West Eau Claire Rehabilitation and Nursing Center LLC
DBA Dove Healthcare
Individual Coverage Health Reimbursement Arrangement
Plan and Summary Plan Description

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Article I. Introduction

1.1 Establishment of Plan

West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare (Employer) has established the West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare Individual Coverage Health Reimbursement Arrangement (HRA) Plan (Plan) effective January 1, 2026 (the "Effective Date"). This Plan is intended to permit an Eligible Employee to obtain reimbursement of premiums for individual policies of insurance, Medicare Part A (Hospital Insurance) and B (Medical Insurance) or Medicare Part C (Medicare Advantage) (collectively referred to in the Plan as Medicare) on a nontaxable basis from Employee's HRA Account.

The Plan Sponsor reserves the right to alter, amend, modify, or terminate the Plan in whole or in part, at any time for any reason.

1.2 Legal Status

This Plan is intended to qualify as an individual coverage health reimbursement arrangement under final regulations allowing plan sponsors to reimburse premiums for individual health insurance policies, and shall be interpreted to accomplish that objective.

Article II. Definitions

2.1 Definitions

Benefits means the reimbursement benefits for Eligible Expenses set forth in the Article entitled Health Reimbursement Benefits.

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

Dependent means a Participant's spouse and (a) any individual who is a Participant's child as defined by Code § 152(f)(1) and who has not attained age 26, and (b) any tax dependent of a Participant as defined in Code § 105(b) provided, however, that any child to whom Code § 152(e) (regarding a child of divorced parents, etc. where one of both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) applies is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent." Participants and dependents may receive without charge the procedures governing qualified medical child support order (QMCSO) determinations.

Eligible Employee means an Employee eligible to participate in this Plan.

Employee means an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employee does not include:

(a) Any leased employee or anyone classified by your employer as a contract worker, independent contractor, or temporary employee, whether or not such employee is on your employer's W-2 payroll;

(b) Any individual who performs services for your employer but is paid by a temporary or other staffing agency;

(c) Any self-employed individual;

(d) Any partner in a partnership;

(e) Any more than 2% shareholder in a Subchapter S corporation.

Employer means West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare.

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

Full-Time Employee means a full-time employee whose standard hours are a minimum of 30 hours per week.

Full-Time Employee Policy: means the West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare policy for identifying full-time employees, whether or not in writing, and for identifying Eligible Employees under the West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare Plan, as amended and in effect from time to time, which policy is incorporated into this Plan by reference.

Highly Compensated Individual means an individual defined under Code § 105(h), as amended, as a "highly compensated individual."

HRA Account means the HRA Account described in Establishment of Account Section.

Individual Coverage HRA means a health reimbursement arrangement as defined under final regulations allowing plan sponsors to reimburse premiums for individual health insurance policies, and shall be interpreted to accomplish that objective.

Participant means an individual who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

Part-Time Employee means an employee whose standard hours are less than the minimum number of hours required to be a Full-Time Employee.

Period of Coverage means the Plan Year with the following exceptions: (a) for Eligible Employees who first become Participants after the first day of the Plan Year, it shall mean the portion of the Plan Year following the date participation commences, as described in Eligibility to Participate Section; and (b) for Participants who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in the Termination of Participation Section. A different Period of Coverage (e.g., monthly) may be established by the Plan Administrator and communicated to Participants.

Plan means this West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare Individual Coverage HRA, as amended from time to time.

Plan Administrator means West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare. The Plan Administrator retains ultimate authority for this Plan including final appeal determinations.

Plan Sponsor West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare.

Plan Year typically means the calendar year during which the Individual Coverage HRA is in effect. The initial Plan Year will be from January 1, 2026 to December 31, 2026. Subsequent Plan Years will be from January 1 to December 31.

Protected Health Information shall have the meaning described in 45 C.F.R. § 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

Seasonal Employee an employee who is hired for a short period of time or for a specific season.

QMCSO means a qualified medical child support order, as defined in ERISA § 609(a).

Waiting Period shall mean the first day of the month following 60 days.

