Health Reimbursement Arrangement for Active Employees

PLAN DOCUMENT

The Plan's Original Effective Date is _____. The Plan's Restated Effective Date is _____. The Plan is available to Employees of the Employer effective _____.

SAMPLE

MidAmerica
Administrative & Retirement Solutions

Plan Document Table of Contents

Page

Introduction 3

Legal Status 3

Participation 3

Participation Opt Out 3

Benefits and Eligibility for Benefits 4

Funding 4

Interest Credit 5

Vesting 5

Continuation Coverage 5

Plan Investments 5

Plan Administrator 5

Administrative Fees 5

Administration 6

Death Benefit 7

Plan Amendments 7

Involuntary Access to Funds 7

Plan Termination 7

HIPAA Compliance 7

Claims Procedure 9

SAMPLE

Introduction

The Employer has established and adopted the MidAmerica Administrative & Retirement Solutions, Inc. Health Reimbursement Arrangement (the "Plan") to enable Participants and their dependents to be reimbursed tax-free for eligible medical and dental expenses. Contributions to the Plan shall be made by the Employer and credited to Participants' accounts. Claims for reimbursement shall be processed and reimbursements paid out on a tax-free basis for medical expenses in accordance with Internal Revenue Service Guidelines for Health Reimbursement Agreements, IRS Publication 502, Internal Revenue Code (the "Code") Sections 213(d), 105 and 106 as described in Revenue Ruling 2002-41 and IRS Notice 2002-45.

Legal Status

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and regulations issued thereunder, as a health reimbursement arrangement as described in IRS Notice 2002-45 and Revenue Ruling 2002-41, and to comply with IRS Notice 2013-54 and shall be interpreted to accomplish those objectives. The expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants' gross income under Code Section 105(b).

Notwithstanding anything to the contrary, the portion of the Plan that reimburses Highly Compensated Individuals, as defined in Code Section 105(h), for premiums paid under an insured plan shall be treated as a separate plan that is not subject to the requirements of Code Section 105(h), pursuant to Treasury Regulation Section 1.105-11(b)(2).

Participation

Employees of the class or classes set forth by the Employer in the Plan Adoption Agreement will be Participants in the Plan. Notwithstanding any election in the Plan Adoption Agreement to the contrary, Employees of the class or classes set forth by the Employer in the Plan Adoption Agreement who are Highly Compensated Employees, as defined in Code Section 105(h), and whose benefits exceed those of other Plan Participants, will be Participants only in that portion of the Plan that reimburses Participants for "premium only medical expenses," as described below. Under no circumstances are such individuals eligible for reimbursements of any medical and dental expenses other than premium expenses. For purpose of this section, a retiree who was a Highly Compensated Individual prior to his or her retirement from the Employer shall be treated as a Highly Compensated Individual thereafter and during retirement.

Participation Opt Out

At least once per Plan Year, Participants shall be entitled to permanently opt out of participation in the Plan. Any such opt out will result in the forfeiture of the Participant's account balance, including any vested funds, and the waiver of any future reimbursements from the Plan. The Participant may, however, continue to submit claims for reimbursement of expenses incurred prior to the opt out date, pursuant to the Run-Off Times section of the Plan Adoption Agreement. Any forfeited amount shall be applied as elected by the Employer in the Plan Adoption Agreement.

In the event that the Participant terminates employment with the Employer, the Participant shall be entitled to permanently opt out of participation in the Plan at the time of termination. In addition to the forfeiture of unvested funds as provided for in the Forfeiture section of the Plan Adoption Agreement, any such opt out will result in the forfeiture of any vested funds and the waiver of any future reimbursements from the Plan. The Participant may, however, continue to submit claims for reimbursement of expenses incurred prior to the opt out date, pursuant to the Run-Off Times section of the Plan Adoption Agreement. Any forfeited amount shall be applied as elected by the Employer in the Plan Adoption Agreement.

SAMPLE

Benefits and Eligibility for Benefits

A Participant shall be entitled to reimbursements of eligible medical and dental expenses upon the occurrence of the event selected in the Plan Adoption Agreement, but in no event until after expenses exceeding the dollar amount of any flexible spending arrangement ("FSA") in which the Participant shall also participate have been paid, or, if the medical or dental expense is reimbursable from a health savings account ("HSA"), amounts shall only be available from this Plan in accordance with paragraph 9 of the Administration section herein.

