

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. ▶

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>TCNB WRAP FORM FILING</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>TRI CITY NATIONAL BANK</u></p> <p><u>6400 S 27TH ST</u> <u>OAK CREEK, WI 53154-1015</u></p>	<p>1c Effective date of plan <u>01/01/2024</u></p> <p>2b Employer Identification Number (EIN) <u>39-1022456</u></p> <p>2c Plan Sponsor's telephone number <u>414-761-1610</u></p> <p>2d Business code (see instructions) <u>522110</u></p>

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/23/2025	SUSAN LEMKE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/23/2025	SUSAN LEMKE
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name TRI CITY BANKSHARES c Plan Name	4b EIN 39-1158740	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	332
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2), 6b, and 6c..... e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	332
	6a(2)	336
	6b	7
	6c	
	6d	343
	6e	
	6f	343
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4B 4D 4E 4F 4H

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input type="checkbox"/> Trust	(3) <input type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules	b General Schedules
(1) <input type="checkbox"/> R (Retirement Plan Information)	(1) <input type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) <input type="checkbox"/> I (Financial Information – Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>4</u>
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____	(4) <input checked="" type="checkbox"/> C (Service Provider Information)
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	(5) <input type="checkbox"/> D (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> G (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan TCNB WRAP FORM FILING</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRI CITY NATIONAL BANK</p>	<p>D Employer Identification Number (EIN) 39-1022456</p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
ANTHEM BLUE CROSS BLUE SHIELD

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
39-0138065	54003	W81224	229	01/01/2024	12/31/2024

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:
 (1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)
	(2) Claim reserves		9d(2)
	(3) Other reserves		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan TCNB WRAP FORM FILING	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 TRI CITY NATIONAL BANK	D Employer Identification Number (EIN) 39-1022456

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
TOKIO MARINE HCC - STOP LOSS GROUP

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-1817054	92711	HCL31877	239	01/01/2024	12/31/2024

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)
	(2) Claim reserves		9d(2)
	(3) Other reserves		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	554216
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan TCNB WRAP FORM FILING</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRI CITY NATIONAL BANK</p>	<p>D Employer Identification Number (EIN) 39-1022456</p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
SUPERIOR VISION PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
39-1736329	52005	212810	331	01/01/2024	12/31/2024

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
---	--------------------------------------

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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	(c) Amount	(d) Purpose	

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4 Current value of plan's interest under this contract in the general account at year end	4	
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6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:
 (1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
 b Dental
 c Vision
 d Life insurance
e Temporary disability (accident and sickness)
 f Long-term disability
 g Supplemental unemployment
 h Prescription drug
i Stop loss (large deductible)
 j HMO contract
 k PPO contract
 l Indemnity contract
m Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3))		9a(4)
b Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))		9b(3)
(4) Claims charged		9b(4)
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees	9c(1)(B)	
(C) Other specific acquisition costs	9c(1)(C)	
(D) Other expenses	9c(1)(D)	
(E) Taxes	9c(1)(E)	
(F) Charges for risks or other contingencies	9c(1)(F)	
(G) Other retention charges	9c(1)(G)	
(H) Total retention		9c(1)(H)
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)
(2) Claim reserves		9d(2)
(3) Other reserves		9d(3)
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	25934
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan TCNB WRAP FORM FILING</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRI CITY NATIONAL BANK</p>	<p>D Employer Identification Number (EIN) 39-1022456</p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE HARTFORD

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-0838648	70815	876447G	309	01/01/2024	12/31/2024

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">1908</p>	<p>(b) Total amount of fees paid</p>
---	---

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

R&R INSURANCE **N14 W23900 STONE RIDGE DR**
WAUKESHA, WI 53188

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1908			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

- a** Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions	7e(5)
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a Health (other than dental or vision)
- b Dental
- c Vision
- d Life insurance
- e Temporary disability (accident and sickness)
- f Long-term disability
- g Supplemental unemployment
- h Prescription drug
- i Stop loss (large deductible)
- j HMO contract
- k PPO contract
- l Indemnity contract
- m Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)
	(2) Claim reserves		9d(2)
	(3) Other reserves		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	175444
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan TCNB WRAP FORM FILING	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TRI CITY NATIONAL BANK	D Employer Identification Number (EIN) 39-1022456	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

BCBSW

39-0138065

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

DELTA DENTAL OF WI

39-6094742

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	DENTAL TPA	14341	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

COMPCARE HEALTH SERVICES INSURANCE

39-1462554

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 49 62	TPA SERVICES AND FEES	137405	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

INGENIORX, INC

82-3062245

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 62	RX REBATES & FEES	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	223976	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

**HEALTH AND WELFARE PLANS
WRAP DOCUMENT**

INTRODUCTION

This is the Plan Document and Summary Plan Description for: Tri City National Bank
(the “Company”) Health and Welfare Plan (the “Plan”), amended and restated 05/01/2025,
with Plan Number: 501.

This Summary Document addresses the Welfare Programs offered and listed in Appendix A of this document.

ARTICLE I

Purpose

The Company sponsors various Welfare Programs to provide to Employees/Participants, and their Spouses, Dependents, and Beneficiaries certain benefits described herein. Those Welfare Programs which are “employee welfare benefit plans” under ERISA Section 3(1) have been written and, when combined with this Plan document, are intended to conform to the written plan document and all other applicable requirements of ERISA Section 402 and applicable provisions of the Code, together with any amendments, rulings, and regulations promulgated thereunder.