Article III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is an Eligible Employee and may become a Participant in this Plan if the individual: (a) is an Employee; (b) is considered to be a Full-Time Employee under the Company Full-time Employee Policy; (c) has completed the Waiting Period for enrollment in the Plan; and (d) is covered under individual medical insurance coverage or Medicare for each month the Employee is covered by the Plan. If an Employee's Dependents are covered by the Plan, they must also be enrolled in individual health insurance coverage or Medicare for each month they are covered by the Plan.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan when the first of the following occurs:

- This Plan terminates;
- The Employee ceases to be an Eligible Employee because of loss of coverage under individual medical insurance coverage or Medicare;
- The Employee's HRA Account balance is exhausted; or
- The Employee ceases to be an Eligible Employee because of termination of employment, reduction in hours, or any other reason, provided participation may continue under COBRA coverage.

If the Plan terminates or the Employee loses coverage under individual medical insurance coverage or Medicare, the Employee's loss of Participant status shall occur immediately upon occurrence of the applicable event. If an Employee ceases to be a Participant for any other reason, the Employee's loss of Participant status shall occur at the end of the month in which the applicable event occurs. Any reimbursement from the HRA Account after termination of participation will be made in accordance with any run-out period for submitting claims for premium reimbursement incurred prior to termination.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant's employment terminates for any reason, including (but not limited to) disability, layoff or voluntary resignation, and the Participant is rehired within 30 days or less of the date of the termination of employment, the Participant will be reinstated with the same HRA Account balance that such individual had immediately before termination, provided the individual meets the other requirements of an Eligible Employee. If an Employee (whether or not a Participant) terminates employment and is not rehired within 30 days or ceases to be an Eligible Employee for any other reason, including (but not limited to) a reduction in hours, the Employee's service before loss of Eligible Employee status will not be taken into account when determining whether the Employee has regained Eligible Employee status, so the Employee will be required to complete any applicable waiting period before becoming eligible to participate in this Plan.

3.4 FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993, as amended (FMLA) or Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

3.5 Non-FMLA and Non-USERRA Leaves of Absence

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

ARTICLE IV. Method and Timing of Enrollment

4.1 Enrollment When First Eligible

An Employee who is not a Participant will commence participation in this Plan on the first day of the Plan Year following the enrollment period upon the Employee's submission of a properly completed Enrollment Form to the Plan Administrator, or on the first day of such later calendar month as may properly be indicated on that Enrollment Form, provided the Employee is an Eligible Employee on the commencement date. Once the Eligible Employee is enrolled as a Participant, his or her participation will continue until his or her participation terminates (subject to permanent opt-out). The Enrollment Form shall identify the Dependents whose Eligible Expenses may be submitted to the HRA. The Participant must promptly notify the Plan Administrator if this information changes.

4.2 Special Enrollment Rights

Participants who decline enrollment for themselves and/or their Dependents because they or their Dependents are enrolled in other health insurance or group health plan coverage may be able to enroll themselves and their Dependents in this Plan if they or their Dependents lose eligibility for such other coverage (or if an employer stops contributing toward such other coverage). In most cases, the Participant must request enrollment within 60 days after such other coverage ends (or after the employer stops contributing toward the other coverage). The Participant or Dependent must request enrollment within 60 days of the loss of coverage under a state CHIP or Medicaid program or the loss of eligibility for premium assistance under those programs.

In addition, if Participants have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll themselves and their Dependents in the Plan. For special enrollment due to marriage or loss of eligibility for other coverage, coverage will begin on the first day of the first month after the Plan receives the enrollment request.

Participants taking advantage of special enrollment as a result of a birth, adoption, or placement for adoption begin coverage for themselves and their Dependents no later than the day of the event. However, they must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. Participants who wish to request special enrollment or obtain more information should contact the Plan Administrator.

The Plan will also permit special enrollment periods consistent with special enrollment periods offered under Marketplaces served by the HealthCare.gov platform and State-based Marketplaces (other than special enrollment periods that result from becoming newly eligible for advance payments of the premium tax credit and cost-sharing reductions).

