The Presbytery of Blackhawk, Presbyterian Church (U.S.A.)

Health Reimbursement Arrangement Plan

(describing healthcare-expense reimbursement benefits
available to employees)

Effective [_____]

TABLE OF CONTENTS

Page

ARTICLE I DEFINITIONS 2

Benefits Plan 2
Claim Administrator 2
COBRA 2
Code 2
Dependent 2
Effective Date 2
Eligible Employee 2
Employer 3
Enrollment Form 3
Health Care Expense 3
HIPAA 3
HRA Account 3
Incurred 3
Participant 3
Period of Coverage 3
Plan 4
Plan Administrator 4
Plan Year 4
Primary Medical Plan 4
Prior Coverage 4
Qualifying Change in Status 4
Special Enrollment Event 5
Spouse 6

ARTICLE II ELIGIBILITY AND ENROLLMENT 6

2.01 Eligibility 6
2.02 Enrollment 6

ARTICLE III TERMINATION OF BENEFITS 7

3.01 Termination Date of Coverage 7
3.02 Coverage Following Severance 7
3.03 Leaves of Absence 7

ARTICLE IV REIMBURSEMENT BENEFITS 8

4.01 Provision of Benefits 8
4.02 Contributions and Funding 8
4.03 Limitations on Reimbursements and Forfeitures 8

4.04 Annual Limits 9
4.05 Expense Reimbursement Procedure 9
4.06 Coordination with Other Sources, Including Flexible Spending Accounts 10
4.07 Reimbursement After Termination (Run-Out) 10

ARTICLE V PAYMENT OF BENEFITS 10

5.01 Application for Benefits 10
5.02 Assignment of Benefits 10
5.03 Payment to Representative 11
5.04 Responsibility for Payment 11
5.05 Overpayments 11
5.06 Missing Person 11

ARTICLE VI ADMINISTRATION OF THE PLAN 11

6.01 Administration of the Plan 11
6.02 Appointment of Claim Administrator 12
6.03 Powers of the Plan Administrator 12
6.04 Claims Procedure 13
6.05 Records and Reports 14
6.06 Fiduciary Duty and Care 14
6.07 Limitation on Liability 14
6.08 Indemnification 14

ARTICLE VII DURATION AND AMENDMENT OF THE PLAN 15

7.01 Right to Amend 15
7.02 Right to Terminate 15

ARTICLE VIII MISCELLANEOUS 15

8.01 Effect on Employment 15
8.02 Effect on Benefits 15
8.03 Legal Compliance 15
8.04 Governing Law 16
8.05 Family Medical Leave Act 16
8.06 Uniform Services Employment and Reemployment Rights Act 16
8.07 Invalid Provisions 16

INTRODUCTION

The Presbytery of Blackhawk Health Reimbursement Arrangement (the "Plan") is established to provide eligible employees of Presbytery of Blackhawk Presbyterian Church (U.S.A.)] ("Employer") with the opportunity to receive reimbursement of certain health care expenses. This document constitutes the Plan, effective [_____].

This Plan is funded solely by the employer and reimburses qualified health care expenses of an employee and dependents up to a maximum amount established by the employer. The Plan is offered as a supplement to the employer's primary health insurance coverage. A participant must be enrolled in the primary health plan as a condition of participation in this Plan.

Blackhawk Presbytery reserves the right to alter, amend, modify or terminate the Plan in whole or in part, for Teaching Elder Employees or for other employees at any time for any reason in a manner consistent with the provisions of Article VII.

This Plan is sponsored by a church organization and is intended to be a church plan as defined in section 414(e) of the Internal Revenue Code, as amended ("Code") that has not made an election under section 410(d) of the Code and is therefore exempt from the requirements of the Employment Retirement Income Security Act of 1974 generally applicable to such plans.

As required by federal law, the marital status of an employee under this Plan must be determined by federal law, not state law. As a result, while a covered partner as defined under the Board's Benefits Plan may be entitled to coverage under those plans, only a spouse of an Eligible Employee as defined under Federal law will qualify for benefits as a spouse under this Plan unless the covered partner qualifies as a dependent under Section 152 of the Code.

