VANTAGELINKS, LLC

HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

 5/1/2016

TABLE OF CONTENTS

HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

We are pleased to establish this Health Reimbursement Arrangement to provide you with additional health coverage benefits. The benefits available under this Plan are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

I
ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan?

You will be eligible to join the Plan once you become covered under our group medical plan.

2. When is My Entry Date?

You can join the Plan on the same day that you enter our group medical plan.

3. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are not eligible to receive medical benefits under our group medical plan.

II
BENEFITS

1. What Benefits Are Available?

The plan allows you to be reimbursed by the Employer for any deductibles which you have to meet under our group medical plan which are incurred by you or your dependents. **The Employee pays the 1st $500 in deductible and the Employer reimburses the 2nd $1,000 in deductible per member. (Maximum of 3 Family Members required to meet Family Deductible)**

The maximum reimbursement allowed each Coverage Period for Deductible is:

Employee Only $1,500	Employee Plus One $3,000	Family Coverage $4,500
1st $500 paid by Employee	1st $500 paid by EE for each member	1st $500 paid by EE for each member
2nd $1,000 paid by Employer	2nd $1,000 paid by ER for each member	2nd $1,000 paid by ER for each member

****This HRA plan will pay Out-of-Network claims up to the In-Network amount.**

Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including a health flexible spending account.

You may submit expenses for yourself, your spouse or your children including step children and foster children. You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

2. When Must Expenses Be Incurred?

You may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each calendar year. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

3. When Will I Receive Payments From the Plan?

During the course of the Coverage Period, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 90 days after the end of the Coverage Period. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

4. What Happens If I Terminate Employment?

Terminated employees may submit claims up to 90 days after date of termination for claims incurred prior to the termination date. Any unused amounts are forfeited.

5. Can I Opt Out of the Plan?

Yes, you can opt out of the Plan and receive no further reimbursement.

6. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

7. Newborns' and Mothers' Health Protection Act

Group health plans 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).

8. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

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III
GENERAL INFORMATION ABOUT OUR PLAN

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

1. General Plan Information

VantageLinks, LLC Health Reimbursement Arrangement is the name of the Plan.

Your Employer has assigned Plan Number 502 to your Plan.

The provisions of your Plan became effective on May 1, 2009 and were revised on May 1, 2016.

2. Employer Information

Your Employer's name, address, and identification number are:

VantageLinks, LLC
One City Place Drive, Suite 285
St. Louis, Missouri 63141
20 – 5435012

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Administrator.

3. Plan Administrator Information

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

VantageLinks, LLC
One City Place Drive, Suite 2853
St. Louis, Missouri 63141
(314) 785 – 0055

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. Third Party Claims Administrator Information

The name, address and business telephone number of the Third Party Claims Administrator are:

BeneFLEX HR Resources, Inc.
10805 Sunset Office Drive, Suite 401
St. Louis, MO 63127
314-909-6979 or 800-631-3539

The Third Party Claims Administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

5. Service of Legal Process

The Employer is the Plan's agent for service of legal process.

6. Type of Administration

The Plan is a health reimbursement arrangement and the claims administration is provided through a Third Party Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

IV
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) Examine, without charge, at the Administrator's office, all Plan documents, 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 Employee Benefits Security Administration.

(b) Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) Continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

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

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.

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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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 medical child support order, you may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent the Plan Participant from obtaining a benefit or from exercising your rights under ERISA.

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.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) 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.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. How to Submit a Claim

When you have a claim to submit for payment, you must:

(a) Obtain a claim form from the Plan Administrator.

(b) Complete the Employee portion of the form.

(c) Attach copies of the Explanation of Benefits (EOB) as documentation from the services provided for which you are requesting reimbursement.

(d) Review claim form for any additional documentation the Plan Administrators may require as documentation needed for reimbursement.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days

Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial.

(b) Reference to the specific Plan provisions on which the denial was based.

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

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following a denial on review.

(e) 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 claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the Claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;

(d) or constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR 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 or its designee.