible for the same self-insured health benefits or to the extent Participants are not subject to

the same eligibility rules or Participant contribution rates, those portions of the Sub-Plan shall be tested for nondiscrimination separately. Further, the Sub-Plans may be combined for nondiscrimination testing purposes under Section 105(h) of the Code to the extent Participants are eligible for the same self-insured health benefits and are subject to the same eligibility rules and Participant contribution rates.

This document along with the Your Benefit Guide/summary plan descriptions for the self-insured benefits under the Plan are collectively intended to serve as the Plan document for those self-insured benefits. This document along with the booklets and certificates for the fully-insured benefits under the Plan are collectively intended to serve as the Plan document for those fully-insured benefits.

1.4 Health Care Reform

The medical and prescription drug benefits under the Plan were amended to comply with the insurance market reforms of Health Care Reform. The required changes included the following:

(a) The definition of Dependent child was revised to allow eligible Dependent children to continue participation in medical and prescription drug benefits under the Plan until at least the child's 26th birthday. However, Employer extends coverage under the medical and prescription drug benefits through the end of the month in which the dependent child turns age 26. **NOTE**: The dental benefits under the Plan are "excepted benefits" not subject to Health Care Reform. However, Plan Sponsor voluntarily uses this same definition of Dependent child for purposes of the dental benefits.

(b) Lifetime limits on the dollar value of essential health benefits under the Plan no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan were eligible to enroll in the Plan.

(c) Annual limits on the dollar value of essential health benefits under the Plan are restricted.

(d) Coverage may not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation or failure to timely pay required premiums for coverage. Thirty days advance notice is required before coverage may be retroactively terminated.

(e) The Plan may not impose a pre-existing condition limitation or exclusion with respect to any Participant.

(f) This Plan is not a grandfathered plan under Health Care Reform. Accordingly, the following additional insurance market reforms under Health Care Reform apply:

(1) The Plan must provide certain preventive care items and services without required Participant cost-sharing.

(2) The Plan must provide certain patient protections such as:

(A) If any medical option under the Plan requires or allows a Participant to designate a primary care physician ("PCP"), Participants have the right to designate any PCP who participates in the network for the medical option in which the Participant is enrolled and who is available to accept the Participant or his or her family members. If the medical option in which the Participant is enrolled designates a PCP automatically, until this designation is made, the Plan will designate a PCP for the Participant. Further, for children, a pediatrician may be designated as the PCP.

(B) Participants do not need prior authorization from the Plan or from any person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the network for the medical option in which the Participant is enrolled who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

(C) The Plan may not require preauthorization for emergency services.

(D) The Plan may not impose a copayment amount or coinsurance rate for emergency services in an out-of-network emergency department of a Hospital that exceeds the requirements for in-network emergency services.

(E) The Plan's annual maximum out-of-pocket limits are capped.

(F) The Plan shall cover routine patient costs associated with clinical trials.

(3) Participant must be afforded additional rights with respect to internal appeals under the Plan and must be provided with the opportunity to undergo a new external review procedure (see Article 6).

Article 2

Definitions

The following terms have the meanings set forth below, wherever the terms appear in this document.

2.1 Appendix

"Appendix" means one of the Appendices attached to and incorporated into the Plan. A separate Appendix is provided for each group of Employees or Candidates and their eligible Dependents. The Basic Provisions and applicable Appendix establish the Sub-Plan for that group of Employees or Candidates and their eligible Dependents. Generally, there will be a new Appendix for each Sub-Plan for each Plan Year. However, if there is not a new Appendix for a Sub-Plan for a Plan Year it means that there will be no changes in the Appendix for the Sub-Plan for the subsequent Plan Year and the current Appendix shall continue to apply.

2.2 Benefit Review Committee

"Benefit Review Committee" means a committee established and appointed by the Plan Administrator to review voluntary level appeals of denied claims for self-insured benefits, as further described in Section 6.3.

2.3 Board of Trustees

"Board of Trustees" means the Board of Trustees of the RBA.

2.4 Cafeteria Plan

"Cafeteria Plan" means the Reformed Benefits Association Cafeteria Plan for Christian Reformed Church in North America Employees.

2.5 Candidate

"Candidate" means a person who has been declared a candidate for the CRC ministry and who resides in the United States.

2.6 Change in Status

"Change in Status" means a circumstance permitting a change in a participating Employee's benefit election during a Plan Year, as set forth in the Cafeteria Plan or another Section 125 plan in which an Employee participates.

2.7 Claim Administrator

"Claim Administrator" means the third party administrator(s), selected by the Plan Administrator to provide certain administrative services under the Plan as described in Section 9.3.

2.8 COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.9 Code

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

2.10 Covered Employment

"Covered Employment" means employment with Employer in an eligible job classification under the Plan. Covered Employment does not include employment as a temporary, on-call or seasonal employee.

2.11 CRCNA

"CRCNA" means the Christian Reformed Church in North America.

2.12 Creditable Coverage

"Creditable Coverage" means coverage of an individual under a group health plan, a group or individual health insurance policy, an HMO, Medicare, Medicaid, S-CHIP, a public health plan or any other health plan as set forth in HIPAA and the regulations issued pursuant to HIPAA.

2.13 Dependent

"Dependent" means:

(a) The Spouse of an Employee or Candidate; and

(b) A child who satisfies the following requirements:

(1) The child is the Employee's or Candidate's:

(A) Natural child;

(B) Legally adopted child or child placed with the Employee or Candidate for adoption (upon entry of a court order awarding custody), where the adoption or placement for adoption occurs before the child attains age 18;

(C) Step-child; or

(D) Ward, governed by a legal guardianship, provided the child lives with the Employee or Candidate at least 50% of the time and the child depends on the Employee or Candidate for Principal Financial Support; AND

(2) The child is:

(A) Younger than 26 years old;

(B) Age 26 or older, if Totally Disabled and where the Employee or Candidate provides the child's Principal Financial Support. Satisfactory proof of Total Disability must be provided to the Plan Administrator within 30 days of the date after coverage would terminate under paragraph (A). Further, continued satisfactory proof of Total Disability must be provided to the Plan Administrator on an ongoing basis.

Notwithstanding the above, a Dependent child shall also include a child for whom an Employee or Candidate is obligated to provide medical care under a "qualified medical child support order," as defined by applicable state and federal law. The Plan Administrator shall maintain procedures governing the determination as to whether a submitted order constitutes a qualified medical child support order. Participants may obtain, without charge, a copy of the procedures from the Plan Administrator.

2.14 Employee

"Employee" means a common law employee of the Employer. Independent contractors and leased employees and other individuals who are not treated as common law employees for tax purposes are not considered employees. If an independent contractor or leased employee is subsequently characterized as a common law employee, the person shall not be eligible to participate in the Plan for any time period before the date on which the person is determined to be a common law employee unless earlier participation if necessary to satisfy the nondiscrimination requirements of the Internal Revenue Code.

2.15 Employer

"Employer" means the Christian Reformed Church in North America (the CRCNA) or a CRC congregation.

2.16 FMLA

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

2.17 Gross Misconduct

"Gross Misconduct" means the termination of an Employee's employment for a violation of Employer's rules, policies or procedures.

2.18 Health Care Reform

"Health Care Reform" means the Patient Protection and Affordable Care Act, as amended.

2.19 HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.20 Open Enrollment Period

"Open Enrollment Period" means the period immediately prior to the beginning of a Plan Year for making benefit elections for the following Plan Year. The changes elected during the Open Enrollment Period will become effective as of the first day of the immediately following Plan Year. The Open Enrollment Period shall be determined by the Plan Administrator and communicated to Participants.

2.21 Participant

"Participant" means an Employee or Candidate who has met the eligibility and participation requirements of Article 3 and who is enrolled for coverage under the Plan. A Participant includes the Dependent of an eligible Employee or Candidate if coverage for the Dependent has been elected by the Employee or Candidate. A Participant also includes an individual who is no longer eligible to participate in the Plan but who is continuing participation under Article 3.

2.22 Plan

"Plan" means the Reformed Benefits Association Health Benefit Plan for Christian Reformed Church in North America Employees.

2.23 Plan Administrator

"Plan Administrator" means the named fiduciary responsible for the operation and administration of the Plan. The Reformed Benefits Association shall be the Plan Administrator.

2.24 Plan Sponsor

"Plan Sponsor" means the Reformed Benefits Association.

2.25 Plan Year

"Plan Year" means the 12-consecutive-month period beginning on January 1 and ending on the following December 31.

2.26 Principal Financial Support

"Principal Financial Support" means that the child must have been reported as a dependent on the Participant's most recent income tax return or must qualify to be taken as a dependent for the current tax year.

2.27 Qualified Military Service

"Qualified Military Service" means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority. Qualified Military Service includes:

(a) Active duty.

(b) Active and inactive duty training.

(c) Full-time National Guard duty under a federal statute.

(d) A period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

(e) A period for which a person is absent to perform funeral honors duty as authorized under 10 U.S.C. §12503 or 32 U.S.C. §115.

(f) Service as an intermittent disaster response appointee upon activation of the National Disaster Medical System or as a participant in an authorized training program under the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

2.28 RBA or Reformed Benefits Association

"RBA" or "Reformed Benefits Association" means the Reformed Benefits Association.