This document, as it may be duly amended, shall constitute the Plan in its entirety. In the event any discrepancies exist between this document and any amendment, the amendment shall govern.

This Plan is intended to qualify as a "health reimbursement arrangement" within the meaning of IRS Notices 2002-45 and 2013-54, and as an "accident and health plan" within the meaning of section 105(e) of the Code, and any other pertinent laws or regulations, so that the benefits provided under the Plan shall be eligible for exclusion from each Employee's income for federal income tax purposes under section 105(b) of the Code. The provisions of this Plan shall be interpreted in accordance with that intent.

ARTICLE I

DEFINITIONS

The following capitalized words and phrases, when used in the text of this document and any attachment or materials incorporated herein or amendment hereto, have the meanings set forth below. Wherever any words are used in the singular form, they shall be construed as if they were also used in the plural form in all cases where the plural form would so apply, and vice versa. Where the definitions include rules regarding the definition, those rules shall apply.

Benefits Plan

Benefits Plan means the Benefits Plan of the Presbyterian Church (U.S.A.) administered by the Board of Pensions of the Presbyterian Church (U.S.A.)

Claim Administrator

Claim Administrator means Blackhawk Presbytery's Treasurer, General Presbyter, or Stated Clerk or others who from time to time may be appointed by the Employer, who shall process all or a designated portion of the claims under this Plan in accordance with the Plan's terms.

COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. Church plans are exempt from certain COBRA requirements applicable to medical or cafeteria plans. The Benefits Plan provides for medical continuation coverage that is comparable to COBRA coverage.

Code

Code means the Internal Revenue Code of 1986, as amended from time to time.

Dependent

Dependent means an Employee's covered partner and any individual who is a dependent of the Employee within the meaning of section 152 of the Code, as modified by statute, regulation, or otherwise.

Effective Date

Effective Date means [_____]. The Effective Date of any amendment or restatement is the effective date specified in the amendment or restatement.

Eligible Employee

Eligible Employee means an individual who is an Eligible Employee within the meaning of Section 2.01.

Employer

Employer means Presbytery of Blackhawk, Presbyterian Church (U.S.A.).

Enrollment Form

Enrollment Form means a form prescribed by the Plan Administrator for purposes of enrolling for coverage under the Plan.

Health Care Expense

Health Care Expense means any co-pay, deductible, or out-of-pocket expense incurred by a Participant, covered Dependent and Spouse that is an expense for medical care within the meaning of section 213(d) of the Code (including dental, vision and hearing), excluding expenses reimbursed by any other health care plan, and other expenses for which coverage under this Plan is proscribed by the Code or other applicable law. The Plan Administrator shall determine whether any other amount constitutes a Health Care Expense that qualifies for reimbursement hereunder.

Excluded from allowable health care expenses are cosmetic surgery and health club dues.

This Plan is intended to provide reimbursements for Health Care Expenses incurred by Eligible Employees.

HIPAA

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

HRA Account

HRA Account means the HRA Account described in the introduction

Incurred

Incurred means, with respect to Health Care Expenses, provided with health care services or supplies. Health Care Expenses are Incurred as of the date they are provided and not the date they are formally billed or charged or the date they are paid.

Participant

Participant means any Eligible Employee who meets the requirements for participation under this Plan and for whom coverage is in effect under this Plan or an individual who has elected continuation coverage under Section 3.04 and for whom coverage is in effect under this Plan.

Period of Coverage

Period of Coverage shall mean the Plan Year, except that:

(a) for Eligible Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 2.01; and

(b) for Eligible Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 2.02.

Plan

Plan means the Presbytery of Blackhawk, Presbyterian Church (U.S.A.) Health Reimbursement Arrangement, as described herein and as amended from time to time.

Plan Administrator

Plan Administrator means the person, persons or committee identified to serve as Plan Administrator in Section 6.01.

Plan Year

Plan Year means the period beginning January 1 and ending December 31.

