

MARATHON COUNTY
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

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Diversified Benefit Services, Inc.

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TABLE OF CONTENTS

INTRODUCTION 1

ELIGIBILITY FOR PARTICIPATION 1

 Eligible Employee 1

HEALTH REIMBURSEMENT BENEFITS 1

 Health Reimbursement Account 1

 Limits on Reimbursement 1

 Deductibles 2

 Eligible Expenses 2

 Coordination with Other Plans 2

 Limits on Certain Employees 2

CLAIMS 2

 Deadlines 2

 Documentation of Claims 3

 Method and Timing of Payment 3

 Where to Submit Claims 3

 Refunds/Indemnification 3

 Beneficiary 3

 Claim Procedures for Health Benefits 3

CONTINUATION RIGHTS 5

 Military Service 5

 COBRA 5

 FMLA 6

YOUR RIGHTS 6

MISCELLANEOUS 7

 Qualified Medical Child Support Orders 7

 Special Enrollment Rights 7

 Women’s Health and Cancer Rights Act 7

 Newborns' And Mothers' Health Protection 8

 Loss of Benefit 8

 Amendment and Termination 8

 Administrator Discretion 8

 Taxation 8

 Privacy 9

 Creditable Coverage 9

ADMINISTRATIVE INFORMATION 9

INTRODUCTION

Marathon County (the "Company") established the Marathon County Health Reimbursement Arrangement (the "Plan") effective 01/01/2012.

Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

You are an "Eligible Employee" if you are eligible to receive benefits from the Employer Sponsored Group Health Plan.

You will stop being a participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date you terminate employment with the Company.

HEALTH REIMBURSEMENT BENEFITS

Health Reimbursement Account

When you become eligible to participate in the Plan, the Plan will establish a health reimbursement account in your name. You will be entitled to receive reimbursement from this account for Eligible Expenses incurred by you, your spouse and dependents - but only if such persons are covered under the Employer Sponsored Group Health Plan (Covered Persons). A dependent is generally someone who you may claim as a dependent on your federal tax return and also includes a child who is under the age of 27 through the end of the calendar year. You may receive reimbursement for Eligible Expenses incurred at a time when you are actively participating in the Plan. The amount of reimbursement for Eligible Expenses is limited to the remaining balance in your account.

Limits on Reimbursement

The annual limits on reimbursement are as follows:

One Covered Person (Participant only): \$750

Two Covered Persons (Participant plus one other Covered Person): \$1,125

More than two Covered Persons (Family coverage): \$1,500

The entire amount of the limit specified above will be credited to your account at the beginning of the Plan Year.

Any amounts remaining in your account at the end of the Plan Year will be carried over to the immediately-following Plan Year, See Addendum. However, any balance remaining in your account on the date you terminate employment with the Company will be forfeited after all claims are paid.

Deductible

The annual Plan deductible is \$0.

Please note that the deductible above is for this plan (the Health Reimbursement Account) and NOT the deductible(s) for Company-sponsored health plan(s).

Eligible Expenses

During the time you are eligible to participate in the Plan, the Plan will reimburse all medical expenses for Covered Persons that are listed on the Eligible Expenses Appendix. The Plan will not reimburse you for the cost of medicines or drugs unless such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source.

Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

Limits on Certain Employees

If you are a highly paid employee or an owner of the Company, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you may receive from the Plan.

CLAIMS

Deadlines

You must submit claims for reimbursement within 90 days after the end of the Plan Year. However, if you terminate employment you must submit claims for reimbursement within 90 days after your date of termination.

Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Where to Submit Claims

All claims must be submitted to Diversified Benefit Services, Inc. at 625 Walnut Ridge Drive Suite 190 PO Box 290 Hartland WI 53029. The telephone number is 262-367-3300 FAX 262-367-5938.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements or any payments/reimbursements that are taxable to you. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Beneficiary

If you die, your beneficiaries may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose provided that such beneficiary is your spouse or one or more of your dependents. If no beneficiary is specified, the Plan Administrator may pay any amount due to your spouse or, if there is no spouse, to your dependents in equal shares.

Claim Procedures for Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly

evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit 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.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial, and (5): (A) 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; or (B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

- (1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of

the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that 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 appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial with a discussion of the decision, (2) the pertinent Plan provisions on which the denial is based, (3) 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, and (4) a statement describing the external appeals process. The determination rendered by the Plan Administrator shall be binding upon all parties.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA

NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving benefits.

YOUR RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections. You have the right to:

Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including insurance contracts.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue health care 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from 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.

In addition, the people who operate the Plan have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under the Plan.

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.

If you disagree with the Plan's decision or lack thereof concerning the status of a qualified medical child support order or national medical support notice, you may file suit in Federal and/or state court.

If you have any questions about the Plan, you should contact the Plan Administrator.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO) and/or National Medical Support Notice. You may obtain a copy of the medical child support procedures from the Plan Administrator, free of charge.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would

like more information on WHCRA benefits, call your Plan Administrator at the number provided at the end of this Summary Plan Description.

Newborns' And Mothers' Health Protection

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).

Loss of Benefit

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

Creditable Coverage

The Plan Administrator may provide you with a certificate of creditable coverage. To the extent required by federal law, this certificate may help you establish coverage under another group health plan.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is Marathon County.
Its address is 500 Forest Street, Wausau, WI 54403.
Its telephone number is 715-261-1181.
Its Employer Identification Number is 39-6005716.
2. The Plan is a welfare benefit plan which has been designated by the sponsor as its plan number 550.
3. The Plan's designated agent for service of legal process is the chief officer of the entity named in paragraph 1. Any legal papers should be delivered to him or her at the address listed in paragraph 1. However, service may also be made upon the Plan Administrator.
4. The Company's fiscal year and the plan year ends on 12/31.

Appendix

Rollover: Participants may rollover 100% of their unused Funding Level dollars listed above.

Balance Maximum: The total amount you can accumulate in your HRA (Balance Maximum) is \$3,750 / **Single**, \$5,625 / **Employee + 1**, and \$7,500 / **Family**. The Balance Maximum includes the Funding Level amounts and Rollover amounts.

Eligible Expenses Appendix

In and Out of Network Deductibles

In and Out of Network Coinsurance

Prescriptions Drugs

Emergency Room Copay

Gastric By-Pass Copay

Smoking Cessation Expenses (\$500 lifetime limit)

Only health plan deductible amounts that are otherwise payable by the Participant under a Company-sponsored medical plan covering the Participant are eligible.

COBRA NOTICE

In General.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. 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 Plan is lost because of the qualifying event. Under the Plan, 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 Plan 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 Plan 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 Plan 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 plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator 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), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Company at 500 Forest Street, Wausau, WI 54403. The Company's telephone number is 715-261-1181.

How is COBRA Coverage Provided?

Once the Plan Administrator 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being

eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator 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 the Plan Administrator.

Plan Contact Information

Marathon County
500 Forest Street
Wausau, WI 54403
715-261-1181.

V3.00-3.00