If the Employer indicates in the Adoption Agreement that Reimbursements shall be for "all eligible section 213(d) medical expenses," eligible medical and dental expenses for purposes of this Plan are those expenses that are:

a. incurred by the Participant, spouse or tax dependent (as defined in paragraph 9 of the "Administration" section);

b. incurred for Medical Care - "Medical Care" shall have the same meaning as in section 213(d) of the Code, and shall include: (i) amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, except that eligible medical and dental expenses shall specifically exclude expenses for a medicine or drug incurred on or after January 1, 2011, unless such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin, and (ii) premiums for medical and dental coverage, including premiums under part B and part D of title XVIII of the Social Security Act (relating to supplementary medical insurance for the aged and prescription drug coverage, respectively); and

c. not compensated through insurance and not paid for with a tax-free distribution from a Medical Savings Account (MSA), Health Savings Account (HSA), or Health Flexible Spending Arrangement and not attributable to a deduction allowed under Code section 213(d) for any prior taxable year.

If the Employer indicates in the Adoption Agreement that reimbursements shall be for "premium only medical expenses," eligible medical and dental expenses for purposes of this Plan are those expenses that are:

a. incurred by the Participant, spouse or tax dependent (as defined in paragraph 9 of the "Administration" section);

b. premiums for medical and dental coverage, including premiums under part B and part D of title XVIII of the Social Security Act (relating to supplementary medical insurance for the aged and prescription drug coverage, respectively); and

c. not paid for with a tax-free distribution from a Medical Savings Account (MSA) or Health Savings Account (HSA) and not attributable to a deduction allowed under Code section 213(d) for any prior taxable year.

Funding

All funds for the Plan shall come exclusively from the Employer and shall constitute either a specified dollar amount and/or a specific percentage of Employees' compensation or retirement pay as the Employer shall from time to time determine. The amount or percentage to be determined by the Employer shall be subject to, and not in contravention of, the Employer's obligations to its Employees. Subject to any vesting schedule which may be elected in the Plan Adoption Agreement, all funds in the Plan belong to the individual Participants as allocated to their accounts. Also subject to any vesting schedule which may be elected in the Plan Adoption Agreement, once funds are allocated to the Plan, the Employer relinquishes all right, title, control, and interest to such funds.

SAMPLE

Interest Credit

Interest shall be credited on a daily basis to Participant accounts based on the rate credited by the underlying AUL fixed annuity investment option. If variable annuity investments are allowed pursuant to the Adoption Agreement, earnings and losses shall be credited on a daily basis based on the investment funds selected.

Vesting

Funds in a Participant's account shall vest and be available to pay eligible medical expenses in accordance with the vesting schedule elected by the Employer in the Plan Adoption Agreement. If a Participant is not fully vested in his account balance when participation hereunder of the Participant and his surviving spouse and/or dependents ends as described in the section hereof entitled "Death Benefit," any forfeited amount shall be applied as elected by the Employer in the Plan Adoption Agreement.

Continuation Coverage

COBRA continuation coverage ("COBRA coverage"). COBRA coverage shall be available on the same terms and conditions as described herein with respect to Participants upon payment of the applicable COBRA premium. Each qualified beneficiary (i.e., the Participant's former spouse and former eligible dependents) shall be entitled to COBRA coverage for a period of 36 months upon the qualifying event of death of Participant, divorce from Participant, or a dependent reaching an age under which he/she is ineligible under the terms of the Plan. The level of coverage will be the Participant's account balance at the time of the qualifying event (adjusted for investment earnings and losses), plus Employer contributions and minus reimbursements for claims paid from the account. Contributions shall be made at the same times as they are made for similarly situated Participants who have not experienced a qualifying event. The balance of the Participant's account shall be available to all qualified beneficiaries electing continuation coverage on an aggregate basis.

The COBRA premium shall be a single premium regardless of the number of qualified beneficiaries electing COBRA coverage. That premium shall be determined annually by the Employer. The Employer shall have no obligation to pay any portion of the COBRA premium.

Coverage in lieu of COBRA. As an alternative to COBRA continuation coverage, qualified beneficiaries may choose to continue to access the Participant's account via coverage in lieu of COBRA. No additional contributions will be made to the Participant's account during the coverage in lieu of COBRA period and no premium will be charged for the coverage. Administrative fees as indicated herein will be applied. The balance of the Participant's account shall be available to all qualified beneficiaries electing coverage in lieu of COBRA on an aggregate basis. Furthermore, if some qualified beneficiaries elect COBRA and others select coverage in lieu of COBRA, all qualified beneficiaries will have access to the Participant's account on an aggregate basis.

Plan Investments

Plan investments will be made in accordance with the Employer's elections in the Plan Adoption Agreement, and will consist of investments in either fixed or variable annuities.

Plan Administrator

The Employer designates as the initial Plan Administrator the entity named in the Plan Adoption Agreement. The initial Plan Administrator shall serve as Plan Administrator until such time as a new Plan Administrator is appointed.

Administrative Fees

An administration fee shall be payable by the Employer. Participants may be charged a distribution fee by the Plan's administrative services provider in such amount as shall be agreed to by the Employer.