Primary Medical Plan

Primary Medical Plan means the Medical Plan of the Presbyterian Church (U.S.A.).

Prior Coverage

Prior coverage means coverage under a group health plan or health insurance coverage that is subject to the requirements of HIPAA, other than coverage under a plan maintained by the Employer.

Qualifying Change in Status

Qualifying Change in Status means, as determined by the Plan Administrator, subject to any restriction under applicable law, the occurrence of one of the following events:

(a) an event that changes an Eligible Employee's legal marital status, including marriage, death of a covered partner, divorce or dissolution of a marriage or qualified covered partnership, legal separation, or annulment;

(b) an event that changes the number of an Eligible Employee's Dependents, including birth of a child, adoption, or placement for adoption or death of a Dependent;

(c) a termination or commencement of employment, a commencement of or a return from a leave of absence, or a change in work site of an Eligible Employee, covered partner of an Eligible Employee, or other Dependent of an Eligible Employee;

(d) a change in employment status of an Eligible Employee, covered partner of an Eligible Employee, or other Dependent of an Eligible Employee that causes the individual to become or cease to be eligible for this Plan;

(e) an event that causes the eligibility of an Eligible Employee's Dependent for coverage under this Plan to change, including attainment of a limiting age;

(f) a change in the residence or work site of an Eligible Employee, covered partner of an Eligible Employee, or other Dependent of an Eligible Employee; or

(g) another change that is determined by the Plan Administrator, consistent with the rules under section 125 of the Code and the regulations promulgated thereunder, to be an occurrence in the life or work of an Eligible Employee, the Eligible Employee's covered partner, or any other of the Eligible Employee's Dependents that would permit the Eligible Employee to elect, waive, or change coverage under this Plan during the Plan Year, including certain changes in benefits coverage for the Eligible Employee, covered partner of the Eligible Employee, or other Dependent of the Eligible Employee, including the elimination of coverage, loss of availability of coverage, substantial decrease in coverage (including material changes in availability of network providers), or other similar fundamental loss of coverage as determined by the Plan Administrator.

Special Enrollment Event

Special Enrollment Event means, with respect to any Eligible Employee as required under HIPAA, as amended:

(a) the marriage of the Eligible Employee; or

(b) the birth, adoption, or placement for adoption of a child of the Eligible Employee; or

(c) the qualifying loss of Prior Coverage by the Eligible Employee or a Dependent, so long as a statement is submitted to the Plan Administrator to such effect in accordance with the rules established by the Plan Administrator. For purposes of this definition, qualifying loss means:

  (i) if the Prior Coverage is provided under COBRA or the Benefits Plan medical continuation coverage, the exhaustion of such coverage; or

  (ii) if the Prior Coverage is not described in a statement as noted in Section (c), the loss of eligibility for such coverage or the termination of employer contributions toward the Prior Coverage; or

(d) the loss of eligibility for coverage in a Medicaid plan under Title XIX of the Social Security Act or a state child healthcare plan under Title XXI of the Social Security Act; and

(e) eligibility for assistance with coverage under a Medicaid plan under Title XIX of the Social Security Act or a state child healthcare plan under Title XXI of the Social Security Act.

Spouse

Spouse means "spouse" as defined under federal law.

ARTICLE II

ELIGIBILITY AND ENROLLMENT

2.01 Eligibility

Individuals enrolled in the Primary Medical Plan shall become eligible to participate in the Plan as follows:

(a) An individual who was an actively employed employee (including a teaching elder) on the day before the Effective Date shall be eligible to participate in this Plan beginning on the Effective Date of the Primary Medical Plan coverage.

(b) Each newly hired or re-employed active employee regularly scheduled to work at least 20 hours per week shall be eligible to participate in the Plan as of the 91st day after the commencement of employment. Teaching Elders are eligible to participate as of the effective date of employment.

(c) The term *Eligible Employee* does not include any employee who performs service for the Employer as a leased employee within the meaning of Code section 414(n) or 414(o), nor an employee who is an in-house temporary employee.