2.29 Retiree

"Retiree" means an Employee who is residing in the United States, who was enrolled in the Plan for at least six months prior to retirement and who retires as follows:

(a) For CRC Ministers, the person is declared retired by his or her Classis; and

(b) For Employees who are not CRC ministers, the Employee terminates employment after attaining age 55 and completing ten Years of Service. However, the age 55 and ten Years of Service requirements shall be waived for Employees who terminate employment due to a Total Disability.

2.30 Special Enrollment Period

"Special Enrollment Period" means the period for an individual with special enrollment rights to elect to enroll in health benefits under the Plan. The circumstances under which an individual has special enrollment rights are described in Article 3 and are prescribed by HIPAA and the regulations issued pursuant to HIPAA.

2.31 Spouse

"Spouse" means a person who is the legal spouse of the Employee or Candidate and who has met all of the requirements of a valid marriage contract in the state in which the marriage of the parties occurs. For purposes of the Plan, "spouse" does not include:

(a) A spouse who is the same sex as the Employee or Candidate;

(b) A common-law spouse;

(c) A spouse who is legally separated from the Employee or Candidate (i.e., in the case of a couple living in Michigan, has had an order or judgment of separate maintenance entered with the court); or

(d) A spouse who is divorced from the Employee or Candidate.

2.32 Sub-Plan

"Sub-Plan" means the terms and conditions of the Plan which apply to a specified group of Employees or Candidates and their eligible Dependents. For any group of Employees or Candidates and their eligible Dependents, the Sub-Plan consists of the Plan document and the provisions of the Appendix which applies to the group of Employees or Candidates and their eligible Dependents.

2.33 Total Disability or Totally Disabled

"Total Disability" or "Totally Disabled" means:

(a) In the case of an Employee, an Illness or Injury which prevents an Employee from performing the material and substantial duties of his or her regular job and the duties of any other job with Employer for which the Employee is suited based on the Employee's education, training and experience.

(b) In the case of a Dependent, an Illness or Injury which prevents a Dependent from engaging in substantially all of the normal educational, physical, recreational or occupational activities of a person of the same age and sex who is in good health.

2.34 Uniformed Service

"Uniformed Service" means the U.S. Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty under federal authority, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or national emergency.

2.35 Year of Service

"Year of Service" means a 12-month period of full-time and certain part-time employment with Employer. An Employee will be credited with Years of Service based on the time between the Employee's date of hire and date of retirement, subject to the following:

(a) Periods of part-time employment will only be included in an Employee's Years of Service where the Employee was regularly working at least 20 hours per week. Periods of part-time employment at less than 20 hours per week will be disregarded.

(b) If an Employee terminates employment and is rehired, the two periods of employment shall be aggregated in calculating the Employee's Years of Service unless there is a gap between the two periods of employment of more than 12 months.

Article 3

Eligibility and Participation

3.1 Generally

There are three types of benefits under the Plan: self-insured health benefits, fully-insured health, welfare and other benefits. These three types of benefits are further described in Article 5.

The eligibility and participation rules set forth in this Article primarily apply to the first type of benefit under the Plan, the self-insured health benefits. Eligibility and participation rules for the fully-insured welfare benefits are set forth in each separate benefit's insurance policy. However, the policy may cross-reference to the eligibility and participation rules in this Plan. The eligibility and participation rules for the other benefits are set forth in the separate documents for those benefits. Again, however, the separate documentation may cross-reference to the eligibility and participation rules in this Plan.

The eligibility and participation rules set forth in this Article shall apply to the self-insured health benefits for all Sub-Plans except as otherwise set forth in the Appendix for a Sub-Plan.

3.2 Eligible Employees and Candidates

(a) Employees Each full-time and part-time Employee of Employer shall be eligible to participate in the self-insured health benefits under the Plan on his or her entry date. "Full-time" means the Employee is regularly scheduled to work at least 30 hours per week and "part-time" means the Employee is regularly scheduled to work at least 20 but less than 30 hours per week. The eligible Employee's entry date is the first day of the month on or after the Employee's first day of employment if the following requirements are satisfied:

(1) The full-time or part-time Employee is employed in Covered Employment; and

(2) The full-time or part-time Employee is employed in an eligible job classification. The eligible job classifications are:

(A) Ordained or licensed ministers employed by a CRC congregation in the United States;

(B) Employees of a CRC congregation in the United States (subject to Section 3.4);

(C) Ordained and unordained Employees in the United States or overseas of CRCNA agencies participating in the Plan; or

(D) Ordained Employees serving in CRCNA-approved positions, including a position in a classis.

If an Employee moves from less than part-time status to a part-time or full-time position, the Employee shall become eligible to participate in the Plan on the first day of the following month.

If an Employee participating in the CRCNA Canadian group health plan transfers to a new job and becomes eligible for this Plan, participation may begin immediately as of the day of transfer provided that a completed enrollment form is submitted within 90 days of the date of initial eligibility (see Section 3.5).

(b) Candidates Each Candidate is eligible for self-insured health benefits (except dental) for up to one year from the first day of a calendar month following the date the person is approved as a Candidate by Synod or until the Candidate becomes eligible as an Employee of a participating Employer, whichever comes first. However, a Candidate shall not be eligible to participate in this Plan as a Candidate if the Candidate is eligible to receive medical benefits under any other group health plan.

Eligible Employees and Candidates who were enrolled in the Christian Reformed Church in North America Consolidated Group Insurance (CGI) Plan as of the end of business on December 31, 2013 shall be immediately eligible to participate in this Plan on January 1, 2014.

3.3 Eligible Dependents

(a) Dependents The Dependents of each eligible Employee and Candidate shall be eligible to participate in the self-insured health benefits under the Plan. Eligible Dependents who were enrolled in the Christian Reformed Church in North America Consolidated Group Insurance (CGI) Plan as of the end of business on December 31, 2013 shall be immediately eligible to participate in this Plan for January 1, 2014.

(b) Qualified Medical Child Support Orders If an Employee or Candidate is required to provide medical care to a child pursuant to a qualified medical child support order, the following rules apply:

(1) The Plan Administrator shall permit the child to be enrolled in the Plan without regard to any enrollment season restrictions.

(2) If the parent is enrolled in the Plan but fails to make application to obtain coverage for the child, the Plan Administrator shall enroll the child upon application by the Friend of the Court or by the child's other parent through the Friend of the Court.

(3) In accordance with the requirements of applicable law, the Plan Administrator shall not eliminate the child's coverage unless required contributions have not been paid by the Employee or Candidate as required by the

Plan or the Plan Administrator is provided satisfactory written evidence that either the order is no longer in effect or that the child is or shall be enrolled in comparable health coverage through another health plan that shall take effect not later than the effective date of the termination of the child's Plan coverage.

(4) The Plan shall provide whatever information is needed to the custodial parent in order for the child to obtain benefits.

(5) The Plan shall permit the custodial parent to submit claims on behalf of the child without the approval of the Employee or Candidate.

(6) The Plan may make benefit payments to the custodial parent or the state administrative agency initiating the qualified medical child support order, in addition to any other parties to which payment may be made as provided under the Plan.

(c) Ineligible Dependents The following Dependents are not eligible to participate in the Plan:

(1) A grandchild, parent, grandparent or other blood relative (other than a child), except as otherwise provided in Section 2.13.

(2) A foster child or a child over whom the Employee or Candidate has a power of attorney.

(3) A spouse or child who is a Participant in the Plan as an Employee or Candidate (or as a Retiree under the RBA plan for Retirees). A person may not be covered under the Plan both as a Dependent and as an Employee, Candidate or Retiree.

(4) If both husband and wife are eligible Employees or Candidates under the Plan (or are Retirees under the RBA plan for Retirees), their children may be covered as Dependents of either parent, but not both.

(d) Obligation to Notify If at any time a Dependent ceases to be eligible for Plan coverage, the Employee or Candidate must notify the Plan Administrator in writing within 30 days of the date of the ineligibility. If the 30-day period has past, the Employee or Candidate shall still be obligated to notify the Plan Administrator of any changes that have caused an enrolled Dependent to lose eligibility. Any claims paid for the Dependent after the date of ineligibility shall be the responsibility of the Employee or Candidate and not the Plan.

3.4 Special Eligibility Rules

The rules set forth in this Section apply notwithstanding any other provision in the Plan. The special eligibility rules are as follows:

(a) If a pastor serves a local CRC or RCA congregation on an interim (non-permanent tenure) basis, the pastor may participate in the Plan on an individual basis and will not be considered part of any group coverage purchased by the CRC or RCA congregation. Such a pastor will have the same health benefit options as a church Employee.

(b) Employees of a CRC congregation are eligible to participate in the Plan only if all eligible Employees of that CRC congregation are enrolled as Participants. However, an Employee in a CRC congregation or other group is not required to participate if the Employee has documented alternative coverage (such as through a spouse's employer's group health plan, Indian health insurance, Medicaid, Medicare or any other public health plan).

(c) If a CRC congregation opts out of participation in the Plan on behalf of its eligible Employees, the CRC congregation will be subject to a waiting period of not less than five years before being allowed to reenroll its Employees in the Plan without a penalty. If reentry occurs before the end of the five-year waiting period, the CRC congregation will be subject to a 20% premium surcharge for the remaining time in the five-year waiting period.