SAMPLE

Administration

1. Health reimbursement requests may be made monthly with no minimum reimbursement dollar amount for recurring claims. There is a $100 minimum claim amount for all other claims unless the participant account balance is less than $100. Additionally, a reimbursement request can only be made for expenses incurred subsequent to the date the Participant first becomes enrolled in the Plan.

2. Participants are entitled to request reimbursements from their accounts as soon as the accounts are funded by the Employer, but only for medical expenses incurred subsequent to the date the Participant first becomes enrolled in the Plan. Hardship withdrawals or loans are not permitted under this Plan and Plan funds may only be used to reimburse Participants and their dependents for qualified medical expenses.

3. In order to receive reimbursement for eligible medical expenses, Participants shall provide the Plan Administrator with whatever information is reasonably required. This Plan shall not and cannot reimburse for any claims other than those allowed under Code Section 213(d) and the regulations thereunder, as generally described in IRS Publication 502.

4. When a request is approved it shall be scheduled for disbursement. Disbursements shall be made not later than the fifteenth (15th) day of each month for all reimbursement requests received by the Plan Administrator prior to the end of the preceding month.

5. Subject to the Claims Procedure rules below, decisions of the Plan Administrator shall be final on the issue of eligible expenditures and such decisions shall be based on Code Section 213(d) and the regulations thereunder, as interpreted by the IRS and court rulings or directives concerning the deductibility of medical expenses for Federal Income Tax purposes, which interpretations shall be controlling for purposes of determining reimbursement eligibility under this Plan.

6. Other than establishing this Plan and providing funding for the Plan, the Employer does not assume any responsibility for any aspect of any Participant's health care. Participant questions shall be directed to the Plan Administrator.

7. Each Participant shall be notified by the Plan Administrator of his or her account balance at the time a deposit is made to his or her account. The Plan Administrator shall provide each Participant with a quarterly statement setting forth the Participant's account balance and earnings and disbursements for the quarter. Additionally, the Plan Administrator shall provide a Participant with a statement of account balance in conjunction with each reimbursement distribution.

8. Funds in a Participant's account at the end of each year shall be rolled into the following year.

9. Reimbursement is available for the Participant, the Participant's spouse, the Participant's tax dependents as defined in Internal Revenue Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and any child (as defined in Code Section 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age twenty-seven (27). For purposes of this Plan, such qualified tax dependents and children shall collectively be referred to as "dependents." Submission of a request for reimbursement on behalf of someone other than the Participant shall be deemed a representation by the Participant that the request for reimbursement is made on behalf of a spouse or dependent.

10. Any act, practice, or omission by a Participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the terms of the Plan and the Plan may rescind coverage as a result.

SAMPLE

Death Benefit

If a Participant dies prior to exhausting his vested account balance, the Participant's surviving spouse and/or dependents are eligible to be reimbursed under this Plan for their eligible medical expenses until the vested account balance is exhausted. In the event of the death of the Participant, the Participant's spouse, and all of the Participant's qualifying dependents, any funds remaining in the account shall be forfeited. Forfeitures shall be applied as elected by the Employer in the Plan Adoption Agreement.

Plan Amendments

The Employer has the authority to amend this Plan at any time, in whole or in part. Participants will be notified of any Plan changes. Any amendment to the Plan shall not adversely affect the rights of existing Participants. Changes imposed by the Internal Revenue Service, either by law change, regulations, or rulings, will be effective immediately and without notice.

Involuntary Access to Funds

Funds in a Participant's Plan account are not assignable by a Participant, either in law or in equity, or subject to estate tax, or to execution, levy, attachment, garnishment, or any other legal processes.

Plan Termination

In the event the Employer elects to terminate this Plan, which it may do, in its sole discretion, at any time and for any reason, amounts credited to Participants' accounts will remain in the Participants' accounts and Participants will continue to utilize their accounts as set forth in this Plan Document until their accounts are exhausted.

HIPAA Compliance

1. Disclosure of Summary Health Information to the Employer

   In accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued and pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), the Plan may disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

   "Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information ("PHI") to the Employer for Plan Administration Purposes

   In order that the Employer may receive and use a Participant's individually identifiable health information or PHI (including electronic PHI) for "Plan Administration" purposes, the Employer agrees to:

   a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

   b. Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

SAMPLE

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware, including any security incident or actual or suspected breach that may compromise PHI;

e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

i. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI;

j. If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such 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 the PHI infeasible; and

k. Ensure that adequate separation between the Plan and the Employer, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

   i. The employees, or classes of employees, or other persons under control of the Employer who are identified in the Plan Adoption Agreement, shall be given access to the PHI to be disclosed.

   ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Employer performs for the Plan.

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

   "Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to

SAMPLE

modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

3. Disclosure of Certain Enrollment Information to the Employer

Pursuant to Section 164.504(f)(l)(iii) of the Privacy Standards (45 CFR 164.504(f)(l)(iii)), the Plan may disclose to the Employer information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Employer.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Employer hereby authorizes and directs the Plan, through the Plan Administrator or its third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) as directed by the Employer for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan, provided that genetic information will not be used for underwriting purposes. Such disclosures shall be made in accordance with the Privacy Standards. The Employer certifies that such disclosures are for Plan administration purposes and that any third party to whom the Employer directs disclosure from the Plan has agreed to also comply with this amendment, as set out in Section 2.b.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

Claims Procedure

A Participant, spouse or dependent (the "Claimant") shall apply for Plan benefits in writing on a form provided by the Plan Administrator, or in such other manner as prescribed by the Plan Administrator. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures. Claims shall be evaluated by the Plan Administrator or such other person or entity designated by the Plan Administrator and shall be approved or denied in accordance with the terms of the Plan and Plan Adoption Agreement. All references to the Plan Administrator shall include any such delegate. No Claimant shall be entitled to benefits unless the Plan Administrator or its delegate determines in its discretion that the Claimant is entitled to benefits.

1. Claims

The Plan Administrator shall make a determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information and the period for making the benefit determination shall be tolled from the date on which the notice of extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information, or the deadline to submit the additional information, if earlier.

SAMPLE

2. Notice of Denial

If the claim is denied in whole or in part, the Claimant will receive a written notice that includes:

a. The specific reason or reasons for the denial;

b. Reference to the specific Plan provision(s) on which the denial is based;

c. A description of any additional material or information needed from the Claimant in connection with the claim and the reason such material or information is needed;

d. An explanation of the claims review procedures and the applicable time limits, including a statement concerning the Claimant's right to bring a civil action following an adverse determination on review;

e. A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (or a statement that a copy will be provided free upon request);

f. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (or a statement that a copy will be provided free upon request); and

g. Any other information required by law.

3. Right to Request Review: Internal Appeal

The Claimant must make a written request for review to the Plan Administrator within 180 days of the initial denial of the claim. If a written request for review is not made within such 180 day period, the Claimant shall forfeit his or her right to review. The Claimant's written request for review may (but is not required to) include issues, comments, documents, and other records the Claimant wants considered in the review. All such information the Claimant submits will be taken into account on review, even if it was not reviewed as part of the initial decision. The appeal will be conducted by a person different from the person who made the initial decision. No deference will be given to the initial decision. The Claimant may ask to examine or receive free copies of Plan documents, records, and other information relevant to the claim by asking the Plan Administrator.

The Claimant will be given the identity of medical or vocational experts if requested, whose advice was obtained by the Plan in connection with the Claimant's initial claim denial, if any, even if their advice was not relied upon in making the initial decision. Where an adverse determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Plan will consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide the Claimant's appeal. The Plan Administrator reserves the right to delegate its authority to make decisions.

4. Decision Upon Review: Internal Appeal

The Plan Administrator shall make a determination within a reasonable period of time, but not later than 60 days after receipt by the Plan of the Claimant's request for review of adverse determination.

5. Notice of Denial of Internal Appeal

If the decision on the appeal is denied, the Claimant will receive a written notice that includes:

SAMPLE

a. The specific reason or reasons for the denial;

b. Reference to the specific Plan provisions on which the denial is based;

c. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;

d. A statement explaining any voluntary appeal procedures offered by the Plan and the Claimant's right to bring a civil action;

e. A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (or a statement that a copy will be provided free upon request);

f. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (or a statement that a copy will be provided free upon request); and

g. Any other information required by law.

6. External Appeal Process

Where required by law, a Claimant may be able to file an external appeal with an independent review organization. The independent review organization may overturn the Plan's decision, and the independent review organization's decision will be binding on the Plan. A Claimant must file a claim for external review within four (4) months of the date the Claimant receives the internal appeal denial notice. Filing a request for external review will not affect a Claimant's ability to bring a legal claim in court. When a Claimant files a request for external review, the Claimant will be required to authorize release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. Additional information on the external review process, where applicable, will be included in the internal appeal determination notice, or the Claimant may contact the Plan Administrator to request such additional information.

SAMPLE

IN WITNESS WHEREOF, this Plan has been executed this ___ day of _____, 20___, by **MidAmerica Administrative & Retirement Solutions, Inc.**

MIDAMERICA ADMINISTRATIVE & RETIREMENT SOLUTIONS, INC.

By: _____

Its: SVP Business Development

IRS Circular 230 Notice: We are required to advise you no person or entity may use any tax advice in this communication or any attachment to (i) avoid any penalty under federal tax law or (ii) promote, market or recommend any purchase, investment or other action.