(d) No Eligible Employee shall become a Participant unless the Eligible Employee submits an Enrollment Form in accordance with the rules set forth in Section 2.02.

2.02 Enrollment

An Eligible Employee must be enrolled for coverage in the Board of Pensions, Presbyterian Church (U.S.A.) Medical Plan and submit a completed Enrollment Form to the Plan Administrator. Coverage is effective immediately for Teaching Elders and upon satisfactory completion of a probation period (up to 90 days) for lay employees.

ARTICLE III

TERMINATION OF BENEFITS

3.01 Termination Date of Coverage

An individual's participation in the Plan shall terminate as of the earliest of:

(a) the date the individual ceases to be enrolled in the employer's Primary Medical Coverage.

(b) the date of termination of this Plan;

(c) the date as of which this Plan is amended to terminate benefits with respect to a classification of employees of which the individual is a member;

(d) the date as of which the individual dies, retires or otherwise ceases to be an Eligible Employee; or

(e) the date as of which the individual enters the armed forces of any country on active, full-time duty, subject to any right to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994, as such Act may be amended from time to time.

Reimbursements after termination of participation in the Plan will be made in accordance with the run-out provisions of Section 4.08 or, if COBRA or other medical continuation coverage is available and elected, Section 3.04.

3.02 Coverage Following Severance

Coverage for an individual shall cease at the end of employment irrespective of any severance agreement.

3.03 Leaves of Absence

(a) An Eligible Employee who takes an unpaid leave of absence from his Employer shall continue to be an Eligible Employee to the extent and only to the extent provided in the personnel policies and practices of the Employer or elsewhere in this Plan.

If the Employee coverage under the Plan terminates during the period of unpaid leave, the Employee shall not be reimbursed for claims incurred during the leave period. Upon the Employee's return to employment, his pre-leave coverage shall be reinstated automatically. Upon reinstatement, coverage shall be reduced by the amount of reimbursements for claims incurred prior to the period of leave.

(b) An Eligible Employee who takes a paid leave of absence from his Employer shall continue to be an Eligible Employee hereunder and shall continue to participate during his leave of absence on the same basis, subject to the same terms and conditions, as he had participated immediately prior to his period of absence.

ARTICLE IV

REIMBURSEMENT BENEFITS

4.01 Provision of Benefits

(a) The benefits available under this Plan for a Plan Year shall take the form of reimbursements for Health Care Expenses Incurred during the Period of Coverage. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses incurred after the employee's participation has commenced and before the employee's participation has ceased.

(b) The Employer shall bear the entire expense of providing the benefits set forth in this Section 4.01. All payments shall be made from the general assets of the Employer, and no assets shall be earmarked or segregated for purposes of providing benefits. The Employer may establish rules, in addition to those hereunder, for minimum and maximum contributions that may be made on an annual, monthly, payroll period, or other basis.

4.02 Contributions and Funding

(a) The Employer will establish and maintain an HRA Account with respect to each Participant but is not required by law to maintain, and does not maintain, actual separate and discrete accounts for Participants under this Plan. All payments shall be made from the general assets of the Employer, and no assets shall be earmarked or segregated for purposes of providing benefits.

(b) The Employer may establish rules in addition to those already prescribed hereunder, for minimum and maximum contributions that may be made on an annual, monthly, payroll period, or other basis.

4.03 Limitations on Reimbursements and Forfeitures

Notwithstanding any provision of this Plan to the contrary, the Participant's reimbursement under this Plan for any Plan Year shall be limited to the smallest of the following:

(a) the Participant's Health Care Expenses for the Plan Year;

(b) the annual maximum amount described in Section 4.04.

(c) any limitation established with respect to the Participant pursuant to Section 4.06 or 8.02.

All contributions and limitations on reimbursement shall be prorated to reflect participation during a period shorter than the entire Plan Year.

4.04 Annual Limits

The annual maximum amount that a Participant may be credited to a Participant's HRA Account for an entire 12-month Plan Year is 6% of effective salary for Teaching elders and 6% of salary or budgeted annual wage. Unused amounts may not be carried over to the next Plan Year.