(d) When a CRC congregation whose Employees do not participate in the Plan receives acceptance of a call from a minister enrolled in the Plan and agrees to purchase group coverage for its eligible Employees, the five-year waiting period and the 20% premium surcharge will be waived.

3.5 Enrollment – Employees and Candidates

(a) **General Rule** An eligible Employee or Candidate will become a Participant in the Plan on the first day of the month on or after the date he or she becomes eligible and the date a completed enrollment form is submitted to the Plan Administrator. The enrollment process referred to in this Section and elsewhere in the Plan may occur in written and/or electronic form in accordance with procedures established by the Plan Administrator.

A completed enrollment form must be submitted to the Plan Administrator within 30 days of the date the Employee or Candidate becomes eligible to participate in the Plan. If a completed enrollment form is not submitted within 30 days, subsequent enrollment may only occur during a Special Enrollment Period (see Section 3.7) or an Open Enrollment Period (see Section 3.8). If an Employee loses eligibility (e.g., due to termination of employment) and subsequently becomes eligible (e.g., due to being rehired or hired in a new position), each subsequent period of eligibility will be treated as an initial period of eligibility for purposes of this Section. However, if such an individual continuously participated in the Plan during the period of ineligibility (e.g., through COBRA continuation coverage), the individual may immediately resume participation upon the date of subsequent eligibility.

(b) Effect of Medicaid An eligible Employee or Candidate may participate in the Plan regardless of whether the individual is covered by Medicaid.

(c) Self-Insured Health Benefits

(1) Employees Eligible Employees may elect self-insured health benefits (medical and dental) in accordance with the applicable Appendix for their Sub-Plan.

Employees may elect self-insured health benefits when initially eligible and during a Special Enrollment Period. Further an annual Open Enrollment Period may be offered under certain Sub-Plans where there are multiple medical benefit options.

(2) Candidates Eligible Candidates may elect a self-insured medical benefit in accordance with the applicable Appendix for their Sub-Plan. Dental benefits are not available.

Candidates may elect the self-insured medical/benefit when initially eligible and during a Special Enrollment Period.

3.6 Enrollment - Dependents

An eligible Dependent may initially become a Participant in the Plan on the later of the following dates:

(a) The date the Employee or Candidate becomes a Participant in the Plan, provided the Dependent is included in the completed enrollment form; or

(b) The later of the date on which the individual becomes an eligible Dependent of the Employee or Candidate (e.g., by marriage, birth or adoption) and the date a completed enrollment form is submitted to the Plan Administrator regarding the new Dependent's participation.

An eligible Dependent may participate in the Plan regardless of whether the individual is covered by Medicaid.

3.7 Special Enrollment Period

Notwithstanding any other provision of the Plan, an Employee or Candidate or a Dependent of an Employee or Candidate has special enrollment rights to enroll in health benefits during a Special Enrollment Period in accordance with HIPAA in the following circumstances:

(a) Where the individual declined coverage when initially eligible or during a subsequent open enrollment period because the individual had coverage under another group health plan or health insurance coverage and the other coverage is lost as follows:

(1) Where the other coverage is COBRA continuation coverage and it has been exhausted;

(2) Where the other coverage is lost due to the individual's ineligibility (i.e., as a result of a Change in Status);

(3) Where the other coverage is lost because employer contributions for the coverage have been terminated;

(4) Where the other coverage was an HMO and the individual no longer lives or works in the service area of the HMO (whether or not within the choice of the individual);

(5) Where coverage is lost because the plan no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees);

(6) Where a benefit package option is terminated unless the individual is provided a current right to enroll in alternative health coverage; or

(7) Where coverage is lost due to the application of a plan's lifetime limit on all benefits.

An individual who voluntarily terminates other coverage or who lost other coverage due to the nonpayment of the required contribution or for cause (e.g., for filing fraudulent claims) shall not have special enrollment rights.

(b) Where the Employee or Candidate has a new Dependent by marriage, birth, adoption or placement for adoption. In this situation, special enrollment rights are available to the Employee or Candidate, the Spouse and any child who becomes a Dependent due to the marriage, birth, adoption, or placement for adoption.

(c) Where an individual's Medicaid or State Children's Health Insurance Program ("CHIP") coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP.

Enrollment must be requested for an individual with special enrollment rights during a Special Enrollment Period, which is during the first 30 days after the loss of other coverage or marriage, birth, adoption or placement for adoption (whichever is applicable). In the case of an individual who loses other coverage due to the application of a plan's lifetime limit on all benefits, this Special Enrollment Period continues until 30 days after the earliest that a claim is denied due to the operation of the lifetime limit. In the case of an individual whose Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or an individual who becomes eligible for a premium assistance subsidy under Medicaid or CHIP, the Special Enrollment Period continues until 60 days after the gain or loss of eligibility. Enrollment shall be effective on the first day of the month after the completed request for enrollment is received except in the case of an application due to birth, adoption, or placement for adoption, in which such case

enrollment is effective as of the date of the birth, adoption, or placement for adoption (for all eligible individuals enrolling as a result of the new Dependent).

3.8 Open Enrollment Period

If an Employee or Dependent of an Employee does not enroll when initially eligible or during a Special Enrollment Period, the individual may enroll during an annual Open Enrollment Period to become effective as of the first day of the following Plan Year (provided the applicable Sub-Plan offers an annual Open Enrollment Period). Individuals already enrolled in the Plan will be allowed to switch coverage options in accordance with the offerings made available under the Sub-Plan in which they participate.

3.9 Termination of Coverage

(a) Employees Each self-insured health benefit under the Plan (medical, dental) shall cease for an Employee on the earliest of the following dates:

(1) Except as otherwise provided in this subsection, the last day of the month during which the Employee ceases to be eligible for a benefit or the Plan, as determined by Section 3.2.

(2) The last day of the month during which the Employee terminates employment or retires, unless coverage continues under the RBA plan for Retirees.

(3) If the Employee is a minister and forfeits his or her ordained status, the last day of the month during which the ordained status is forfeited.

(4) The date of discontinuance of the Plan as a whole or discontinuance of that particular coverage.

(5) The effective date of the Employee's voluntary withdrawal from a benefit or the Plan. In the case of an Employee who pays any required contribution for coverage under the Cafeteria Plan, voluntary withdrawal may only occur in the event of a Change in Status or during an Open Enrollment Period.

(6) The first day of the period for which any required contribution for the Employee's coverage is not timely paid.

(7) The date as of which the Employee's participation is terminated for cause by the Plan Administrator. A termination for cause means that the Employee is found to misrepresent information in an application for participation or on a claim for benefits. It also includes failure to timely reimburse the Plan for ineligible amounts paid on the Employee's behalf as the result of error.

(8) The date the Employee dies. However, in case of an Employee who was a minister, the Employee's Dependents may continue to participate upon paying the required contributions. The surviving Dependents may make coverage election changes in the same manner as an Employee.

(b) Candidates The self-insured medical benefit under the Plan shall cease for a Candidate on the earliest of the following dates:

(1) The date as of which the Candidate becomes an Employee of a participating Employer.

(2) The first day of the 13th month after the person is approved by Synod as a Candidate.

(3) The date of discontinuance of the Plan as a whole or discontinuance of that particular coverage.

(4) The effective date of the Candidate's voluntary withdrawal from a benefit or the Plan.

(5) The first day of the period for which any required contribution for the Candidate's coverage is not timely paid.

(6) The date as of which the Candidate's coverage is terminated for cause by the Plan Administrator. A termination for cause includes a termination for fraud or misrepresentation in an application for participation or in a claim for benefits. It also includes failure to timely reimburse the Plan for ineligible amounts paid on the Candidate's behalf as a result of error.

(7) The date the Candidate dies.

(c) Dependents Each self-insured health benefit under the Plan shall cease for a Dependent of a participating Employee or Candidate on the earliest of the following dates:

(1) The date on which that particular coverage terminates for the Employee or Candidate with respect to whom the Dependent coverage is provided. In the event of the death of the active Employee who was a minister, survivor coverage shall be provided.

(2) The last day of the month during which the Dependent ceases to come within the Plan's definition of Dependent.

(3) With respect to a Dependent of an active Employee, the last day of the month during which the Employee terminates employment or retires, unless in the application to continue coverage after retirement, the Employee also elects to continue coverage for the Dependent.

(4) The date of discontinuance of the Plan as a whole or discontinuance of that particular coverage.

(5) The effective date of the Dependent's voluntary withdrawal from a benefit or the Plan. However, in the case of a Dependent of an Employee where the Employee pays any required contribution for Dependent coverage under the Cafeteria Plan, voluntary withdrawal may only occur in the event of a Change in Status or during an Open Enrollment Period.

(6) The first day of the period for which any required contribution for the Dependent's coverage is not timely paid.

(7) The date as of which the Dependent's participation is terminated for cause by the Plan Administrator. A termination for cause means that an adult Dependent is found to misrepresent information on a claim for benefits. It also includes failure to timely reimburse the Plan for ineligible amounts paid on the Dependent's behalf as a result of error.