4.3 Enrollment in Individual Insurance or Medicare

As a condition of eligibility for this Plan, Eligible Employees and (if applicable) their Dependents must be enrolled in individual insurance coverage or Medicare. Eligible Employees who are not already enrolled in an individual policy or Medicare must select an insurance plan and pay the first month's premium within the 60-day period before the first day of the Plan year. The first month's premium will be reimbursed from the Plan in the following month (except to the extent that any portion is paid with pre-tax dollars through a Section 125 cafeteria plan).

Employees and Dependents who first become eligible for the Plan during the Plan Year (i.e., new hires and Employees or Dependents with special enrollment rights), but do not currently have individual insurance coverage or Medicare, have up to 60 days from the date they would be eligible for coverage under the Plan to select an individual policy of insurance. No reimbursement shall be made from the Plan until the Employee is enrolled in individual insurance coverage or Medicare.

4.4 Opt-Out

An Eligible Employee or Dependent may elect to opt out of and waive future reimbursements on behalf of the Participant and all Dependents once, and only once, with respect to each Plan Year. The opt-out must occur in advance of, and with respect to, the Plan Year. No similar offer shall be required at termination of employment because the Participant forfeits any excess balance in their HRA Account (unless they elect COBRA continuation coverage). If a Participant opts out of an individual coverage HRA, the individual coverage HRA is considered waived for the Participant's eligible Dependents as well.

Participants may not claim premium tax credits for coverage purchased on their state's Health Insurance Marketplace (also known as "Exchange") for any month they are covered by the Plan. Nor may they claim the premium tax credit for the Exchange coverage of any family members for any month the family members are covered by the Plan. If an Eligible Employee opts out of the Plan and the Plan is considered affordable, they may not claim the premium tax credit for themselves or any family members who were eligible. However, if the Plan is considered unaffordable, an Eligible Employee may opt out of the Plan and remain eligible for premium tax credits on the Exchange.

A Participant may determine whether the individual coverage HRA is affordable by visiting the website of their state's exchange.

Article V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When an Eligible Employee becomes a Participant, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Eligible Expenses, which are limited to the reimbursement of premiums for individual health insurance or Medicare. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Expenses.

5.2 Employer and Participant Contributions

(a) Employer Contributions. The Employer funds the full amount of the HRA Accounts.

(b) Participant Contributions. There are no Participant contributions for Benefits under the Plan, except in the case of COBRA coverage.

(c) No Funding Under Cafeteria Plan. Under no circumstances will the HRA Accounts be funded with salary reduction contributions, employer contributions to a cafeteria plan (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employer contributions to the Plan.

(d) Separate Funding of Certain Premiums through a Cafeteria Plan Permitted. If the Plan does not cover its Participants' full premiums for individual insurance coverage, the employer may permit employees to pay the balance of the premiums for health insurance policies that are not purchased through a healthcare exchange. Premiums for qualified plans purchased through a healthcare exchange are not eligible for reimbursement from a cafeteria plan.

5.3 Funding of the Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

Article VI. Health Reimbursement Benefits

6.1 Benefits

The Plan will reimburse Participants for Eligible Expenses up to the unused amount in the Participant's HRA Account, as set forth in this Article.

6.2 Eligible Expenses

Under the HRA Account, a Participant may receive reimbursement for Eligible Expenses incurred during a Period of Coverage.

(a) *Eligible Expenses.* "Eligible Expenses" means premiums for individual health insurance and Medicare that (1) are paid by the Participant on an after-tax basis or (2) paid directly by the Plan on behalf of the Participant. The portion of any premium for individual health insurance coverage that is paid by salary reduction through a § 125 cafeteria plan, including from the last month of one Plan Year to be applied to premiums incurred in the first month of the following Plan Year, may not be reimbursed from the individual coverage HRA.

(b) *Incurred.* An Eligible Expense that is a monthly premium for individual health insurance coverage or Medicare is generally incurred on the later of: (1) the first day of each month of coverage, even if the Participant or Employer paid the premium for the coverage prior to the first day of the Plan Year, or if later, (2) the date the premium is actually paid.