~~4.06~~4.05 Expense Reimbursement Procedure

Reimbursement of Health Care Expenses shall be made in accordance with the following rules:

(a) To receive reimbursement for Health Care Expenses under this Plan, a Participant must submit a written application to the Claim Administrator not later than 30 days following the end of the Plan Year in which such Health Care Expenses were incurred or billed to the Participant

(b) The Claim Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement.

Each request for reimbursement shall include:

(i) the name of the employee;

(ii) the name for whom the Health Care Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of that person to the Participant;

(iii) the name of the provider to whom the Health Care Expense was or is to be paid;

(iv) a statement that the Participant has not been reimbursed nor is reimbursable for the Health Care Expense by insurance or otherwise, and that the Participant has not been allowed a deduction for such Health Care Expense under section 213 of the Code;

(v) verification of expense by providing a bill, receipt, canceled check, explanation of benefits or other written evidence of payment or obligation to pay health care expenses.

The Claim Administrator reserves the right to require the Participant to provide, to the Claim Administrator's satisfaction, further proof of any of the

above-described information and other information reasonably necessary to determine the eligibility for and amount of any reimbursement under the Plan. The Claim Administrator may require the Participant to provide written authorization to obtain information from the Benefits Plan, any group medical, HMO, dental, vision care, prescription drug, or other health benefit plans in which Participant or his Dependents are enrolled.

4.06 Coordination with Other Sources, Including Flexible Spending Accounts

Reimbursement of Health Care Expenses under this Plan shall be permitted only to the extent that such Health Care Expenses have not been previously reimbursed and are not reimbursable from another source. To the extent that a Health Care Expense is reimbursable from another source, the other source shall provide reimbursement prior to any reimbursement from the HRA Account. For example, if a Participant's Health Care Expenses are covered by both this HRA and the Participant's health flexible spending account, then this HRA shall not reimburse the Participant for such Health Care Expenses until the amounts available for reimbursement from the Participant's flexible spending account have been exhausted.

4.07 Reimbursement After Termination (Run-Out)

When a Participant ceases to be a Participant in this Plan under Section 2.01 for any reason, the Participant shall not be eligible to be reimbursed from the HRA for Health Care Expenses incurred after the date on which participation terminates. However, such Participant may claim reimbursement for any Health Care Expense incurred during the Period of Coverage prior to termination of participation, provided that the Participant files a claim no later than 60 days following the close of the Period of Coverage in which the Health Care Expense was Incurred.

ARTICLE V

PAYMENT OF BENEFITS

5.01 Application for Benefits

To be entitled to reimbursement under this Plan, a Participant must comply with the rules the Claim Administrator has established for claiming benefits.

5.02 Assignment of Benefits

Except to the extent provided in this Plan, no benefit payable at any time under this Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment,

attachment, pledge or bankruptcy): the Plan, the Plan Administrator, the Claim Administrator and the Employer.

5.03 Payment to Representative

In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under this Plan, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under the Plan remain unpaid, the Plan Administrator may direct the Claim Administrator to make direct payment to the executors or administrators of the Participant's estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Plan and the obligations of the Plan Administrator, the Claim Administrator and the Employer.

5.04 Responsibility for Payment

It is the Participant's responsibility, in all cases, to pay for Health Care Expenses. Any benefit payment made directly to a Participant or the Participant's representative (as described in Section 5.03) for a Health Care Expense shall completely discharge all liability of this Plan, the Claim Administrator, the Plan Administrator and the Employer with respect to such expense.

5.05 Overpayments

If, for any reason, any benefit under this Plan is erroneously paid or exceeds the amount payable on account of a Participant's Health Care Expenses, the Participant shall be responsible for refunding the overpayment to the Plan. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable under the Plan, or any other method as the Plan Administrator, in its sole discretion, may require.

5.06 Missing Person

If, within two years after any amount becomes payable under this Plan to a Participant, the Participant has not accepted or been available to receive the reimbursement, the amount shall be forfeited to the Employer and shall cease to be a liability of this Plan, provided an appropriate level of care shall have been exercised by the Plan Administrator in attempting to make such payment.