3.10 FMLA Extension of Coverage

Notwithstanding Section 3.9, an Employee who is eligible under FMLA and who goes on a family or medical leave, as defined by FMLA, may continue the same level of benefits under the Plan for the Employee and his or her Dependents as if the Employee had continued in active employment continuously for the duration of the leave. Coverage shall be available under this Section until the earlier of the last day of the leave or 90 days (or the maximum period provided under FMLA, if longer).

The Employee must pay any required contributions in accordance with Employer's FMLA policy. If the Employee fails to timely pay any required contributions, the Employee's participation in the Plan may be suspended after receiving 15 days advance written notice in accordance with FMLA, subject to the right of immediate reinstatement of participation upon return to work from the FMLA leave.

If an Employee takes an FMLA leave and does not return to active employment with Employer at the end of the FMLA leave, the Employee shall experience a Qualifying Event for purposes of Section 3.11 on the last day of the FMLA leave.

If the Participant fails to return to work from the FMLA leave for any reason other than the continuation, recurrence, or onset of a "serious health condition" as defined by FMLA or another circumstance considered by the Plan Administrator as beyond the control of the Employee, Employer may recover any Employer contribution paid to maintain coverage for the Participant during the leave.

Other provisions regarding an FMLA leave are set forth in FMLA, the accompanying regulations and Employer's FMLA policy.

This Section also applies where Employer is not subject to FMLA but voluntarily elects to comply.

3.11 Continuation Coverage

Participants in the Plan may extend their health benefits in certain circumstances where coverage under the Plan would otherwise terminate in accordance with the continuation coverage provisions of COBRA, as described in this Section. Employer is not subject to COBRA but voluntarily elects to comply.

The Plan Administrator may delegate some of its responsibilities with respect to COBRA continuation coverage to a third party COBRA administrator, as further indicated in the Summary Plan Description and in the COBRA notice to Participants.

(a) Eligibility for Continuation Coverage The Employee and/or the Dependents of the Employee who are eligible to purchase continuation coverage are "Qualified Beneficiaries." If a child is born to or adopted by or placed for adoption with an Employee during a period of COBRA continuation coverage, the newborn or newly-adopted child is also a Qualified Beneficiary. However, the newborn or newly-adopted child's maximum continuation period is measured from the date of the initial Qualifying Event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle an Employee and/or the Dependents (as Qualified Beneficiaries) to continuation coverage are "Qualifying Events." A Qualifying Event occurs when health coverage under the Plan is lost, even if Employer pays the cost of continuation coverage for a period of time.

The Qualifying Events, the Qualified Beneficiaries, and the maximum initial continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours[1] or termination of employment[2]	Employee & Dependents	18 (24 months if ordained minister without call)
Employee's death	Dependents	36
Employee's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36

[1] A reduction in hours due to a family or medical leave, as defined by the Family and Medical Leave Act of 1993 ("FMLA"), does not cause an Employee's participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave is not a Qualifying Event. However, if the Employee does not return to work at the end of the FMLA leave, a Qualifying Event will occur as of the last day of the FMLA leave.

[2] Continuation coverage is not available if employment is terminated for gross misconduct.

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Employee's divorce/legal separation[3]	Dependents	36

(b) Extensions of Continuation Coverage If the Employee and/or the Employee's Dependents become entitled to continuation coverage as a result of the Employee's reduction in hours or termination of employment, the initial 18-month continuation period may be extended for the Employee and/or the Employee's Dependents in the following three circumstances ("Extension Events"):

(1) Second Qualifying Event If a second Qualifying Event that is a divorce, legal separation, the Employee's death, or a Dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or during the additional 11-month period in the event of disability, as described below), the Qualified Beneficiaries who are the Employee's Dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of the Employee's reduction in hours or termination of employment. Notice of this second Qualifying Event must be provided to the Plan Administrator within 60 days after the date of the second Qualifying Event. If notice is not timely provided, an extension of the continuation period will not be available.

(2) Medicare Entitlement If the Employee becomes entitled to Medicare benefits before the expiration of the initial 18-month period, the Qualified Beneficiaries who are the Employee's Dependents may be eligible to elect continuation coverage for a maximum period of 36 months, beginning on the date of the Employee's reduction in hours or termination of employment, if ignoring the original Qualifying Event, the Participant's entitlement to Medicare would have been a Qualifying Event under the Plan. Notice of the Employee's entitlement to Medicare in this situation must be provided to the third party COBRA administrator within 60 days after the date of Medicare entitlement. If notice is not timely provided, an extension of the continuation period will not be available.

A special rule applies if the Employee becomes entitled to Medicare before his or her reduction in hours or termination of employment. In that situation, the maximum continuation period for the Qualified Beneficiaries who are the Employee's Dependents ends on the later of 36 months after the date of the Employee's Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of the Employee's reduction in hours or

[3] Elimination of a dependent's health coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example) is not a Qualifying Event. But the subsequent divorce or legal separation may be a Qualifying Event if it can be proven that coverage was dropped in anticipation of the divorce or legal separation. Continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the date of the divorce or legal separation. Legal separation means an order of separate maintenance entered by a court. A couple who separates and files for divorce has not experienced a legal separation.

termination of employment. Notice of the Employee's entitlement to Medicare in this situation must be provided to the third party COBRA administrator within 60 days of the date of the reduction in hours or termination of employment. If notice is not timely provided, an extension of the continuation period will not be available.

(3) Disability If a Qualified Beneficiary is determined to be entitled to Social Security disability benefits either before the Employee's reduction in hours or termination of employment or within 60 days after the Employee's reduction in hours or termination of employment, the disabled Qualified Beneficiary and the Qualified Beneficiaries who are his or her family members will be entitled to purchase an additional 11 months of continuation coverage (29 months total). Notice of the Social Security disability determination must be provided to the Plan Administrator within 60 days of the date of the disability determination (or within 60 days of the Employee's reduction in hours or termination of employment, if later) and before the end of the 18-month continuation period. If notice is not timely provided, an extension of the continuation period will not be available.

If there is a final determination that the disabled Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan Administrator within 30 days of the final determination. In this event, continuation coverage for the additional 11-month period for the disabled Qualified Beneficiary and the Qualified Beneficiaries who are his or her family members will terminate as of the first day of the month beginning more than 30 days after the date of the final determination, or on the date continuation coverage would otherwise terminate, if earlier.

(c) Plan Administrator's Notice Obligations The Plan Administrator will offer Qualified Beneficiaries the opportunity to elect continuation coverage only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the Employee's divorce, a legal separation or a Dependent child's loss of Dependent status under the Plan, the Qualified Beneficiary has the obligation to notify the Plan Administrator of the Qualifying Event, as described in subsection (d).

(d) Qualified Beneficiary's Notice Obligations In some situations, the Employee and/or the Employee's Dependents have the obligation to provide notice of a Qualifying Event or Extension Event to the Plan Administrator in order to trigger their eligibility for continuation coverage or an extension of continuation coverage. An "Extension Event" is an event which permits an extension of the initial 18-month continuation period. The Extension Events are described in subsection (b).

The Employee and/or the Employee's Dependents have the obligation to provide notice of a Qualifying Event or Extension Event in the following situations:

(1) **Notice of Certain Initial Qualifying Events** The Employee, one of the Employee's Dependents, or an individual acting on behalf of the Employee and/or the Employee's Dependents must inform the Plan Administrator of a Qualifying Event that is a divorce or legal separation or of a child losing Dependent status under the Plan, within 60 days after the later of:

(A) The date of the Qualifying Event; or

(B) The date the Qualified Beneficiary loses health coverage under the Plan on account of that Qualifying Event.

(2) **Notice of an Extension Event** In order to qualify for an extension of the continuation coverage period due to an Extension Event described in subsection (b), the Employee, one of the Employee's Dependents, or an individual acting on behalf of the Employee and/or the Employee's Dependents must notify the Plan Administrator of the Extension Event within the time limit that applies to that Extension Event, as described in subsection (b).

These notices must be provided in accordance with the requirements of subsection (e). If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, the notice will be defective, and continuation coverage or an extension of the continuation period may not be available as a result of the Qualifying Event or Extension Event.

The Plan Administrator will provide a "notice of the unavailability of continuation coverage" where the Plan Administrator determines that continuation coverage or an extension of continuation coverage is not available after receiving notice of a potential initial Qualifying Event that is a divorce, legal separation, or a Dependent child's loss of Dependent status under the Plan or of a potential Extension Event. The determination that continuation coverage or an extension of continuation coverage is not available could be made because the Plan Administrator determines that no Qualifying Event or Extension Event occurred, or because the notice of the Qualifying Event or Extension Event was defective.

The Plan Administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the Plan Administrator receives the notice of the potential Qualifying Event or Extension Event, or if later, the deadline for submission of additional information requested by the Plan Administrator. The notice of unavailability of continuation coverage will be sent to the individual who submitted the notice of the Qualifying Event or Extension Event, and to all individuals for whom continuation coverage or an extension of continuation coverage could have been available as a result of the potential Qualifying Event or Extension Event.

(e) **Notice Procedures** This section describes the procedures a Qualified Beneficiary must follow to notify the Plan Administrator of Qualifying Events and Extension Events (which are described in subsection (b)).