(c) *Cannot Be Reimbursed or Reimbursable from Another Source.* Eligible Expenses may be reimbursed from the Participant's HRA Account only to the extent that the Participant or other individual incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through another source (such as an individual coverage HRA maintained by the employer of a Participant's spouse).

(d) *Ineligible Expenses.* The Plan will not reimburse any medical expenses other than insurance premiums for individual policies of health insurance and Medicare. Specifically, the plan will not reimburse premiums for:

- Any form of group health plan;
- Association health plans;
- Health care sharing ministries;
- Short-term limited duration insurance (STLDI);
- Self-insured student health plans;
- Excepted benefits such as vision or dental insurance, or
- Other medical expenses under section 213(d) of the Code.

6.3 Nondiscrimination Requirements

The Plan limits reimbursement to employees to premium paid to purchase health insurance policies. HRAs that make available reimbursements to employees only for premiums paid to purchase health insurance policies, including individual health insurance policies, but not other expenses, are not subject to the nondiscrimination rules under section 105(h) and its related regulations.

6.4 Establishment of HRA Account

The Plan Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) *Crediting of Accounts.* A Participant's HRA Account will be credited at the beginning of each calendar month during a Period of Coverage with an amount equal to the applicable maximum dollar limit for the Period of Coverage divided by the number of months in that Period of Coverage (e.g., divided by 12 in a 12-month Plan Year). No amount shall be credited for a calendar month, however, if the Participant is not still an Eligible Employee on the first day of that calendar month.

(b) *Debiting of Accounts.* A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Eligible Expenses incurred during the Period of Coverage.

(c) *Available Amount.* The amount available for reimbursement of Eligible Expenses is the amount credited to the Participant's HRA Account under subsection (a), reduced by prior reimbursements debited under subsection (b).

6.5 Forfeiture

If any Available Amount remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be forfeited.

In addition, any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Eligible Expense was incurred shall be forfeited.

6.6 Reimbursement Procedure

(a) *Annual Substantiation.* The Plan has implemented procedures to annually verify, before the first day of the Plan year, that Participants and Dependents whose premiums are reimbursable by the Plan are, or will be, enrolled in individual health insurance coverage or Medicare for the entire Plan Year. These verification procedures also apply to Participants and Dependents who become eligible for coverage after the first day of the Plan Year (for example, a new hire). Employees who timely purchase individual policies of insurance through Gravie Agency L.L.C. ("Gravie") will automatically meet the annual substantiation requirement and need not verify their enrollment separately. Individuals who are enrolled in Medicare or who purchase individual policies of insurance other than through Gravie must provide written verification of enrollment in Medicare or individual health insurance coverage not later than the last day of the individual coverage HRA open enrollment period (individuals who are not eligible to participate in Plan on the first day of the Plan Year must provide such verification by the date Plan coverage begins). Individuals who must verify enrollment may do so by providing a written attestation of annual coverage on a form made available by the Plan Administrator or through submitting a Proof of Coverage which outlines the premium, carrier, plan name, start and end dates of the coverage, and those individuals covered by the plan. Proof of Coverage can be uploaded via the Gravie Member portal or submitted through Gravie Care.

(b) *Monthly Substantiation and Claims*. In addition to the annual substantiation of coverage, the Plan may not reimburse a Participant for any premiums unless, prior to each reimbursement, the Participant provides substantiation that they were enrolled in individual health insurance coverage or Medicare during the month for which the premium expense was incurred. If and to the extent premiums are paid on behalf of the Participant by the Plan, the monthly substantiation requirement shall be deemed to be satisfied without submission of verification by the Participant. If the Participant pays the premium and submits a claim for reimbursement, the Participant must verify enrollment by providing a request for reimbursement with a written attestation of annual coverage on a form made available by the Plan Administrator. Claims for premium reimbursement must be submitted no later than 180 days following the date the Eligible Expense was incurred.