ARTICLE VI
ADMINISTRATION OF THE PLAN

6.01 Administration of the Plan

The Personnel Committee of Blackhawk Presbytery shall serve as Plan Administrator responsible for the administration of the Plan and shall be a named fiduciary of this Plan

and shall make all determinations under the eligibility provisions set forth in Article II of the Plan.

6.02 Appointment of Claim Administrator

The Treasurer shall serve as the primary Claim Administrator. The General Presbyter and Stated Clerk as alternative Claim administrators. The Claim Administrator shall have the authority to process all portions of claims under this Plan in accordance with its terms. Each Claim Administrator shall have the authority and discretion to interpret the Plan with respect to its duties and to decide questions and disputes arising under the Plan with respect to such duties, which interpretations and decisions shall be final and binding for purposes of the Plan, subject to any right of Participants to appeal the interpretation and decisions under this Plan.

6.03 Powers of the Plan Administrator

The Plan Administrator is specifically given the discretionary authority and such powers as are necessary for the proper administration of this Plan, including, but not limited to, the following:

(a) to make claim decisions and benefit payments or direct the Claim Administrator to process all or a designated portion of claims and to make benefit payments to or on behalf of Participants entitled to benefits under this Plan;

(b) to have the authority and discretion to interpret the Plan, to decide questions and disputes, to supply omissions, to correct defects, and to resolve inconsistencies and ambiguities arising under the Plan, which interpretations and decisions shall be final and binding for purposes of this Plan;

(c) to obtain from Participants and others, such information as shall be necessary for the proper administration of this Plan, such as proof of other coverage and financial data needed to determine if an individual qualifies as the Dependent of an employee (e.g., income tax returns);

(d) to retain the right, authority, and discretion to make claim payment and benefit decisions upon appeal to the extent it has the authority to make such appeal determinations under Section 6.04;

(e) to prescribe forms and procedures for enrollment, claim filing, and other administrative purposes under the Plan and to require their use for such purposes and, notwithstanding anything in this Plan to the contrary, to the extent permitted by applicable law, to establish and maintain a procedure whereby any submission requiring a written form may be made telephonically or electronically and whereby submissions made in accordance with such procedure shall be deemed to have been made as if on the applicable written form;

(f) to adopt rules for the administration of the Plan; and

(g) to maintain records of administration of the Plan.

No determination of the Plan Administrator or the Claim Administrator in one case shall create a bias or retroactive adjustment in any other case.

6.04 Claims Procedure

The Claim Administrator shall review claims for benefits under this Plan and respond thereto within 30 days after receiving the claim. This period may be extended one time for up to 15 days. The Claim Administrator shall provide to every claimant who is denied a claim for benefits written notification setting forth:

(a) the specific reason or reasons for the denial;

(b) specific reference to pertinent Plan provisions upon which the denial is based;

(c) a description of any additional material or information necessary for the claimant to perfect the claim;

(d) if an internal rule, guideline, or protocol was relied upon in making the determination, a copy of the rule, guideline, or protocol or a statement that it will be provided free of charge upon request; and

(e) an explanation of the claim review procedure set forth below.

The claimant or the claimant's duly authorized representative may request a full and fair review of the claim by the Plan Administrator. The claimant's request for review by the Plan Administrator must be submitted to the Plan Administrator in writing within one hundred eighty (180) days of the claimant's receipt of a notice of denial from the Claim Administrator.

The review of a claim by the Plan Administrator shall be subject to the following rules. The claimant or the claimant's duly authorized representative may review pertinent documents and may submit issues and comments, including without limitation appropriate evidence or testimony of an expert, in writing. The review will not afford deference to the initial adverse benefit determination. The review will not be conducted by the individual who made the adverse benefit determination or by that individual's subordinate. The Plan Administrator shall make a decision promptly, and not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing and shall include specific reasons for the decision, and specific references to the pertinent Plan provisions on which the decision is based.