The Plan Administrator may have a form which can be used to provide the required notice. Any such form can be obtained by contacting the Plan Administrator. While use of the notice form, if available, will help ensure that the Qualified Beneficiary provides all of the required information, use of the notice form is not required. Written notification that contains all of the following information will also be accepted:

(1) The name and Social Security number of the Employee or former Employee.

(2) The name of the individual(s) for whom continuation coverage is being requested (i.e., the Qualified Beneficiary(ies)).

(3) The current address(es) of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.

(4) The date of the Qualifying Event or Extension Event.

(5) The nature of the Qualifying Event or Extension Event (for example, a divorce).

(6) If the notice relates to a divorce, a copy of the judgment of divorce.

(7) If the notice relates to a legal separation, a copy of the judgment of separate maintenance or other relevant court documents establishing the legal separation.

(8) If the notice relates to the Employee's entitlement to Medicare, a copy of the document(s) establishing the entitlement.

(9) If the notice relates to a determination that a Qualified Beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.

(10) If the notice relates to a determination that a Qualified Beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline, is not made in writing and/or does not contain all of the required information is defective and may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage may not be available with respect to the potential Qualifying Event or Extension Event described in this Section.

If the Plan Administrator receives notice of a Qualifying Event or Extension Event that is defective because it is not in writing or does not contain all of the required information, the Plan Administrator will request the missing information. The Plan Administrator will send the request to the individual who submitted the notice and each individual who is a Qualified Beneficiary or a potential Qualified Beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the Plan Administrator requests the additional information, the notice may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to the potential Qualifying Event or Extension Event described in the notice.

The Plan Administrator may also request additional information or documentation that the Plan Administrator deems necessary to determine whether a Qualifying Event or Extension Event has occurred. If the Plan Administrator does not receive the requested information or documentation within 30 days of the date the Plan Administrator requests the information or documentation, continuation coverage or an extension of continuation coverage may not be available.

(f) Qualified Beneficiary's Election of Continuation Coverage If a Qualified Beneficiary chooses to purchase continuation coverage, the Qualified Beneficiary must notify the Plan Administrator within 60 days after the later of the date the Qualified Beneficiary loses health coverage on account of the Qualifying Event, or the date on which the Qualified Beneficiary is sent notice of his or her eligibility for continuation coverage. If the Qualified Beneficiary does not elect continuation coverage during the 60-day period, his or her participation in the Plan shall end as provided in subsection (i).

(g) Coverage If a Qualifying Event occurs, the Qualified Beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the Qualified Beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the Qualifying Event. Each Qualified Beneficiary has the right to make an independent election to receive continuation coverage.

Qualified Beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated Participants, the same modifications shall apply to the Qualified Beneficiary and his or her Dependents. Qualified Beneficiaries who purchase continuation coverage shall have the opportunity to elect different types of coverage during any Annual Open Enrollment Period just as active Employees.

(h) Cost of Coverage Generally, the Qualified Beneficiary must pay the total cost of continuation coverage. This cost will be up to 100% of the cost of identical coverage for similarly-situated participants.

The initial premium must be paid within 45 days after the Qualified Beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium shall be due within the first 45 days after the Qualified Beneficiary initially elects continuation coverage.

(i) **Termination** Generally, continuation coverage shall terminate at the end of the applicable continuation period described in subsection (a) or at the end of the period for an Extension Event described in subsection (b). However, continuation coverage shall terminate sooner upon the occurrence of any of the following events:

(1) Employer no longer offers group health coverage for its Employees;

(2) The Qualified Beneficiary fails to timely pay for the continuation coverage;

(3) The date on which the Qualified Beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision does not apply during any time period the other group health plan contains any exclusion or limitation with regard to any pre-existing condition, other than an exclusion or limitation which does not apply to the Qualified Beneficiary or is satisfied by the Qualified Beneficiary due to HIPAA **(Note:** Group health plans may not impose a pre-existing condition exclusion or limitation with respect to any Participant beginning in 2014.);

(4) The date on which the Qualified Beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare benefits (Part A or Part B); or

(5) The date on which a Qualified Beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated nonQualified Beneficiaries (see Section 3.9).

(j) **Other Coverage Options** There may be other coverage options for Qualified Beneficiaries. When key parts of Health Care Reform take effect as of January 1, 2014, Qualified Beneficiaries will be able to buy coverage through the Health Insurance Marketplace (also known as the exchange). In the Marketplace, Qualified Beneficiaries could be eligible for a new kind of tax credit that lowers the individual's monthly premiums right away, and Qualified Beneficiaries can see what their premiums, deductibles and out-of-pocket costs will be before making a decision to enroll. Being eligible for COBRA does not limit eligibility for coverage for a tax credit through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov. Additionally, Qualified Beneficiaries may qualify for a special enrollment opportunity for another group health plan for which the individual is eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if enrollment is requested within 30 days.

(k) **Questions** Employees and/or their Dependents should contact the Plan Administrator if they have questions regarding COBRA.

(l) **Keep Plan Administrator Informed of Address Changes** To protect their rights under COBRA, it is important that the Employee and his or her Dependents keep the Plan Administrator informed of any changes in address. They should also keep a copy, for their records, of any notices they send to the Plan Administrator.

3.12 Continuation of Health Coverage upon Military Leave

If an Employee ceases to be eligible for health coverage under the Plan due to Qualified Military Service, the Plan shall offer the Employee and his or her eligible Dependents the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). Any extension of coverage under this Section shall run concurrently with any extension of coverage under Section 3.11 (COBRA rules).

(a) The Employee may elect to continue health coverage under the Plan for the Employee and his or her eligible Dependents for the period that is the **lesser** of:

(1) 24 months beginning with the first day the Employee is absent from work for Qualified Military Service; or

(2) The period beginning on the first day the Employee is absent from work for Qualified Military Service and ending with the date the Employee fails to return to employment or apply for reemployment as provided under U.S. Department of Labor regulation 20 C.F.R. §§1002.115-123.

(b) If the Employee gives Employer advance notice of his or her Qualified Military Service for a period that will be 30 days or less, the Plan Administrator shall treat the notice as an election to continue health coverage pursuant to this Section unless the Employee specifically notifies Employer, in writing, that the Employee wants to cancel his health coverage during his or her Qualified Military Service. The Employee must pay the required premium for his or her health coverage pursuant to Section 3.12(e) and (f), but the Employee shall not be required to complete an election form to continue his or her health coverage during the Qualified Military Service.

(c) If the Employee gives Employer advance notice of his or her Qualified Military Service and that service is expected to be 31 days or longer, the Plan Administrator shall provide the Employee with a notice of the right to elect to continue health coverage pursuant to this Section and a form on which the Employee shall elect whether to continue health coverage for the Employee and his or her eligible Dependents pursuant to this Section. If the Employee fails to return the completed election form to the Plan Administrator within 60 days of the date the election form was provided to the Employee, the Employee and his or her eligible Dependents shall cease to be eligible to continue coverage pursuant to this Section as of the Employee's last day of work before

beginning Qualified Military Service (although coverage may be continued under the extension provided under COBRA pursuant to Section 3.11).

(d) If the Employee fails to give Employer advance notice of his or her Qualified Military Service the health coverage of the Employee and his or her eligible Dependents shall not be continued under this Section. However, the health coverage of the Employee and his or her eligible Dependents may be reinstated under this Section retroactive to the first day Employee was absent from work for Qualified Military Service under the following circumstances:

(1) The Employee is excused from providing advance notice of his or her Qualified Military Service as provided under USERRA regulations (e.g., it was impossible or unreasonable for the Employee to provide advance notice or the advance notice was precluded by military necessity);

(2) The Employee elects to reinstate the coverage; and

(3) The Employee pays all unpaid premiums for the retroactive coverage.

(e) If the period of Qualified Military Service is 30 days or less, the Employee's required contributions for health coverage shall equal the required contributions for the identical coverage paid by similarly-situated active Participants. If the period of Qualified Military Service is more than 30 days, the Employee's required contributions shall be 100% of the cost of identical coverage for similarly-situated active Participants as of the Employee's 31st day of Qualified Military Service.

(f) Coverage continued pursuant to this Section shall be cancelled if the Employee does not timely pay any required premiums for that coverage. The initial premium must be paid within 45 days after the Employee elects to continue coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the Employee initially elects continuation coverage. Coverage shall be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of continuation coverage pursuant to this Section with no right to reinstate.

(g) Upon reemployment after Qualified Military Service, health coverage of the Employee and his or her eligible Dependents shall be immediately reinstated under the Plan (i.e., no waiting period shall apply) and the pre-existing exclusion under the Plan shall not apply. However, the waiting period and pre-existing condition exclusion shall apply with respect to any condition of the Employee which is determined by the U.S. Secretary of Veterans Affairs (or his representative) to have been incurred in or aggravated during the Employee's Qualified Military Service.

3.13 Conversion Privileges

When the Employee or Candidate or one of his or her Dependents is no longer eligible for self-insured health benefits under the Plan under the other sections of this Article, he or she may be eligible to obtain an individual conversion policy, if offered, through the Claim Administrator. Conversion privileges are also offered by the insurer(s) in connection with the fully-insured welfare benefits.

3.14 Certificates of Creditable Coverage

The Plan shall issue a certificate of Creditable Coverage in connection with the self-insured health benefit under the Plan in the following circumstances:

(a) Where an individual is a Qualified Beneficiary entitled to elect COBRA continuation coverage, a certificate of Creditable Coverage shall automatically be provided no later than when a notice is required to be provided for a Qualifying Event under COBRA.

(b) Where an individual loses coverage under the Plan and is not a Qualified Beneficiary entitled to elect COBRA continuation coverage, a certificate of Creditable Coverage shall automatically be provided within a reasonable time after coverage ceases.

(c) Where an individual is a Qualified Beneficiary and has elected COBRA continuation coverage, a certificate of Creditable Coverage shall automatically be provided within a reasonable time after the cessation of COBRA continuation coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

(d) A certificate of Creditable Coverage shall be provided upon the request of, or on behalf of, an individual at any time within 24 months after the individual loses coverage under the Plan. Such a request must be submitted to the Plan Administrator or the Claim Administrator or to any other authorized agent or contractor. After such a request is received, a certificate of Creditable Coverage shall be issued as soon as administratively feasible.

This requirement shall no longer apply after December 31, 2014.

Article 4

Plan Funding

4.1 Plan Sponsor Contributions

Self-insured benefits under the Plan shall be funded through the Reformed Benefits Association Trust (the "Trust").

Contributions shall be made to the Trust in the amount required to fund the present value of the benefit payments expected to be made to Participants amortized over a reasonable period of years, and to establish and accumulate such reserves as the Plan Sponsor deems reasonable and necessary under the Plan. The contributions shall be actuarially determined and made on a level basis. The Trust shall be used for the exclusive benefit of the Participants to pay the benefits provided by the Plan and to defray the reasonable expenses of administering the Plan. The Trust shall be maintained pursuant to a Trust Agreement.

4.2 Participant Contributions

Participants may be required to contribute to obtain benefits under the Plan as periodically determined by the Participant's Employer and communicated to Participants. Prior consent of a Participant is not required in order to change the contribution amount. Employees who participate in the Cafeteria Plan shall pay any required contributions on a pre-tax basis.

4.3 Insurance

Although the Plan is primarily a self-insured Plan, insurance may be obtained to provide protection from large individual and/or aggregate losses. Further, insurance may be obtained to provide certain benefits (i.e., the fully-insured welfare benefits). The insurance shall contain terms which are generally consistent with the provisions of the Plan and the benefits provided by the Plan. Any such policy may contain any additional provisions which the Plan Administrator may require. However, if there is any conflict between the terms of the Plan and any insurance policy, the terms of the policy shall control only to the extent necessary to avoid a requirement that the Plan pay benefits which are not applied against or eligible for coverage under the policy.

4.4 Arrears Policy and Procedures

In the event of the delinquency by an Employer or Participant with respect to required contributions for a Participant's coverage, the following rules shall apply:

(a) In the event required contributions for coverage are more than 30 days late, the Participant and/or Employer shall be notified in writing.

(b) If required contributions for coverage are more than 60 days late, the Participant and/or Employer shall be sent written notice that if the delinquency is not corrected within 90 days, coverage shall be terminated.

(c) If the delinquency is not corrected within the 90-day period, the Participant's coverage shall be terminated and the Participant and/or Employer shall be notified in writing.

(d) Payment plans may be set up as an accommodation. However, failure to be faithful to payment plans may result in a Participant's coverage being suspended or terminated.

(e) Reentry into life products (including elective life products) where there was a gap in coverage may only occur during an Open Enrollment Period and may require evidence of insurability by the insurer.

The Plan Administrator may adopt an arrears policy and procedure consistent with the above rules.

Article 5

Benefits

5.1 Generally

There are three different types of benefits under the Plan. The first is self-insured health benefits. The second is fully-insured health and welfare benefits. The third is other benefits. The three benefit types are further described in this Article. The Appendix for each Sub-Plan will list the available benefits for that Sub-Plan.

5.2 Self-Insured Health Benefits

There are two types of self-insured health benefits provided under the Plan, medical (including prescription drug) and dental. For these benefits, the Plan document will consist of this document plus the Your Benefit Guide/summary plan descriptions. The available self-insured health benefit options for each Sub-Plan are listed in the applicable Appendix.

5.3 Fully-Insured Health and Welfare Benefits

The Plan provides various fully-insured health and welfare benefits such as health insurance benefits, life and AD&D insurance benefits, and long-term disability insurance benefits. The terms and conditions of each fully-insured benefit are set forth in the policy from the insurer.

5.4 Other Benefits

The Plan provides other benefits such as Section 125 cafeteria plan benefits. The terms and conditions of these other benefits are set forth in the separate documents for those other benefits.

Article 6

Claims and Appeals

6.1 Generally

The procedures for claims and appeals for fully-insured health and welfare benefits shall be set forth in the applicable policy and/or certificate of coverage. The procedures for claims and appeals for self-insured health benefits shall be set forth in the Your Benefit Guide/summary plan descriptions. However, those procedures shall be modified by the rules set forth in this Article. As a result, to the extent the claim and appeal procedures for self-insured health benefits in any of the Your Benefit Guide/summary plan descriptions are inconsistent with the provisions of this Article, the provisions of this Article shall apply.

6.2 Examination and Release of Information

The Plan Administrator may require a Participant to be examined by a Physician selected and paid for by the Plan Administrator in connection with the processing of a claim. Further, as a condition for receiving benefits under the Plan for a specific claim, the Participant authorizes the release of all necessary information and records in connection with the processing of the claim.

6.3 Benefit Review Committee

There shall be two levels of internal appeal for pre-service claims and post-service health benefit claims. Both levels of appeal for self-funded benefits shall be administered by the Claim Administrator. In addition, after the claimant has exhausted the internal appeal process, the claimant may submit a request for an external review of an adverse benefit determination of a denied medical or prescription drug benefit claim. The external review procedure shall satisfy federal regulations issued in connection with Health Care Reform. However, an adverse benefit determination relating to an individual's failure to meet the requirements for eligibility under the terms of the Plan is not eligible for an external review.

After a Claimant has exhausted the internal appeal process and the external review procedure (if applicable), the claimant may submit a denied claim to the Benefit Review Committee for a voluntary review. The request for a voluntary review must be submitted within 60 days after receiving notice of the final level of the determination made pursuant to the internal appeal/external review procedures applicable to the claim. The request for a voluntary review to the Benefit Review Committee must include the information required by the Benefit Review Committee. The Benefit Review Committee shall notify the claimant of its determination within 60 days after receipt of the claimant's request for a voluntary review of an adverse benefit determination.

6.4 Legal Actions

No legal action may be brought to recover self-insured health benefits under the Plan until:

(a) A claim for benefits has been submitted in accordance with the Plan;

(b) The Plan Administrator or its agent or contractor has provided the Participant with a written notice denying the claim, in whole or in part;

(c) The Participant has exhausted the claim review procedure set forth in the summary plan descriptions and this Article; and

(d) The Participant has exhausted all other appeals and remedies available under the Plan (other than voluntary appeal to the Benefit Review Committee). If the Plan fails to strictly adhere to the internal appeals procedures described in this Article, the claimant shall be deemed to have exhausted the internal appeal procedures and as a result, may immediately initiate an external review or file a legal proceeding. However, this rule does not apply to minor, de minimis violations.

No legal action may be brought with respect to a claim after the expiration of one year after the time the Participant has been provided with a written notice denying the claim under the final level of review available under the Plan.

6.5 Facility of Payment

Whenever a Participant or provider to whom self-insured health benefits are directed to be paid shall be mentally, physically, or legally incapable of receiving or acknowledging receipt of a payment, the RBA shall not be under any obligation to have a legal representative appointed or to make payments to a legal representative, if appointed. Payments may be made in any one or more of the following ways, at the Plan Administrator's sole discretion:

(a) **Direct** Directly to the Participant or provider.

(b) **Legal Representative** To the legal representative of the Participant or provider.

(c) **Relative** To a Spouse, child, or other relative, by blood or marriage, of the Participant or provider.

(d) **Resident** To a person with whom the Participant or provider resides.

(e) **Benefit** By expending the amount directly for the exclusive benefit of the Participant or provider.

A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator or its agent or contractor, and the RBA shall not be liable to any person as the result of a payment made, and shall be fully discharged from all future liability with respect to a payment made pursuant to this Section.

6.6 Nonassignability

No self-insured health benefit payable under the Plan is subject to alienation or assignment, whether voluntary or involuntary, except for assignment to a health care provider for services rendered or supplies provided, to the federal government in accordance with backup withholding laws, or in accordance with any assignment of rights as required by a state Medicaid program and in accordance with any state law which provides that the state has acquired the rights to payment with respect to a Participant. Any attempt to otherwise alienate or assign any benefit payable under the Plan shall be void. The right of a Participant to receive a benefit under the Plan shall not be considered an asset of the Participant or beneficiary in the event of his or her divorce, insolvency, or bankruptcy.

6.7 No Interest

The Plan shall not be required to pay interest on any claim for self-funded Plan benefits regardless of when paid.

Article 7

HIPAA Privacy and Security Compliance

7.1 Permitted and Required Uses and Disclosure of Protected Health Information ("PHI")

Subject to obtaining written certification pursuant to Section 7.3, the Plan may disclose PHI to Plan Sponsor, provided Plan Sponsor does not use or disclose such PHI except for the following purposes:

(a) To perform Plan Administrative Functions which Plan Sponsor performs for the Plan.

(b) Obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan; or

(c) Modifying, amending or terminating the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

7.2 Conditions of Disclosure

Plan Sponsor agrees that with respect to any PHI, it shall:

(a) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

(b) Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Plan Sponsor with respect to PHI.

(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor or the Company.

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.

(e) Make available to individual Plan Participants who request access, the Plan Participant's PHI in accordance with 45 CFR § 164.524.

(f) Make available to individual Plan Participants who request an amendment, the Participant's PHI and incorporate any amendments to the Participant's PHI in accordance with 45 CFR § 164.526.

(g) Make available to individual Plan Participants who request an accounting of disclosures of the Participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(h) Make its internal practices, books, and records, relating to the use and disclosures of PHI received from the Plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy rules.

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

(j) Ensure that the adequate separation between Plan and Plan Sponsor, required in 45 CFR § 164.504(f)(2)(iii), is satisfied and that terms set forth in Section 7.5 are followed.

(k) Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Plan Sponsor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

7.3 Certification

The Plan shall disclose PHI to Plan Sponsor only upon the receipt of a Certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that Plan Sponsor agrees to the conditions of disclosure set forth in Section 7.2.

7.4 Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to Plan Sponsor, provided such Summary Health Information is only used by Plan Sponsor for the purpose of:

(a) Obtaining premium bids from health plan providers for providing health coverage under the Plan; or

(b) Modifying, amending or terminating the Plan.

7.5 Adequate Separation between Plan and RBA

(a) The Employees, or classes of Employees, designated in the RBA's HIPAA privacy and security policies and procedures shall be given access to PHI.

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administrative Functions that Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

(d) To comply with the HIPAA security rule, the Plan Sponsor shall ensure that the provisions of this Article are supported by reasonable and appropriate security measures to the extent that the authorized Employees or classes of Employees have access to electronic PHI.

7.6 Disclosure of Certain Enrollment Information to Plan Sponsor

Pursuant to 45 CFR 164.504(f)(1)(iii), the Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any health insurance issuer or health maintenance organization offered by the Plan.

7.7 Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

Plan Sponsor authorizes and directs the Plan, through the Plan Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the HIPAA privacy rules.

7.8 Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

7.9 Definitions

For purposes of this Article, the following terms shall have the following meanings:

(a) "Business Associate" means a person or entity who:

(1) performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration; data analysis, underwriting, etc.); or

(2) provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

(b) "Plan Administrative Functions" mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administrative functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-plans–such as vision and dental. PHI for these purposes may not be used by or between the Plan or business associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan administrative functions specifically do not include any employment-related functions.

(c) "Protected Health Information" or "PHI" means information that is created or received by the Plan, or a business associate of the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the participant (whether living or deceased). The following components of a Participant's information are considered to enable identification:

(1) Names;

(2) Street address, city, county, precinct, zip code;

(3) Dates directly related to a participant's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death;

(4) Telephone numbers, fax numbers and electronic mail addresses;

(5) Social Security numbers;

(6) Medical record numbers;

(7) Health plan beneficiary numbers;

(8) Account numbers;

(9) Certificate/license numbers;

(10) Vehicle identifiers and serial numbers, including license plate numbers;

(11) Device identifiers and serial numbers;

(12) Web Universal Resource Locators (URLs);

(13) Biometric identifiers, including finger and voice prints;

(14) Full face photographic images and any comparable images; and

(15) Any other unique identifying number, characteristic or code.

(d) "Summary Health Information" means information that may be individually identifiable health information that:

(1) Summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Plan Sponsor has provided health benefits under a health plan; and

(2) From which the information described at 45 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

7.10 Hybrid Entity

This Section applies to the extent the Plan provides any non-health benefits such as (but not limited to), disability benefits or group term life insurance benefits. The Plan is a separate legal entity whose business activities include functions covered by the HIPAA privacy and security rules and non-covered functions. As a result, the Plan is a "Hybrid Entity," as that term is defined in the HIPAA privacy and security rules. The Plan's covered functions are its health benefits ("health care component"). All other benefits are non-covered functions. Therefore, the Plan hereby designates that it shall only be a covered entity under the HIPAA privacy and security rules with respect to the health care component (the health benefits) of the Plan.

7.11 Participant Notification

Participants shall be notified of this Article in the notice of privacy practices.

Article 8

Plan's Right to Reimbursement and Subrogation Right

This Article applies only with respect to the self-funded health benefits provided under the Plan.

8.1 Plan's Right to Reimbursement

If the Plan pays benefits and another party (other than the Participant or the Plan) is or may be liable for the expenses, the Plan has a right of reimbursement which entitles it to an equitable lien to be reimbursed from the Participant or another party 100% of the amount of benefits paid by the Plan to or on behalf of the Participant.

The Plan's equitable lien and right to 100% reimbursement applies:

(a) Not only to any recovery the Participant receives or is entitled to receive from the other party but also to any recovery the Participant receives or is entitled to receive from the other party's insurer or a plan under which the other party has coverage.

(b) To any recovery from the Participant's own insurance policy, including, but not limited to, coverage under any uninsured or underinsured policy provisions.

(c) To any recovery, even if the other party is not found to be legally at fault for causing the Participant to incur the expenses paid or payable by the Plan.

(d) To any recovery, even if the damages recovered or recoverable from the other party, its insurer or plan or the Participant's policy are not for the same charges or types of losses and damages as those for which benefits were paid by the Plan.

(e) To any recovery, regardless whether the recovery fully compensates the Participant for his or her Injuries and regardless whether the Participant is made whole by the recovery.

(f) To the entire amount of the recovery to the extent of the expenses payable by the Plan. The Plan's right to reimbursement from the recover is not affected or reduced in any way by the Participant's attorneys' fees or costs in obtaining the recovery. The Plan disavows any obligation to pay all or any portion of the Participant's attorneys' fees or costs in obtaining the recovery. The "common fund doctrine" and similar doctrines do not reduce or affect the Plan's right to reimbursement.

8.2 Plan's Subrogation Right to Initiate Legal Action

If a Participant does not bring an action against the other party who caused the need for benefits paid by the Plan within a reasonable period of time after the claim arises, the Plan shall have the right to bring an action against the other party to enforce and protect its right

to reimbursement as described in this Article. In this circumstance, the Plan shall be responsible for its own attorneys' fees.

8.3 Cooperation of Participant

A Participant shall do whatever is necessary and shall cooperate fully to secure the rights of the Plan described in this Article. This includes assigning the Participant's rights against any other party to the Plan and executing any other legal documents that may be required by the Plan.

8.4 Plan's Right to Withhold Payment

The Plan may withhold payment of benefits when it appears that a party other than the Participant or the Plan may be liable for the expenses until such liability is legally determined. Further, as a pre-condition to paying benefits when it appears that the need for the benefits paid by the Plan was caused by another party, the Plan may withhold the payment of benefits until the Participant signs an agreement furnished by the Plan Administrator setting forth the Plan's right to reimbursement and subrogation right.

8.5 Preconditions to Participation and the Receipt of Benefits

All of the following rules are preconditions to an individual's participation in the Plan and the receipt of Plan benefits:

(a) The Participant agrees not to raise any make-whole, common fund or other apportionment claim or defense to any action or case involving reimbursement or subrogation in connection with the Plan, and acknowledges that the Plan expressly disavows such claims or defenses.

(b) The Participant agrees not to raise any jurisdictional or procedural issue which would defeat the Plan's claim to reimbursement or subrogation in connection with the Plan.

(c) The Participant specifically acknowledges the Plan's fiduciary right to bring an equitable reimbursement recovery action should the Participant obtain or be entitled to obtain a recovery from another party who is or may be liable for the expenses paid by the Plan and to obtain an equitable lien over any recovery. The equitable lien shall apply over the recovery/property to the extent of the expenses payable by the Plan.

(d) The Participant specifically recognizes that the Plan has the right to intervene in any third party action to enforce its reimbursement rights. The Participant consents to such intervention.

(e) The Participant specifically agrees that the Plan has the right to obtain injunctive relief prohibiting the Participant from accepting or receiving any settlement or other recovery related to the expenses paid by the Plan until the Plan's right to reimbursement is fully satisfied. The Participant consents to such injunctive relief.

8.6 Notice and Settlement of Claim

A Participant shall give the Plan Administrator written notice of any claim against another party as soon as the Participant becomes aware that he/she may recover damages from another party. A Participant shall be deemed to be aware that he/she may recover damages from another party upon the earliest of the following events:

(a) The date the Participant retains an attorney in connection with the claim; and

(b) The date a written notice of the claim is presented to another party or the other party's insurer or attorney by the Participant or the Participant's insurer or attorney.

A Participant shall not compromise or settle any claim against another party without the prior written consent of the Plan Administrator. If a Participant fails to provide the Plan Administrator with written notice of a claim as required in this Section or if a Participant compromises or settles a claim without prior written consent as required in this Section, the Plan Administrator shall deem the Participant to have committed fraud or misrepresentation in a claim for benefits and accordingly, shall terminate the Participant's participation in the Plan.

Article 9

Administration

9.1 Plan Administrator

The RBA shall have the sole responsibility for the administration of the Plan and is designated as named fiduciary and Plan Administrator.

9.2 Responsibilities of Plan Administrator

The Plan Administrator shall have the discretionary authority and responsibility for the general administration of the Plan. The Plan Administrator's duties and powers shall include, but shall not be limited to, the following:

(a) Plan Benefits Establish eligible expenses and benefits payable under the Plan.

(b) Construction With respect to benefits which are not fully-insured, construe and interpret the Plan; decide all questions of eligibility; and determine the amount, manner, and time of payment of benefits. With respect to the fully-insured benefits, the insurer has the ultimate discretionary authority and responsibility to construe and interpret the terms of the policy; decide all questions of eligibility under the policy; and determine the amount, manner and time of payment of benefits.

(c) Procedures Prescribe procedures and forms to be used by Participants, including procedures and forms regarding application for participation, evidence of disability, and claims.

(d) Disclosure Make any and all disclosures to Participants.

(e) Information Receive from, and transmit to, the RBA, the Claim Administrator and the Participants all information necessary for the proper administration of the Plan.

(f) Benefit Payments Authorize benefits which are to be paid pursuant to the provisions of the Plan.

(g) Agents Appoint individuals or entities to assist in the administration of the Plan or trust and other agents it deems advisable, including legal counsel.

(h) Advisors and Administrative Expenses The RBA may employ such advisors, including legal counsel, actuaries and accountants, as may be reasonably necessary in managing the Plan and advising the RBA as to its rights, duties and liabilities under the Plan.

9.3 Claim Administrator Appointment

The Plan Administrator may enter into an administration agreement with one or more Claim Administrators, under which such Claim Administrator(s) shall be given broad authority by the Plan Administrator to administer self-insured benefit payments under the Plan and to render other administrative services on behalf of the Plan. Any such Claim Administrator shall review, interpret, and evaluate all claims for benefits under the Plan. Any such Claim Administrator shall have no power to modify any terms of the Plan, or any benefit provided by the Plan; or to waive or fail to apply any requirements of eligibility for a benefit under the Plan. The Plan Administrator shall have the sole and final discretion regarding whether any expense is covered by the Plan.

To the extent that these administrative responsibilities are assumed by a Claim Administrator under an administration agreement, the RBA shall have no responsibility for these functions. The Plan Administrator may, from time to time, amend the administration agreement or enter into similar agreements with any other Claim Administrator as the Plan Administrator shall in its discretion select.

9.4 Standard of Care

The Plan Administrator shall administer the Plan solely in the interest of Participants and for the exclusive purposes of providing benefits to the Participants and their beneficiaries and defraying reasonable expenses of administration. The Plan Administrator shall administer the Plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with like matters, would use in the conduct of an enterprise of a like character and with like aims. The Plan Administrator shall not be liable for any act or omission relating to its duties under the Plan, unless the act or omission violates the standard of care described in this Section. The Plan Administrator shall not be liable for any act or omission of another relating to the Plan, except as provided under applicable law.

9.5 Indemnification

Except as otherwise provided in any contract between the parties, the RBA shall indemnify each Employee or agent to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act, except when the action or failure to act is judicially determined to be due to the gross negligence or willful misconduct of the person. The RBA may choose, at its own expense, to purchase and keep in effect sufficient liability insurance for each person to cover any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act in connection with the execution of his or her duties as an Employee or agent of the RBA.

9.6 Interrelationship of Fiduciaries

Each fiduciary may rely upon any direction, information, or action of another fiduciary as being proper and is not required to inquire into the propriety of the direction,

information, or action. Each of the fiduciaries shall be responsible for the proper exercise of its own responsibilities.

Article 10

Amendment and Termination of Plan

10.1 Plan Amendment

Plan Sponsor reserves the right to amend any of the Plan provisions, including the modification, reduction or elimination of benefits, or to discontinue all or any part of the Plan as Plan Sponsor, in its sole discretion, deems necessary, without prior notice to any Participant. Discontinuance of any coverage shall not prejudice any claims for expenses incurred before the date of such discontinuance, provided that a claim for benefits is submitted within the allowable time periods stated in the Plan.

10.2 Plan Termination

Although Plan Sponsor intends to maintain the Plan indefinitely, Plan Sponsor may terminate all or a portion of the Plan at any time by action of its Board of Trustees. In addition, the Plan shall terminate upon either of the following events:

(a) Liquidation The liquidation or discontinuance of the business of Plan Sponsor, the adjudication of Plan Sponsor as bankrupt, or a general assignment by Plan Sponsor to or for the benefit of its creditors; or

(b) Merger The merger or consolidation of Plan Sponsor into another corporation which is the surviving corporation, the consolidation or other reorganization of Plan Sponsor, or the sale of substantially all of its assets, unless the successor or purchasing corporation adopts the Plan within 90 days thereafter.

10.3 Benefits on Termination

Upon termination, the Plan shall pay benefits for eligible expenses incurred prior to the termination date. Any assets remaining in the Trust shall be used for the exclusive benefit of Participants and defraying the reasonable administrative expenses of the Plan.

Article 11

Miscellaneous

11.1 Captions

The captions contained in this Plan are included solely for convenience in locating various provisions and are not determinative of the intent or scope of these provisions.

11.2 Construction

The Plan shall be construed to prevent duplication of benefits and to cover expenses specifically included within each type of benefit. Each type of benefit shall be considered exclusive of each other type of benefit to prevent benefits which are not specifically included within a type of benefit from being paid by the Plan.

11.3 No Vested Rights

A Participant does not have any vested right to current or future benefits under the Plan. A Participant's right to benefits is limited to claims incurred before the earliest of the following dates: The amendment of the Plan, the termination of the Plan, the expiration of the applicable limitations period and the Participant's termination of participation (including any extension of participation for which the Participant has properly elected and paid).

11.4 Employment Rights

The existence of the Plan does not give a Participant any legal right to continue as an Employee, nor affect the right of the RBA to discharge any Participant.

11.5 Participants' Rights

Except as may be required by law, the existence of the Plan shall not give any Participant or beneficiary any interest in the assets, business, or affairs of the CRCNA or the RBA; the right to challenge any action taken by the RBA's officers or Board of Trustees, or any policy adopted or followed by the RBA; or the right to examine any of the books and records of the CRCNA or the RBA. The rights of all Participants and beneficiaries shall be limited to their right to receive payment of their benefits when due and payable in accordance with the terms of the Plan.

11.6 Counterparts

This instrument may be executed in any number of counterparts each of which shall be considered an original.

11.7 Severability

The unenforceability of any provision of the Plan shall not affect the enforceability of the remaining provisions of the Plan.

11.8 Governing Law

The Plan shall be construed in accordance with the laws of the state of Michigan.

Signature

Plan Sponsor has adopted the Reformed Benefits Association Health Benefit Plan for Christian Reformed Church in North America Employees effective January 1, 2014.

REFORMED BENEFITS ASSOCIATION

Dated: _____

_____
Signature

_____
Printed Name and Title

Schedule A

Plan Benefits as of January 1, 2014

1. Self-funded health (medical, prescription drug and dental) benefits:

    a. Blue Cross HDHP Plan for Domestic Agency Employees, Church Employees and Candidates
    b. Blue Cross Dental Plan – one option for Domestic Agency Employees and one option for Church Employees

2. Fully-insured health (medical, prescription drug and dental) benefits:

    a. Aetna Plan for Overseas Agency Employees

3. Fully-insured welfare benefits:

    a. Group term life and AD&D insurance for all Employees
    b. Supplemental life insurance for all Employees
    c. Long term disability benefits for unordained Domestic Agency Employees

4. Other benefits:

    a. Section 125 Cafeteria Plan for Domestic and Overseas Agency Employees and Church Employees

Appendices for Sub-Plans - 2014

Name of Group	Appendix Number
Domestic Agency Employees, Church Employees and Candidates	1
Overseas Agency Employees	2

Appendix 1
Domestic Agency Employees, Church Employees and Candidates[4]

January 1, 2014

Self-Insured Medical/Prescription Drug:	HDHP
Self-Insured Dental:	Yes
Group Term Life/AD&D:	Yes
Supplemental Life:	Yes
Long-Term Disability:	Yes, for unordained full-time Domestic Agency Employees No, for unordained Church Employees (Ordained Employees receive long-term disability coverage under the Pension Plan)
Section 125 Cafeteria Plan:	Yes

[4] Candidates are only eligible for the self-insured medical/prescription drug benefit.

Appendix 2
Overseas Agency Employees

January 1, 2014

Fully-Insured Medical/Prescription Drug:	Yes
Fully-Insured Dental:	Yes
Group Term Life/AD&D:	Yes
Supplemental Life:	Yes
Long-Term Disability:	Yes, for unordained full-time Employees (ordained Employees receive long-term disability coverage under the Pension Plan)
Section 125 Cafeteria Plan:	Yes, but only for purposes of paying premiums on a pre-tax basis