(c) *Timeline for Reimbursement.* Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Plan will reimburse the Participant for the Participant's Eligible Expenses (if the Plan Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied. The 30-day time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

6.7 Reimbursements After Termination

When a Participant ceases to be a Participant, and subject to the right of the Participant and Dependents to elect COBRA continuation coverage as described later in this document, the Participant will not be able to receive reimbursements for Eligible Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Eligible Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim: 1) no later than 180 days following the date the Eligible Expense was incurred; and 2) within 45 days following the close of the Plan Year in which the Eligible Expense was incurred. Any amounts remaining in the HRA Account after this period will be forfeited.

6.8 Named Fiduciary

Named Fiduciary. The named fiduciary for the Plan for purposes of ERISA § 402(a) shall be West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare.

6.9 Coordination of Benefits

Benefits under this Plan are solely intended to reimburse Eligible Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Eligible Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan.

Article VII. Appeals Procedures

7.1 Claim Denial

If a claim is denied, the plan must provide a notice of adverse benefit determination. The notice will include the following information:

(a) The specific reason or reasons for the adverse determination

(b) Reference to the specific plan provisions on which the determination is based;

(c) Description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

An adverse benefit determination includes any rescission of coverage, but does not include a rescission of coverage for failure to pay COBRA premiums.

7.2 Appeals

A Participant may appeal a claim denial subject to the following:

(a) The participant has 180 days to appeal a notice of adverse benefit determination.

(b) Review must be conducted by an "appropriate named fiduciary" who is not the same person that made the initial adverse benefit determination, nor that person's subordinate.

(c) If the plan considers or relies on any new or additional evidence or rationale in issuing an adverse determination, it must provide that information to the Participant free of charge (and not only on request). The information must be provided as soon as possible and before a final decision so that the participant can respond to it.

(d) Participants have the right to review their claim file and present evidence and testimony as part of the internal claims and appeals process.

(e) The Plan must avoid conflicts of interest in claims and appeals. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator) must not be made based upon the likelihood that the individual will support the denial of benefits.

Participants will be notified of the decision on any internal appeal within 60 days after receipt of their request for review. A notice of adverse determination on appeal will Include the following:

(a) The specific reason or reasons for the adverse determination

(b) Reference to specific plan provisions

(c) Statement that they can receive copies of all documents, records, relevant to claim

(d) Statement of any voluntary appeal procedures and right to bring an action

(e) Statement of what rule, protocol, etc. criterion was relied on

(g) A statement regarding voluntary alternative dispute resolution options through the local DOL or state insurance regulatory office.

7.3 External Review

External review for an individual coverage HRA that only reimburses premiums for individual policies of insurance and Medicare is available only for rescissions of coverage (a rescission is a retroactive termination of coverage but does not include retroactive terminations of coverage resulting from eligibility determinations). The Plan Administrator will provide information on the availability of external review if an internal appeal is denied.

7.4 Preservation of Other Remedies

After exhaustion of the claims and appeals procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available.

7.5 Overpayments or Errors

If it is determined that a Participant or any Dependent received an overpayment or a payment was made in error, the Participant will be required to refund the overpayment or erroneous reimbursement to the Plan.

If the Participant does not refund the overpayment or erroneous payment, the Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from the Participant's W-2 compensation.

Article VIII. HIPAA Privacy and Security

8.1 General

The Plan shall comply with the standards set forth by HIPAA for the privacy of protected health information (PHI) in the Privacy Rule, the security of Electronic PHI in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

8.2 Definitions

For purposes of this Article, the following definitions shall apply:

Breach means the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan determines there is a low probability that the PHI has been compromised. A Breach does not include: (1) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Breach Notification Rule means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

Electronic Protected Health Information or **Electronic PHI** means PHI that is transmitted by or maintained in electronic media.

Health Care Operations is as defined under 45 CFR § 160.501.

HIPAA Health Plan is as defined under 45 CFR § 160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR § 160.103.

Payment is as defined under 45 CFR § 160.501, and means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

Privacy Policy means the Employer HIPAA Privacy Policy.

Privacy Rule means the regulations issued under HIPAA set forth in subpart E of 45 CFR Part 164.

Protected Health Information or **PHI** means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant or Dependent, provision of health care to a Participant or Dependent, or payment for such health care; (2) can either identify the Participant or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant or Dependent; and (3) is received or created by or on behalf of the Plan.

Responsible Employee means an employee (including a contract, temporary, or leased employee) of the Plan or of the Employer whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the employee will receive or have access to PHI. A Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates or receives PHI on behalf of the Plan, even though the employee's duties do not (or are not expected to) include creating or receiving PHI. Responsible Employees are within the Employer's HIPAA firewall when they perform Plan functions.

Security Incident is as defined under 45 CFR § 164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Security Rule means the regulations issued under HIPAA set forth in subpart C of 45 CFR Part 164.

Summary Health Information means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

8.3 Responsible Employees

Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Plan. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Plan administration functions that the Employer performs on behalf of the Plan.

(a) Employer employees who perform the following functions on behalf of the Plan are Responsible Employees: (1) claims determination and processing functions; (2) Plan vendor relations functions; (3) benefits education and information functions; (4) Plan administration activities; (5) legal department activities; (6) Plan compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions.

(b) In addition to those individuals described in subsection (a), the Plan HIPAA privacy officer and security official, and Employer employees to whom the Plan HIPAA privacy officer and security official have delegated any of the following responsibilities, shall also be Responsible Employees: implementation, interpretation, and amendment of the Privacy Policy; (2) Privacy Rule, Breach Notification Rule, or Security Rule training for Employer employees; (3) investigation of and response to complaints by Participants or Dependents, and/or employees; (4) preparation, maintenance, and distribution of the Plan's privacy notice; (5) response to requests by Participants or Dependents to inspect or copy PHI; (6) response to requests by Participants or Dependents to restrict the use or disclosure of their PHI; (7) response to requests by Participants or Dependents to receive communications of their PHI by alternate means or in an alternate manner; (8) amendment and response to requests to amend the PHI of Participants, Spouse or Dependents; (9) response to requests by Participants or Dependents for an accounting of disclosures of their PHI; (10) response to requests for information by the Department of Health and Human Services; (11) approval of disclosures to law enforcement or to the military for government purposes; (12) maintenance of records and other documentation required by the Privacy Rule, Breach Notification Rule, or Security Rule; (13) negotiation of Privacy Rule, Breach Notification Rule, and Security Rule provisions and/or reasonable security provisions into contracts with third-party service providers; (14) maintenance of Plan PHI or Electronic PHI security documentation; or (15) approval of access to Electronic PHI by Participants or Dependents.

8.4 Permitted Uses and Disclosures

Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the Plan, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Plan's own Payment and Health Care Operations functions;

(b) uses and disclosures for another HIPAA Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 CFR § 160.103, for the health care provider's treatment activities;

(d) disclosures to the Employer, acting in its role as Plan sponsor, of: (1) Summary Health Information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;

(e) disclosures of a Participant's or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR § 164.502(g);

(f) disclosures to a Participant's or Dependent's family members or friends involved in the Participant's or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's or Dependent's family in the event of an emergency or disaster relief situation;

(g) uses and disclosures to comply with workers' compensation laws;

(h) uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;

(i) disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;

(j) uses and disclosures for other governmental purposes, such as for national security purposes;

(k) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(l) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;

(m) uses and disclosures required by other applicable laws; and

(n) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR § 164.508.

8.5 Prohibited Uses and Disclosures

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.

(a) *Genetic Information.* Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility for benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

(b) *Employment-Related Actions.* Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

(c) *Other Benefits.* Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted in the Section entitled Permitted Uses and Disclosures, shall not be a permitted use or disclosure.

8.6 Certification Requirement

The Plan shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Plan agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described the Section entitled Permitted Uses and Disclosures, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

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

(j) to take reasonable steps to ensure that there is adequate separation between the Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

8.7 Mitigation

In the event of noncompliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

8.8 Breach Notification

Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR § 164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR § 164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR § 164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

Article IX. Recordkeeping and Plan Administration

9.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out in accordance with its terms for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

9.2 Powers of the Plan Administrator

The Plan Administrator shall have such authority and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate;

(f) to receive, review, and keep on file such reports and information concerning the Benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

9.3 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan will remain the obligation of the Employer.

9.4 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of this Plan.

9.5 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, the Plan Administrator shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of its duties shall be paid by the Employer.

9.6 Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third party administrative service provider, actuary, consultant, accountant, attorney, specialist or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, shall be paid by the Employer, provided, however, that each Participant shall bear the monthly cost (if any) charged by a third party administrator for maintenance of his or her HRA Account unless otherwise paid by the Employer.

9.7 Disbursement Reports

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

9.8 Timeliness of Payments

Payments shall be made as soon as administratively feasible after the required forms and documentation have been received by the Plan Administrator.

9.9 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

9.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the HRA Account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

Article X. General Provisions

10.1 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

10.2 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason.

10.3 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of Minnesota, to the extent not superseded by the Code, ERISA, or any other federal law.

10.4 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

Individual health insurance coverage that is paid for with amounts from the Plan is not subject to the rules and consumer protections of ERISA. Participants should contact their state insurance department for more information regarding their rights and responsibilities with respect to individual health insurance coverage.

10.5 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.6 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

10.7 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.8 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and shall not be construed as defining or limiting the meaning or construction of any provision.

10.9 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

10.10 Severability

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

Article XI. Notice of COBRA Continuation Rights

11.1 Introduction

HRAs sponsored by employers with 20 or more full-time employees are subject to COBRA. If your employer is subject to COBRA, this section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the HRA. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the HRA. It can also become available to other members of your family who are covered under the HRA when they would otherwise lose their coverage.

You may have other health coverage options as well. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage, and provide more coverage. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. You can learn more about many of these options at www.healthcare.gov or by calling 1-800-318-2596.

11.2 What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of HRA coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the HRA is lost because of the qualifying event. Under the HRA, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the HRA because either one of the following qualifying events happens:

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

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

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

Your dependent children will become qualified beneficiaries if they lose coverage under the HRA because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the HRA as a “dependent child.”

11.3 When is COBRA Coverage Available?

The HRA will offer COBRA continuation coverage to qualified beneficiaries only after your employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your employer will be aware of the qualifying event and you will not have to notify your employer.

11.4 You Must give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee or a dependent child’s losing eligibility for coverage as a dependent child), you must notify your employer within 60 days after the qualifying event occurs. You must notify your employer within 60 days of a qualifying event, such as divorce that would result in a loss of coverage for a dependent. Qualified beneficiaries that wish to continue coverage must notify your employer in writing. Your employer must notify qualified beneficiaries of the option to continue coverage within 10 days of receiving notice of a qualifying event.

Qualified beneficiaries have 45 days from the date of choosing continuation to pay the first continuation charges, except that surviving dependents of a deceased employee have 90 days to pay the first continuation charges. After this initial grace period, qualified beneficiaries must pay charges monthly in advance to your employer to maintain coverage in force.

11.5 Charges for Continuation

Charges for continuation will be equal to a premium determined by your employer plus a two (2) percent administration fee (if the qualifying event for continuation is the employee’s total disability, the administration fee is not required). Premiums are determined under section 4980B of the Internal Revenue Code. All charges are paid directly to your employer. Your employer will provide qualified beneficiaries, upon request, written verification of the cost of continuation coverage at the time of eligibility or at any time during the continuation period.

11.6 How is COBRA Coverage Provided?

Once your employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. Because the HRA will terminate on December 31, 2026, COBRA continuation coverage for your HRA will not extend beyond that date.

11.7 Non-Replication of Account Balance

Regardless of whether a qualifying event causes the family unit to separate, a qualified beneficiary can only elect to continue the coverage that existed before the qualifying event. Upon a qualifying event of divorce or loss of eligibility of a dependent, the spouse or former dependent losing coverage will continue to have access to the account balance that existed before the qualifying event until that account balance is depleted. Employer contributions that are made to the HRA following the election of continuation coverage by a former spouse or dependent will be separated into a subaccount. This means that Employer contributions made for the former spouse or dependent will not be available for use by the employee. Similarly, contributions made to the HRA for the employee after the divorce or a dependent child's loss of eligibility will not be available to the former spouse or dependent.

11.8 If You have Questions

Questions concerning your HRA or your COBRA continuation coverage rights should be addressed to your employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

11.9 Keep your Employer Informed of Address Changes

In order to protect your family's rights, you should keep your employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer.

Article XII. Other Legal Notices

12.1 HIPAA Privacy Rule Notice of Privacy Practices

The HRA is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the HRA's Notice of Privacy Practices (which summarizes the HRA's Privacy Rule obligations, your Privacy Rule rights, and how the HRA may use or disclose health information protected by the Privacy Rule) from the Plan Administrator. Your employer is the Plan Administrator of the HRA. HRA HIPAA privacy and security obligations are stated in a separate document(s), which is incorporated by reference.

12.2 Statement of ERISA Rights of HRA Participants

As a participant in the HRA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all HRA participants shall be entitled to:

1. Receive Information About Your HRA and Benefits.
2. Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the HRA and a copy of the latest annual report (Form 5500 series) filed by the HRA with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
3. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the HRA and copies of the latest annual report (Form 5500 series) and

the latest updated summary plan description. This Summary serves as the Plan Document for this benefit. The Plan Administrator may make a reasonable charge for the copies.

4. Receive a summary of the plan's annual financial report, if applicable (generally only employers with 100 or more employees are required to file an annual report). The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
5. Continue Group Health HRA Coverage. Continue health care coverage if there is a loss of coverage under the HRA as a result of a qualifying event. You or your eligible family members may have to pay for such coverage. Review this Summary for your HRA COBRA continuation rights.

Prudent Actions by HRA Fiduciaries. In addition to creating rights for HRA participants ERISA imposes duties upon the people who are responsible for the operation of this HRA. The people who operate your HRA, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other HRA Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit provided under this HRA or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of HRA documents or the latest annual report from the HRA and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the HRA's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

12.3 Administrative Information

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

Name of Plan: West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare Individual Coverage Health Reimbursement Arrangement Plan

Plan Administrator's Employer Identification Number (EIN): 93-3494224

Plan Number: 501

Plan Year: The Plan Year will be from January 1, 2026 to December 31, 2026. Subsequent Plan Years will be from January 1 to December 31.

Agent for Service of Process: Service may be made on the Plan Administrator at the address listed below.

Type of Plan: The Plan is intended to qualify as an individual coverage health reimbursement arrangement under final regulations allowing plan sponsors to offer individual coverage health reimbursement arrangements, subject to certain requirements, and guidance issued thereunder, and as subsequently defined by the IRS.

Type of Administration: The Plan Administrator pays applicable Benefits from the general assets of the Employer. The Plan is administered by employees of the Plan Sponsor and under an administrative services contract with a third-party administrator.

Funding: The Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which Benefits are paid.

Plan Administrator: West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare & 1405 Truax Blvd Eau Claire, WI 54703

Plan Sponsor: West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare & 1405 Truax Blvd Eau Claire, WI 54703

Named Fiduciary: West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare & 1405 Truax Blvd Eau Claire, WI 54703

Third Party Administrator (claims administrator): Gravie Administrative Services LLC, 10 NE 2nd Street, Suite 300, Minneapolis, MN 55413.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare Individual Coverage Plan, this Plan is executed on the 1st day of January 2026.

West Eau Claire Rehabilitation and Nursing Center LLC DBA Dove Healthcare

By : Tatum Everson
Tatum Everson (Feb 6, 2026 09:14:11 CST)

Date: Feb 6, 2026

Alex Stevens
Alex Stevens (Feb 6, 2026 09:20:27 CST)

Feb 6, 2026