In the event that the Claim Administrator or Plan Administrator does not make a determination with respect to a claim within the time limit prescribed by this Section, the claim or appeal of such claim decision shall be deemed denied.

6.05 Records and Reports

The Claim Administrator and Plan Administrator shall maintain all such books, accounts, records and other data as may be necessary for the proper administration of this Plan.

The Plan Administrator shall make available to each Participant for examination at reasonable times during normal business hours such records under the Plan in its possession as pertain to him.

6.06 Fiduciary Duty and Care

All fiduciaries under this Plan, including the Claim Administrator and the Plan Administrator, shall discharge their respective fiduciary responsibilities solely in the interest of the Participants of this Plan for the exclusive purpose of providing benefits to Participants and defraying the reasonable expenses of administering this 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 such matters would use in the conduct of an enterprise of a like character and with like aims and in accordance with the provisions of this Plan.

6.07 Limitation on Liability

A Plan fiduciary shall be entitled to rely upon information from any source assumed reasonably and in good faith to be correct. The Employer, Plan Administrator and Claims Administrator shall not be subject to any liability with respect to his duties under this Plan unless it acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission to act of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

6.08 Indemnification

To the extent permitted by law, the Employer shall indemnify and hold harmless each director, officer, or employee of the Employer to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs, and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities, and obligations under this Plan, other than such liabilities, costs, and expenses as may result from the gross negligence or willful misconduct of any such person or amounts paid by such person in a settlement to which the Employer does not consent. The Employer may obtain, pay for and keep current a policy or policies of insurance, insuring any of its employees who has any fiduciary responsibility with respect to this Plan from and against any and all liabilities, costs, and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities, and obligations under this Plan.

ARTICLE VII

DURATION AND AMENDMENT OF THE PLAN

7.01 Right to Amend

The Employer reserves the right to amend the Plan at any time, in any manner, including, without limitation, the right to amend the Plan to reduce, add to or modify the type and amount of benefits provided for any and all Participants. Any amendment shall be formally adopted in writing.

7.02 Right to Terminate

Although the Employer intends to maintain this Plan for an indefinite period, the Employer reserves the absolute right to terminate or partially terminate the Plan at any time, for any reason. Any termination or partial termination of the Plan shall not adversely affect the payment of benefits to which a Participant was entitled under the Plan prior to the date of termination or partial termination. If the Plan is terminated, each Participant shall be entitled to benefits for Health Care Expenses Incurred prior to the date of termination, provided that the Participant appropriately follows the terms of this Plan for reimbursement. Thereafter, the Employer shall have no liability or obligation to make any reimbursements under the Plan.

ARTICLE VIII
MISCELLANEOUS

8.01 Effect on Employment

Nothing in this Plan shall be construed as a contract of employment between the Employer and any of its employees. Participation in this Plan shall not lessen or otherwise affect the responsibilities of such an employee to perform fully his duties in a satisfactory and businesslike manner, nor shall it affect the Employer's right to discipline, discharge, or take any other action with respect to such an employee.

8.02 Effect on Benefits

Nothing in this Plan shall be construed as a guarantee that the Employer will continue to provide benefits to employees in the future.

8.03 Legal Compliance

The Employer may prospectively limit, reallocate or deny any benefit for a Participant or any group of Participants to the extent necessary to avoid discrimination under or otherwise comply with any pertinent provision of the Code or other applicable law.

8.04 Governing Law

This Plan shall be governed by and construed in accordance with applicable federal laws and, to the extent not superseded, with the laws of the State of Illinois. Benefits provided under this Plan are intended to be exempt from taxation under section 105 of the Code, and the Plan is intended to comply with any other Code sections as may be applicable to church plans for purposes of retaining such tax exemption.

8.05 Family Medical Leave Act

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Treasury Regulation section 1.125-3.

8.06 Uniform Services Employment and Reemployment Rights Act

Notwithstanding any provision of this Plan to the contrary, contributions, benefits, and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

8.07 Invalid Provisions

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Executed this _____ day of _____, 20____.

_____
EMPLOYER

By: _____
Name:
Title: