MEDICAL EXPENSE REIMBURSEMENT PLAN (MERP)

MEDICAL EXPENSE REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

AS ADOPTED BY:

COMMUNITY ACTION COMMITTEE OF PIKE

EFFECTIVE 10/01/2014

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INTRODUCTION

Community Action Committee of Pike (the "Employer") has established a plan known as a "Medical Expense Reimbursement Plan" (the "Plan" or "Medical Expense Reimbursement Plan (MERP)"). Medical Expense Reimbursement Plan (MERP) is designed to reimburse eligible employees (those that are participating in the Employer's Insured Health Plan) for a portion of their and their covered dependents' health claims that count toward the deductible under Employer Insured Health Plan.

This Summary Plan Description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. This is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. If there is a conflict between the plan documents and this summary, the plan documents will apply.

PART I
GENERAL INFORMATION ABOUT THE MEDICAL EXPENSE REIMBURSEMENT PLAN

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to reimburse employees covered under the Plan for a portion of the medical expenses they incur each year which count toward the deductible under the Employer's Insured Health Plan to the extent that they are incurred while they are employed with the Employer and the Plan remains in effect.

Q-2. When did the Plan take effect?

The Plan became effective on 10/01/2014.

Q-3. Who can participate in the Medical Expense Reimbursement Plan (MERP) Plan?

Each full-time employee of the Employer who is eligible to participate in the Employer's Insured Health Plan is eligible to participate in the Medical Expense Reimbursement Plan (MERP)Plan. A full-time employee is an employee who is regularly scheduled to work 17.5 hours per week. Participation in the Medical Expense Reimbursement Plan (MERP) Plan is automatic upon the employee's Participation in the Employer's Insured Health Plan. Participation in Medical Expense Reimbursement Plan (MERP) shall terminate on the earliest of : i) the date an Employee ceases to be an Employee; ii) when an Employee ceases to meet the eligibility requirements of this Plan (e.g., the Employee loses coverage under the Insured Health Plan by failing to pay any applicable premium); and iii) the date this Plan is amended to exclude the Employee or is terminated.

Q-4. What does the term Out-of-Pocket mean?

"Out-Of-Pocket" means the total amount of Eligible Medical Expenses to be paid by either the employee or the employer, which is typically the sum of the Deductible Amount plus the Co-Insurance Amount (Co-Insurance Rate multiplied by the Co-Insurance Corridor). The Out-of-Pocket can also include specific types of employee pay or employee or employer expenses that may be itemized on the Plan's Annual Benefit Summary.

Q.5 What amount of Eligible Medical Expenses may be reimbursed by Medical Expense Reimbursement Plan (MERP) each Year?

5080.00 for an Employee Only tier and no more than 10160.00 for a Family tier.

Community Action Committee of Pike has purchased a High Deductible Health Plan from UnitedHealthCare. The UnitedHealthCare plan has a $6350.00 in-network Deductible. A family must meet 2 deductibles and will have a total out-of-pocket cost of $12,700.00.

CAC of Pike County MERP Plan

To reduce your out-of-pocket costs Community Action Committee of Pike has established the CAC of Pike County MERP Plan under which your actual out-of-pocket expenses include a $0.00 individual in-network deductible with a family required to meet 2 deductibles.

After the individual $0.00 deductible, this plan will pay 80% of eligible expenses up to a total reimbursement of $5080.00 for an individual and $10160.00 for a family.

There is no reimbursement for Out of Network Claims. PLEASE NOTE: YOU HAVE 90 DAYS FROM THE END OF THE PLAN YEAR 9/30 (DECEMBER 29TH) TO TURN IN CLAIMS THAT WERE INCURRED FROM 10/1 TO 9/30 OF THE PRIOR PLAN YEAR. For example: Claims from 10/1/13 to 9/30/14 need turned in before December 29th, 2014.

Q-6. What is an Eligible Medical Expense?

Eligible Medical Expenses are those expenses incurred by the Employee, or the Employee's Dependents, after the date of the Employee's participation in the Employer's Insured Health Plan and in Medical Expense Reimbursement Plan (MERP). Such expenses must be incurred during the Plan Year and otherwise allowable as deductions under Code Sec. 213 (without regard to the limitations contained in Sec. 213(a)). Such expenses must also be covered expenses which count toward the satisfaction of the Employee's annual deductible, 0.00 in-network, under the Employer's Insured Health Plan for medical expenses. Once the employer's maximum annual payment of 5080.00 in-network for an Employee Only tier under the Insured Health Plan is exceeded, medical expenses become fully reimbursable under Insured Health Plan, and no further Benefits shall be payable under Medical Expense Reimbursement Plan (MERP). For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense. You will not receive reimbursement under this Plan until you have satisfied this Plan's annual deductible of 0.00.

Q-7. How do I receive Benefits under the Plan

EXAMPLE 1:

Bob's employer has a group policy with the insurance carrier for a $6350.00 deductible with a co-insurance band of 20% with a total participant out-of-pocket of $12700.00 . Bob has a deductible of $0.00 under his employer's Medical Expense Reimbursement Plan.

If Bob has a claim of $700, he files the claim with the insurance company as he always has. Bob will send Patrick Benefit Administrators a copy of the Explanation of Benefits showing how the insurance company has applied the claim to the In-Network plan. Patrick Benefit Administrators will then process the claim for the employer. The first $0.00 is applied to the deductible. Any remaining amount will be paid by the plan at a 80% coinsurance rate.

Your employer has contracted with Patrick Benefit Administrators to process the claims on its behalf. Please note that it is not necessary that you have actually paid an amount due for Eligible Medical Expense -- only that you have incurred the expense, that you have submitted it to UnitedHealthCare, that it has been processed and reported by them via the EOB, and that it is not being paid for or reimbursed from any other source.

Q-8. When must the expenses be incurred for which I may be reimbursed?

Eligible Medical Expenses must have been incurred during the Plan Year 10/1 through 9/30. You may not be reimbursed for any expenses arising before the Plan became effective, before you became covered under the Plan (at the time you became covered under your Employer's Insured Health Plan), or for any expenses incurred after the close of the Plan Year, or, except for Continuation Coverage, after a separation from service. You have 90 days at the end of the plan year to submit claims for reimbursement that incurred during the prior plan year.

Q-9. Does the plan also provide benefits for my family?

The Plan provides reimbursement for Eligible Medical Expenses incurred by you, your spouse, and your dependents as long as these eligible individuals are covered under the Employer's Insured Health Plan.

Q-10. What happens if my claim for benefits is denied?

All claims are adjudicated (reviewed for approval under the provisions of the Employer's Insured Health Plan) by UnitedHealthCare only. All amounts due under Medical Expense Reimbursement Plan (MERP) are based upon the determination made by UnitedHealthCare.

You will be notified in writing by UnitedHealthCare via EOB within 30 days of the date you submitted your claim if the claim is denied. If an extension is necessary, UnitedHealthCare shall, prior to the termination of the initial 30-day period, furnish you with written notice indicating the reasons requiring an extension and the date by which a decision is expected to be rendered. In no event shall an extension exceed a period of 15-days from the end of the initial 30-day period. If the reason the extension is necessary is due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall have 45 days from receipt of the notice within which to submit the information. The time period in which UnitedHealthCare must make a decision under these claims procedures is suspended until the earlier of the date you submit the required information or the end of the 45-day period, whichever occurs first.

If UnitedHealthCare wholly or partially denies a claim, you will be furnished a notice written in setting forth:

- the specific reasons your claim was denied;
- specific reference to pertinent Plan provisions on which the denial is based;
- if UnitedHealthCare relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy will be provided upon request and free of charge.
- a description of any additional material or information necessary for the claim to be approved and an explanation of why such material or information is necessary;
- instructions on how to appeal the denied claim (including the applicable time frames); and
- a statement indicating that the claimant has a right to bring a civil action in federal court pursuant to ERISA Section 502(a) if the claim is denied after appeal to Plan Administrator.

If a claim is denied under Medical Expense Reimbursement Plan (MERP) but approved under the Employer's Insured Health Plan, you will further be advised of your right to request an administrative review of the denial of such claim, and you may make a written request for a review at any time within the 180 -day period after you have received notice that such claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review.

The review will take into account all comments, documents, records and other information that you submitted relating to the claim without regard to whether such information was submitted or considered in the initial determination. In no event will a determination upon review be made by the same individual(s) who made the initial determination or someone who is a subordinate of any individual who made the initial determination. If the decision is based in whole or part on medical judgment, the Plan Administrator will consult with an independent health care professional who has expertise in the field of medicine involved in the determination.

The decision on review shall be in writing and shall include the following:

- specific reasons for the decision, as well as specific references to the specific Plan provisions on which the decision is based;
- a statement notifying the claimant of his or her right to request, free of charge, all documents, records, or other information relevant to the claim;
- if an internal rule, protocol or guideline or other similar rule was relied upon in making the determination, a statement notifying the claimant of his or her right to receive a copy of such internal rule, protocol or guideline;

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement notifying the claimant of his or her right to receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances; and

- a statement indicating the claimant's right to bring a civil action in federal court pursuant to ERISA Section 502(a).

After you have exhausted these internal appeals procedures, you are entitled to an external review procedure, or you could file suit in federal court. You cannot file suit in federal court until you have exhausted these appeals procedures. For more information on the external review procedure, contact Patrick Benefit Administrators

Q-11**. Does my coverage under this Plan end when my employment terminates?**

Yes. Your normal participation will cease at the end of the last day before your employment with the Employer terminates. However, you and your family will have the opportunity to continue to be covered under the Plan under the terms of the Continuation Coverage provisions described in Answer Q-12, below.

Q-12. What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your spouse and dependents' rights, to continue to be covered under this Medical Expense Reimbursement Plan and the Insured Health Plan if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." You must also continue coverage under the Employer's Insured Health Plan in order to continue benefits hereunder. A Qualifying Event is:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours.

- Your death.

- Divorce or legal separation from your spouse.

- You become eligible to receive Medicare benefits.

- When a dependent of yours ceases to be a dependent.

It will be your or your covered dependent's obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the later of the occurrence of the event or the date that you would lose coverage as a result of the event, other than a change in your employment status or your death. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

For those taking a qualified military leave of absence, coverage will be continued in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). For example, coverage may be continued on the same terms and conditions for up to 24 months (or the date that you were required to return to work in accordance with USERRA).

Q-13. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time.

PART II
ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and, if applicable, and copies of the latest annual report (Form 5500 series) and updated summary plan description.. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report (if applicable). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

(This section applies only if the Plan is subject to HIPAA) Exclusionary periods of coverage for preexisting conditions under your group health plan may be reduced or eliminated if you have creditable coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan 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 welfare benefit from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan 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 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 plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or 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 the Plan, 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 obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits and Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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 and Security Administration.

PART III:
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information that you may need to know about the Plan.

1. General Plan Information

Community Action Committee of Pike has established a plan for payment of certain expenses for the benefit of its eligible employees to be named and known as the Community Action Committee of Pike Medical Expense Reimbursement Plan. Sometimes the Plan is referred to as Medical Expense Reimbursement Plan (MERP).

Your Employer has assigned Plan Number to your Plan.

The provisions of the Plan described herein became effective on 01/01/2011.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The first Plan Year begins on 10/01/2014 and ends on 09/30/2015. In subsequent years Medical Expense Reimbursement Plan (MERP) will begin on 10/01/2014 and end on 09/30/2015.

2. Employer Information

Your Employer's name and address are:

Community Action Committee of Pike
941 Market Street
Piketon, OH 45661

3. Plan Administrator Information

The name, address, and business telephone number of your Plan's Administrator are:

Community Action Committee of Pike County
941 Market Street
Piketon, OH 45661
740-289-2371

The Administrator appoints a Committee, which keeps the records for the Plan and is responsible for the administration of the Plan. The Committee will also answer any questions you may have about our Plan. You may contact the Committee at the above address for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Community Action Committee of Pike
941 Market Street
Piketon,OH 45661
Phone:(740) 289-2371

Coordination of Benefits

The Plan is intended to pay Benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its Benefits shall not be taken into account when determining benefits payable under any other plan. However. certain coverages (e.g., Medicare for Participants who are active employees and their Dependents, and TRICARE benefits as required by law) will pay benefits only after this Plan to the extent required by applicable law.

5 Legal Notices

Newborns' and Mothers' Health Protection Act of 1996--Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998
For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the individual's attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications resulting from the mastectomy (including lymphedemas)

These mastectomy-related benefits are subject to deductibles and coinsurance limitations that are consistent with those applicable to other medical and surgical benefits under your health plan coverage option. Call your health plan for more information.