Notwithstanding the number and types of Welfare Programs incorporated hereunder, the Plan is, and shall be treated as, a single welfare benefit plan for purposes of annual reporting and certain other purposes, as necessary to comply with ERISA.

If any of the assets of such Welfare Programs are held in any related trust fund maintained under Code Section 501(c)(9), then, to the extent required to comply with such Code section and the regulations thereunder, such assets shall be held for the exclusive purposes of providing benefits to Participants and Beneficiaries and for defraying the reasonable expenses of administration of such Welfare Programs. The name, title, and address of any trustees will be provided in the documents describing the applicable Welfare Program.

ARTICLE II

Definitions

- 2.1 “**ACA**” means the Patient Protection and Affordable Care Act of 2010, as amended.
- 2.2 “**Beneficiary**” means a beneficiary as defined under a Welfare Program.
- 2.3 “**Code**” means the Internal Revenue Code of 1986, as amended from time to time.
- 2.4 “**Company**” means Tri City National Bank, located at 6400 S 27th Street, Oak Creek, WI 53154, AND WITH Employer Identification Number (“EIN”) 39-1022456, and any entity which succeeds to the business and assumes the obligations of the Company hereunder. The Company’s Chief Executive Officer and any officer of the Company authorized by the Company’s Chief Executive Officer may act on behalf of the Company for purposes of the Plan.

- 2.5 **“Dependent”** means a dependent as defined under a Welfare Program. To the extent required under ERISA Section 715, however, a Dependent for purposes of any Welfare Program that is a group health plan (other than a retiree medical plan or a plan that provides “excepted benefits” described under ERISA Section 733(c)) shall include a Participant’s eligible children who have not attained age 26 (or such later age as determined by the Plan Administrator).
- 2.6 **“Employee”** means any individual identified as an employee on the payroll records of the Company or a Participating Employer. Unless otherwise specified under the terms of a Welfare Program or required by applicable law, independent contractors and leased employees (within the meaning of Code Section 414(n)) shall not be Employees for purposes of this Plan (even if re-characterized by the Internal Revenue Service as employees).
- 2.7 **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended.
- 2.8 **“Former Employee”** means any person formerly employed as an Employee.
- 2.9 **“Participant”** means an Employee or Former Employee who: (1) is eligible to participate in a Welfare Program; (2) is enrolled for coverage under one or more Welfare Programs; and (3) whose participation in such Welfare Program(s) has not terminated.
- 2.10 **“Participant Contribution”** means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as a condition for coverage under a Welfare Program as determined by the Company. The term “Participant Contribution” includes amounts a Participant contributes for coverage under a self-insured arrangement under which benefits are funded from Company assets and amounts a Participant contributes for coverage under an insured arrangement under which benefits are funded by the insurer.
- 2.11 **“Participating Employer”** means any member of one of the following groups that includes the Company, if such member adopts the Plan with the Company’s authorization as provided in Section 10.1: (i) a controlled group of corporations within the meaning of Code Section 414(b); (ii) a group of trades or businesses under common control within the meaning of Code Section 414(c); (iii) an affiliated service group within the meaning of Code Section 414(m); or (iv) a trade or business required to be aggregated pursuant to Code Section 414(o).
- 2.12 **“Plan”** means the Tri City National Bank Company Health and Welfare Plan, as set forth herein, including each Welfare Program incorporated hereunder by reference, as amended from time to time.
- 2.13 **“Plan Administrator”** means the Company or such other individual, committee, or firm as the Company shall designate from time to time. The Plan Administrator may be contacted at:

COMPANY Tri City National Bank
BUSINESS ADDRESS 6400 S 27th Street, Oak Creek, WI
TELEPHONE NUMBER 414-761-1610
- 2.14 **“Plan Year”** means the twelve consecutive month period beginning 5/1/2025 and ending on 4/30/2026. A Welfare Program under this Plan may be administered on a benefit year that differs from the Plan Year.
- 2.15 **“Spouse”** means a spouse as defined under a Welfare Program. If no such definition is provided, the term “Spouse” shall mean an individual to whom the Participant is lawfully married.

Notwithstanding anything to the contrary contained herein, the term “Spouse” shall include a same-sex spouse who is legally married under applicable law.

- 2.16 **“Welfare Program”** means a written arrangement incorporated into this Plan that is offered by the Company which provides an employee benefit, including those that would be treated as an “employee welfare benefit plan” under Section 3(1) of ERISA if offered separately. Welfare Program also means any plan established pursuant to Code Section 125 or Section 132(f). Each Welfare Program under the Plan is identified in Appendix A which is incorporated into and a part of the Plan. The documents for each Welfare Program are incorporated into this document. The Company may add or delete a Welfare Program from the Plan by amending Appendix A, without any need to otherwise amend the Plan.

In the event that the provisions of any Welfare Program conflict with or contradict the provisions of this document or any other Welfare Program, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan, including the written terms and provisions of any Welfare Program document, so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant, Spouse, Dependent, or Beneficiary to benefits available under any Welfare Program.

ARTICLE III

Eligibility and Participation

3.1 Eligibility.

- (a) Except as otherwise provided in paragraph (b) below, an “Eligible Employee” with respect to this Plan shall be any Employee of the Company or a Participating Employer who is classified by the Company or a Participating Employer as eligible to participate in and receive benefits under one or more Welfare Programs. An individual classified by the Company or a Participating Employer as anything other than an Employee will not be considered Eligible Employees, regardless of any subsequent re-classification by the IRS or other party, unless expressly designated as such under one or more Programs.
- (b) An Employee’s eligibility to participate in a Welfare Program shall be determined by and limited to his or her eligibility to participate under the terms and conditions of such Welfare Program. An Eligible Employee may be able to participate in one Welfare Program but not another, consistent with the terms of each Welfare Program.

If the terms and conditions of a Welfare Program do not specify which Employees are eligible to participate in such Welfare Program, then, except as otherwise noted in this paragraph, an Employee shall be eligible to participate in such Welfare Program if he or she is classified by the Company or his or her Participating Employer as regularly scheduled to work 30 or more hours of work per week, after a probationary period of 1st of the month following Date of Hire days.

- 3.2 Enrollment. The Plan Administrator shall establish procedures in accordance with each Welfare Program for the enrollment of Eligible Employees with respect to such Welfare Program and their eligible Spouses and Dependents, if any, in such Welfare Program. For Welfare Programs in which an Eligible Employee must elect to enroll, the Plan Administrator or its delegate shall prescribe enrollment forms that must be completed (whether in writing or electronically) by a prescribed deadline prior to commencement of coverage under the Welfare Program. Once an Eligible

Employee has been enrolled for coverage under a Welfare Program, his or her participation in such Welfare Program will commence at the time set forth under the terms of the Welfare Program.

- 3.3 Termination of Participation. Except as otherwise noted herein or under the terms of the applicable Welfare Program, a Participant's participation in a Welfare Program shall cease, and his or her coverage and, if applicable, the coverage of his or her Spouse, Dependents, and/or Beneficiaries under such Welfare Program shall terminate, when the Participant ceases to be an Employee eligible to participate in such Welfare Program, when the Employee fails pay timely any required Participant Contribution for such Welfare Program coverage, or as otherwise described under the provisions of such Welfare Programs. A Participant shall cease to be a Participant when he or she is no longer covered under any Welfare Program.

ARTICLE IV

Funding and Benefits

4.1 Funding.

- (a) Notwithstanding anything to the contrary contained herein, participation in each Welfare Program and the payment of benefits under such Welfare Program may be conditioned on a Participant contributing his or her share of the cost of coverage under such Welfare Program (i.e., the Participant Contribution) at such time and in such amount as the Company or Plan Administrator shall establish from time to time. The Plan Administrator may require that Participant Contributions for any Welfare Program be made by payroll deduction. Nothing herein requires the Company, a Participating Employer, or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, Spouse, Dependent, or Beneficiary in conjunction with this Plan or any Welfare Program. No Participant, Spouse, Dependent, or Beneficiary shall have any right to, or interest in, the assets of the Company or Participating Employer.
- (b) The Company shall have no obligation, but shall have the right to provide benefits under any Welfare Program through the purchase of insurance. To the extent the Company purchases insurance to provide benefits under any Welfare Program, the obligation to provide such benefits shall be the sole responsibility of the insurer, and neither the Company nor any Participating Employer shall have any responsibility for the payment of such benefits. Except as otherwise permitted by rulings or regulations under ERISA, any Participant Contribution made with respect to an insured Welfare Program shall be remitted to the appropriate insurer as soon as practicable but not later than 90 days after such contributions are made and would otherwise have been paid to Participants in cash.

- 4.2 Benefits. Benefits will be paid solely in the form and amount specified in the relevant Welfare Program and pursuant to the terms of such Welfare Program.

ARTICLE V

Plan Administration and Fiduciary Duties

- 5.1 Named Fiduciary. The Plan Administrator shall be the "named fiduciary" of the Plan, as defined in ERISA Section 402(a)(2), unless (a) the Company appoints a replacement, or (b) as to a Welfare Program, as otherwise specified under the terms of such Welfare Program.

5.2 Plan Administration. Except as otherwise provided in a Welfare Program, the Plan Administrator shall have:

- (a) The sole discretion and authority to control and manage the operation and administration of the Plan and all Welfare Programs;
- (b) The complete discretionary authority to interpret or apply the provisions of the Plan, make findings of fact, correct errors, supply omissions, or otherwise administer the Plan, and all decisions, findings, and interpretations by the Plan Administrator shall be final, conclusive, and binding on all persons, subject only to the Claims Procedure in Article VI of the Plan, and may not be overturned unless found by a court to be arbitrary and capricious;
- (c) All other powers necessary or desirable to administer the Plan, including, but not limited to, the following:
 - (i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;
 - (ii) To prepare and distribute information explaining the Plan to Participants;
 - (iii) To receive from the Company (or Participating Employer) and Participants, Spouses, Dependents, and Beneficiaries such information as the Plan Administrator shall deem necessary for the proper administration of the Plan;
 - (iv) To keep records of enrollment, elections, claims, and disbursements for claims under each Welfare Program, and any other records it deems advisable;
 - (v) To appoint individuals, committees, or organizations to assist in the administration of the Plan and/or any Welfare Program and to obtain any other information required by ERISA, the Code, or other law;
 - (vi) To purchase any insurance deemed necessary for providing benefits under the Plan;
 - (vii) To accept, modify, or reject Participant elections under the Plan;
 - (viii) To promulgate election forms and claims forms to be used by Participants with respect to, and otherwise establish administrative procedures for, any Welfare Program;
 - (ix) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA, or any other laws;
 - (x) To determine and announce any Participant Contributions required hereunder;
 - (xi) To determine and enforce any limits on benefits elected hereunder;
 - (xii) To take such action, and work with the Company and Participating Employers, as may be necessary to cause any required payroll deduction of any Participant Contributions required hereunder; and

- (xiii) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Spouse, Dependent, or Beneficiary, in whatever manner the Plan Administrator determines is appropriate, including recoupment of past payments, or offsets against future payments due that Participant, Spouse, Dependent, or Beneficiary; and
 - (d) The sole discretion and authority regarding the distribution, or other use, of dividends, demutualization, and/or rebates, if any, from group health insurers.
- 5.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan or any Welfare Program, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan and each Welfare Program, subject to the terms of the Welfare Program.

ARTICLE VI

Claims and Subrogation

- 6.1 Claims Procedure. Except as provided in Sections 6.2, 6.3 and 6.4, a claim for benefits under a Welfare Program shall be submitted in accordance with and to the party designated under the terms of such Welfare Program.
- 6.2 Claims Procedures for Group Health Plans.
- (a) This Section is intended to comply with Department of Labor Regulations, 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, and shall apply specifically to claims under a group health plan as defined in Department of Labor Regulation 29 C.F.R. § 2560.503-1. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions, or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure, to the extent such other claims procedure complies with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.
 - (b) Written Claim For Benefits. Any Participant, Spouse, Dependent, Beneficiary, or authorized representative that asserts a right to any benefit under the Plan must file a written claim for such benefit with the Plan Administrator. For purposes of this Article, claimant shall mean a Participant, Spouse, Dependent, Beneficiary, or authorized representative who files a claim for any benefit under the Plan.
 - (c) Benefit Determinations.
 - (i) Post-Service Claims. A post-service claim is any claim that is filed for benefits after health care has been received.
 - (A) Upon the denial of a post-service claim, the Plan Administrator shall notify the claimant in writing of such denial within 30 days of receipt of the claim. The Plan Administrator shall be permitted one 15-day extension to the 30-day claim determination period, provided the Plan Administrator determines that such extension is necessary due to matters beyond the

Plan's control and notifies the claimant before the end of the initial 30-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision.

If such extension is required due to the claimant's failure to submit all information necessary to decide the claim, the extension notification must specifically describe the required information and the claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim. The time period to consider a post-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(B) A denial notice shall explain:

- (i) The reason(s) for the denial;
- (ii) Refer to the Section(s) of the Plan on which the denial is based;
- (iii) Describe any additional material or information necessary for the claimant to perfect a claim and why that material or information is necessary;
- (iv) Provide the claim appeal procedures and the time limits applicable to such procedures;
- (v) Include a statement regarding the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review and any contractual limitations that apply to the claimant's right to bring such an action; and
- (vi) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit 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 benefit 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

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.

The denial notice must also comply with any additional requirements described in Department of Labor Regulation 29 C.F. R. § 2590.715-2719.

(ii) Pre-Service Claims. A pre-service claim is any claim for benefits that requires certification or approval prior to the performance of the requested health care service.

(A) Upon receiving a pre-service claim, the Plan Administrator shall notify the claimant in writing of the Plan's benefit determination within a reasonable period but no later than 15 days after receipt of the claim. The Plan Administrator shall be permitted one 15-day extension provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan Administrator's control and notifies the claimant before the end of the initial 15-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision.

The Plan Administrator shall, within 5 days of receiving any deficient claim, notify the claimant of such deficiency and the steps necessary to correct the claim. Notification may be oral unless the claimant requests written notification. The claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim. The time period to consider a pre-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(B) A denial notice shall include the information described in Section 6.2(c)(i)(B) above.

(iii) Urgent Care Claims. An urgent care claim is a claim that requires notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize the claimant's life, health, or the ability to regain maximum function, or, in the opinion of a doctor with the knowledge of the claimant's health condition, could cause severe pain.

(A) An urgent care claimant shall receive notice of the benefit determination in writing or electronically as soon as possible, but no later than 72 hours (or such other time as prescribed in Department of Labor Relations) after the Plan Administrator receives all necessary information, taking into account the severity of the claimant's condition. Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If the claimant files an urgent care claim improperly, the Plan Administrator, within 24 hours after the claim is received, shall notify the claimant of the improper filing and how to correct it. The claimant shall have 48 hours (or such other time as prescribed in Department of Labor Regulations) to provide the requested information and shall be notified of a determination no later than 48 hours after receipt of the corrected claim or the end of the 48-hour period afforded to the claimant to provide the requested additional information.

(B) A denial notice shall include the information described in Section 6.2(c)(i)(B) above. The denial notice must also describe the expedited review process applicable to urgent care claims.

(iv) Concurrent Care Claims.

(A) Any request by a claimant to extend an on-going course of treatment beyond a previously approved specified period of time or number of treatments that is an urgent care claim as defined in Section 6.2(c)(iii) above shall be decided as soon as possible, and the Plan Administrator shall notify the claimant of the determination within 24 hours of receipt of the claim, provided the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments. If the claimant's request for extended urgent care treatment is not made at least 24 hours prior to the end of the approved treatment, the request shall be treated as an urgent care claim in accordance with Section 6.2(c)(iii).

(B) If an on-going course of treatment was previously approved for a specified period of time or number of treatments, and the claimant's request to extend treatment is non-urgent, the claimant's request shall be considered a new claim and decided in accordance with post-service or pre-service timeframes, as applicable.

(C) A denial notice shall include the information described in Section 6.2(c)(i)(B) above. The denial notice must also describe the expedited review process applicable to urgent care claims.

(d) Appeal of Claim Denial.

(i) Any claimant shall have the right to appeal an "adverse benefit determination" as defined in Department of Labor Regulation 29 C.F.R. § 2590.715-2719 within 180 days of receipt of such adverse benefit determination. Any appeal shall be submitted to the Plan Administrator in writing. If the appeal relates to a claim for payment, the claimant's request should include: the patient's name and plan identification number; the date(s) of health care services(s); the provider's name; the reason(s) the claimant believes the claim should be paid; and any documentation or other written information to support the claimant's request for claim payment.

(ii) An appeal shall be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with an independent and impartial health care professional who has appropriate training and experience in the particular field of medicine in order to make the health care judgment and who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, independent and impartial medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. Upon request and free of charge the claimant has the right to reasonable access to and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

- (iii) Upon being notified of an adverse benefit determination under an appeal, the claimant shall be permitted, within 60 days of receiving notice of such determination, to submit notice of a “second-level appeal” to the Plan Administrator. A second-level appeal shall be decided in accordance with the rules in paragraph (ii).
- (e) Timeframes for Appeals Determinations.
- (i) Pre-Service Claim Appeal. Upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a pre-service claim, the Plan Administrator shall have 15 days to notify the claimant electronically or in writing of the appeal determination.
 - (ii) Post-Service Claim Appeal. Upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a post-service claim, the Plan Administrator shall have 30 days to notify the claimant electronically or in writing of the appeal determination.
 - (iii) Urgent Care Claim Appeal. Upon receiving a notice to appeal (or second-level appeal) the determination of a claim involving urgent care, the Plan Administrator shall notify the claimant of the appeal determination as soon as possible taking into account medical exigencies surrounding the claim, but no later than 72 hours (or such other time as prescribed in Department of Labor Regulations). Notice shall be given to the claimant by telephone, facsimile, or other similarly expeditious manner. If the notice is communicated orally, a written or electronic confirmation shall follow.
 - (iv) Interpretation. The Plan Administrator has the exclusive right to interpret and administer the Plan and its decisions with respect to claims are conclusive and binding.
- (f) External Appeals. Except as otherwise required by applicable law, if a claimant exhausts all internal appeals procedures, the claimant may seek external review. The external review process will comply with applicable state or federal law and other rules and procedures for non-Grandfathered Plans as prescribed in Department of Labor Regulation 29 C.F.R. § 2590.715-2719.
- (g) Notice of Denial on Appeal. In the case of an adverse benefit determination on appeal, the notification to the claimant shall—
- (i) Set forth the specific reason or reasons for the adverse benefit determination;
 - (ii) Reference the specific Plan provisions on which the adverse benefit determination is based;
 - (iii) State 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;
 - (iv) Describe any voluntary appeal procedures offered by the Plan and the claimant’s right to obtain the information about such procedures;

- (v) Describe the claimant’s right to bring an action under ERISA Section 502(a) and any contractual limitations that apply to the claimant’s right to bring such an action;
- (vi) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, describe either the specific rule, guideline, protocol, or other similar criterion; or state that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- (vii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or state that such explanation will be provided free of charge upon request; and
- (viii) Include the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

6.3 Claims Procedure for Benefits Based on Determination of Disability.

- (a) This Section shall apply to any claim made under a Welfare Program which bases benefits on a determination of a disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions, or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure to the extent such other claims procedure complies with the Department of Labor Regulation 29 C.F.R. § 2560.503-1.
- (b) If a claim for benefits based on a determination of disability is denied in whole or in part, the claimant or the claimant’s Beneficiary shall receive written notification within a reasonable period of time, but no later than 45 days after the Plan Administrator’s receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator’s control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. Any notice of extension must be sent to the claimant before the end of the initial 30-day period, and shall explain the circumstances requiring the extension, the date by which the Plan Administrator expects to render a decision, the standards on which the claimant’s entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, the claimant must submit. The claimant shall be provided with at least 45 days to provide the additional information. The period from which the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

- (c) In the event a claim is denied, the denial notice shall:
- (i) Explain the reason(s) for denial,
 - (ii) Refer to the Section(s) of the Plan on which the denial is based;
 - (iii) Describe any additional material or information necessary for the claimant to perfect a claim and why that material or information is necessary;
 - (iv) Describe the claim appeal procedures and the time limits applicable to such procedures;
 - (v) Include a statement regarding the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review and any contractual limitations that apply to the claimant's right to bring such an action;
 - (v) Discuss the decision, providing an explanation of the basis for disagreeing with or not following:
 - The views of health care professionals treating the claimant and vocational professionals who evaluated the claimant as presented by the claimant to the Plan;
 - The views 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
 - A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
 - (vi) Provide either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
 - (vii) Include 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) The claimant shall have 180 days to appeal an adverse benefit determination. The claimant shall be notified of the Plan Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Plan Administrator receives the claimant's appeal request. The 45-day period may be extended for an additional 45-day period if the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time and provided that the claimant is notified of the extension prior to the expiration of the initial 45-day period. Such notice shall state the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

- (e) Notice of Denial on Appeal. In the case of an adverse benefit determination on appeal, the notification to the claimant shall—
- (i) Set forth the specific reason or reasons for the adverse benefit determination;
 - (ii) Reference the specific Plan provisions on which the adverse benefit determination is based;
 - (iii) State 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;
 - (iv) Describe any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures;
 - (v) Describe the claimant's right to bring an action under ERISA Section 502(a) and any contractual limitations that apply to the claimant's right to bring such an action;
 - (vi) Provide either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
 - (vii) Include 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.
- (f) The time period to consider a claim for benefits based on a determination of disability or to consider an appeal of an adverse benefit determination shall be suspended from the date of any notification of extension is sent to the claimant or appellant until such individual fulfills such request for additional information.

6.4 Claims Procedure for Benefits Other Than Health Benefits or Those Based on Determination of Disability.

- (a) This Section is intended to comply with ERISA Section 503 with respect to any Welfare Program that is subject to ERISA and is not described in Section 6.2 or 6.3. To the extent this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions, or other written materials for such Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure, to the extent such other claims procedure complies with Section 503 of ERISA. If the Welfare Program is not subject to ERISA as determined by the Plan Administrator, then the claims procedure contained in the policies, contracts, summary plan descriptions, or other written materials for the Welfare Program shall supersede this procedure.
- (b) If a Participant or former Participant asserts a right to any benefit under the Plan that the Participant has not received, the Participant or his or her authorized representative shall file a written claim for such benefit with the Plan Administrator. If the Plan Administrator wholly or partially denies such claim, it shall provide written or electronic notice to the

claimant within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan Administrator, unless the Plan Administrator determines that special circumstances require an extension of time, not to exceed 90 days, for processing the claim. If the Plan Administrator determines that an extension of time is required, it shall provide the claimant with written notice of the extension before the end of the initial 90-day period. Such notice shall describe the special circumstances requiring the extension of time and specify the date by which the Plan Administrator expects to render a benefit determination. If the Plan Administrator wholly or partially denies a claim, it shall set forth in its benefit determination, which shall be written in a manner calculated to be understood by the claimant, and include at least the following information:

- (i) The specific reasons for the denial of the claim;
 - (ii) Specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;
 - (iii) A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
 - (iv) An explanation of the Plan's claims review procedure including the time limits applicable under such procedure; and
 - (v) A statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and any contractual limitations that apply to the claimant's right to bring such an action.
- (c) A Participant or former Participant whose claim for benefits is denied may request a full and fair review of the adverse benefit determination within 60 days after notification of the adverse benefit determination by the Plan Administrator. The Participant or former Participant:
- (i) Shall be provided a review that takes 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 determination;
 - (ii) Shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
 - (iii) May submit written comments, documents, records, and other information relating to the claim to the Plan Administrator for review.
- (d) Subject to Department of Labor Regulation 29 C.F.R. § 2560.503-1(i)(1)(ii), a decision on review by the Plan Administrator shall be made within a reasonable period of time, but not later than 60 days after receipt by the Plan Administrator of a request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing, in which case the claimant shall be provided with written notice of the extension before the end of the initial 60-day period. Such notice shall describe the special circumstances requiring the extension and specify the date by which the Plan Administrator expects to render its decision. In no event shall the decision be rendered later than 120 days after the Plan Administrator's receipt of the request for review.

- (e) The Plan Administrator shall provide written or electronic notice of its decision with respect to the claimant's appeal, which shall be written in a manner calculated to be understood by the claimant. If there is an adverse benefit determination on review, the Plan Administrator's decision shall include:
- (i) The specific reasons for the adverse benefit determination;
 - (ii) Specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;
 - (iii) 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;
 - (iv) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to receive information about any such procedures; and
 - (v) A statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following the adverse benefit determination on review and any contractual limitations that apply to the claimant's right to bring such an action.

6.5 Unclaimed Benefits. If, within one year after any amount becomes payable hereunder to a Participant, Spouse, Dependent, or Beneficiary and the same shall not have been claimed, or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised by the Plan Administrator in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

6.6 Right of Subrogation. To the extent the subrogation provisions of this Section 6.6 are inconsistent with provisions of the policies, contracts, summary plan descriptions, or other written materials for a Welfare Program that expressly address rights of subrogation under such Welfare Program, the subrogation provisions of such other policies, contracts, summary plan descriptions, or other written materials shall supersede this Section 6.6.

- (a) Definitions. For purposes of this Section, the following definitions shall apply:
- (i) Award. "Award" means any amount paid to or on behalf of a Covered Individual, from a Third Party with respect to a Covered Individual's Illness, Injury, or other loss regardless of whether such amount is received as a result of a judgment of a court of competent jurisdiction, settlement, compromise, or otherwise, and regardless of whether such amount is categorized as punitive, compensatory, reimbursement for medical expenses, or otherwise.
 - (ii) Covered Individual. "Covered Individual" includes the Participants, Spouses, Dependents, and Beneficiaries for whom benefits are paid by the Plan and their heirs, guardians, executors, or other representatives.
 - (iii) Injury or Illness. "Injury" or "Illness" means such term as defined in each Welfare Program.
 - (iv) Reimbursement. "Reimbursement" means the Plan's right to recover any and all amounts paid for medical expenses from a Covered Individual who receives any

award related to the Illness, Injury, or other loss that resulted in the payment of such benefits by the Plan.

- (v) Subrogation. “Subrogation” means the right of the Plan to be substituted in place of any Covered Individual with respect to that Covered Individual’s lawful claim, demand, or right of action against a Third Party who may have wrongfully caused the Covered Individual’s Injury, Illness, or other loss that resulted in a payment of benefits by the Plan.
 - (vi) Third Party. “Third Party” includes, but is not limited to, any person or entity that caused, contributed to, or may be responsible for the Injury, Illness, or other loss to the Covered Individual. Third Party shall include any party, such as an insurance company, that acquires or may acquire responsibility through the actions of such person or entity, and shall also include uninsured motorist coverage.
- (b) Subrogation, Reimbursement and Benefit Offsets. For any and all benefits paid by the Plan to or on behalf of a Covered Individual by reason of Illness, Injury, or other loss, the Plan shall have the following rights:
- (i) Subrogation to any and all rights of recovery the Covered Individual may have arising from such Injury, Illness or other loss;
 - (ii) Reimbursement for the amount of any and all benefits paid to or on behalf of the Covered Individual by reason of Injury, Illness, or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) above from any Award arising out of such Injury, Illness, or other loss; and
 - (iii) Benefit offsets of future claims payable by the Plan on behalf of the Covered Individual or members of such Covered Individual’s immediate family to recover any and all amounts paid to or on behalf of the Covered Individual by reason of such Illness, Injury, or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) and a right to Reimbursement pursuant to paragraph (ii) but which have not, for any reason whatsoever, been reimbursed to or recovered by the Plan.

The Plan’s subrogation/reimbursement/benefit offset rights (herein referred to collectively as “Recovery Rights”) shall include the right to recover the amount due and owing to the Plan pursuant to its Recovery Rights from any Award paid to or for the benefit of the Covered Individual. The Plan does not recognize the “made whole” doctrine and a Covered Individual may not be whole after the Plan’s Recovery Rights are satisfied.

- (c) Payment Prior to Determination of Responsibility of a Third Party. The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Individual for any Illness, Injury, or other loss which a Third Party caused, contributed to or may be responsible for to the extent that the Covered Individual receives any Award from any Third Party. However, subject to the terms and conditions of this Section, the Plan will, after receipt of an executed reimbursement/subrogation/assignment agreement on such form as the Plan Administrator may require, make advance payment of benefits in accordance with the terms of the Plan, until an Award is paid to or for the benefit of the Covered Individual by a Third Party with respect to such Illness, Injury, or loss. The terms

and provisions of such reimbursement/subrogation/assignment agreement are incorporated herein by reference and any such agreement shall constitute a part of the Plan.

By accepting any advance payment of benefits from the Plan, the Covered Individual(s) jointly and severally agree that:

- (i) the Plan has a priority lien against any Award paid to or on behalf of the Covered Individual to assure that Reimbursement is promptly made; and
- (ii) the Plan will be subrogated to such Covered Individual's right of recovery from any Third Party to the extent of the Plan's advance payment of benefits; and
- (iii) such Covered Individual(s) will, jointly and severally, reimburse the Plan out of any and all Awards paid or payable to such Covered Individual(s) by any Third Party to the extent of the Plan's advance payment of benefits for claims related to the Illness, Injury, or other loss; and
- (iv) such Covered Individual(s) will assign to the Plan all of their right, title, and interest in and to any Award paid to or on their behalf by any Third Party to the extent of any advance payment of benefits made or to be made in accordance with the terms of the Plan.

The Plan's Recovery Rights include but are not limited to all claims, demands, actions, and rights of recovery of all Covered Individuals against any Third Party, including any workers' compensation insurer or governmental agency, and will apply to the extent of any and all advance payment of benefits made or to be made by the Plan.

- (d) Recovery Actions. The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its Recovery Rights, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Individual. However, in doing so, the Plan will not represent, or provide legal representation for, any Covered Individual with respect to such Covered Individual's damages to the extent those damages exceed any advance payment of benefits made or to be made in accordance with the terms of this Plan.

The Plan may at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Individual against any Third Party on account of any alleged negligent, intentional, or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury, or other loss that resulted in any advance payment of benefits by the Plan.

- (e) Reimbursement/Subrogation/Assignment Agreement. Prior to the advance payment of benefits for which a Third Party may be responsible, the Covered Individual on whose behalf an advance payment of benefits may be payable must execute and deliver any and all agreements, instruments, and papers requested by or on behalf of the Plan including an executed reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require. The failure of a Covered Individual to execute any such reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require, for any reason, shall not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's Recovery Rights if the Plan, at its discretion, makes

an advance payment of benefits for any reason in the absence of a reimbursement/subrogation/assignment agreement.

- (f) Administrative Procedure. The Plan's standard administrative procedure will be to determine whether a Third Party could be held liable for a claim. Claims will not be paid until this determination is made. If it is determined that the claim may be the responsibility of a Third Party for any reason, the Plan will not process any claims without a properly signed reimbursement/subrogation/assignment agreement as described in this Section.
- (g) Cooperation with the Plan by All Covered Individuals. By accepting an advance payment of benefits, the Covered Individual agrees not to do anything that will waive, compromise, diminish, release, or otherwise prejudice the Plan's Recovery Rights and to do whatever is necessary to protect the Plan's Recovery Rights.

By accepting an advance payment for benefits the Covered Individual agrees to notify and consult with the Plan Administrator or its designee before:

- (i) starting any legal action or administrative proceeding against a Third Party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in the Plan's advance payment for benefits; or
- (ii) entering into any settlement agreement with a Third Party that may be related to any actions by the Third Party that may have caused or contributed to the Covered Individual's Illness, Injury, or other loss that resulted in the Plan's advance payment for benefits related to such Illness, Injury or other loss.

Furthermore, by accepting any advance payment of benefits, the Covered Individual agrees to keep the Plan Administrator or its designee informed of all material developments with respect to all such claims, actions, or proceedings.

The Plan's Recovery Rights are Plan assets. The Plan or its designee may institute a lawsuit against a Covered Individual if such Covered Individual does not adequately protect the Plan's Recovery Rights.

- (h) All Recovered Proceeds Are to be Applied to Reimburse the Plan. By accepting an advance payment of benefits for an Illness, Injury, or other loss, the Covered Individual agrees to reimburse the Plan for all such advances from any Award paid or payable to or on behalf of such Covered Individual by any Third Party. In such event, the Plan must be fully reimbursed within 31 days of payment of any Award or the Covered Individual will be liable for interest and all costs of collection, including reasonable attorney's fees.

If a Covered Individual fails to reimburse the Plan as required by this Section, the Plan may apply any future claims for benefits that may become payable on behalf of such Covered Individual or any member of such Covered Individual's immediate family to the amount not reimbursed.

Notwithstanding, anything contained in the Plan to the contrary, the Plan will not pay future benefits for claims related to an Illness, Injury, or other loss with respect to which an Award was paid to or on behalf of a Covered Individual unless the Plan

Administrator determines that the Award was reasonable and the subsequent claims were not recognized in the Award.

- (i) Pre-Emption of State Law. To the extent that this Plan is a self-insured employee welfare benefit plan, ERISA preempts any state law purporting to limit, restrict, or otherwise alter the Plan's Recovery Rights.
- (j) No-Fault Insurance Coverage. Notwithstanding anything contained in the Plan to the contrary, if a Covered Individual is required to have no-fault automobile insurance coverage, the automobile no-fault insurance carrier will initially be liable for any and all expenses payable by this Plan up to the greater of:
 - (i) the maximum amount of basic reparation benefit required by applicable law, or
 - (ii) the maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of this Plan in which the Covered Individual is provided coverage. Before related claims will be paid through the Plan, the Covered Individual will be required to sign a reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require.

If the Covered Individual fails to secure no-fault insurance as required by state law, the Covered Individual will be treated as self-insured and must pay the amount of any and all expenses payable by the Plan for any and all Covered Individuals arising out of the accident.

- (k) Refund of Overpayment of Benefits – Right of Recovery. If the Plan pays benefits for expenses incurred on account of a Covered Individual, the Covered Individual or any other person or organization that was paid must refund the Plan if:
 - (i) all or some of the expenses did not legally have to be paid by the Covered Individual;
 - (ii) all or some of the payments made by the Plan exceeds the benefits under the Plan; or
 - (iii) all or some of the expenses were recovered from or paid by a source other than this Plan, including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a Third Party for negligence, intentional or otherwise wrongful acts or omissions.

The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If a Covered Individual or any person or organization that was paid does not promptly refund the full amount due under this Section, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

ARTICLE VII

Special Compliance Provisions

7.1 Uses and Disclosures of Protected Health Information.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- (a) Any Welfare Program under the Plan that is a health plan shall use protected health information (“PHI”) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). For purposes of this Section, health plan shall have the meaning as defined in HIPAA. Specifically, any health plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. For example, any health plan may disclose PHI to an insurer or health care provider as necessary to determine what benefits, if any, are due under the health plan.
- (b) A health plan will use and disclose PHI as required by law and as permitted by authorization of the Participant, Spouse, Dependent, Beneficiary, or other covered individual. With an authorization, a health plan may disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers’ compensation insurers, for purposes related to administration of the health plan. A Participant, Spouse, Dependent, Beneficiary, or other covered individual may revoke this authorization as permitted by law.
- (c) With respect to any PHI received from a Welfare Program that is a health plan, the Company or Plan Administrator shall:
 - (i) not use or further disclose PHI other than as permitted or required by the health plan document or as required by law;
 - (ii) ensure that any agents, including subcontractors, to whom the Company or Plan Administrator provides PHI received from a health plan agree to the same restrictions and conditions that apply to the Company or Plan Administrator with respect to PHI;
 - (iii) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
 - (iv) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Company unless authorized by an individual;
 - (v) report to the health plan’s designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;

- (vi) make PHI available to an individual in accordance with HIPAA's access requirements;
 - (vii) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
 - (viii) make available the information required to provide an accounting of disclosure;
 - (ix) make the Company's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for the purposes of determining the health plan's compliance with HIPAA;
 - (x) ensure that adequate separation between the health plan and the Company or Plan Administrator is established as required by HIPAA; and
 - (xi) if feasible, return or destroy all PHI received from the health plan that the Company or Plan Administrator maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible).
- (g) Only those Employees or classes of Employees identified in the Plan's privacy policies and procedures may have access to and use and disclose PHI for Plan administration functions that the Company or Plan Administrator performs for the health plan. If such individuals do not comply with this Plan, the Company or Plan Administrator shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.
- (h) Security. The Company or Plan Administrator shall implement security measures with respect to PHI to the extent of and in accordance with the security rules implemented by HIPAA. Specifically, the Company or Plan Administrator shall:
- (i) implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the plan;
 - (ii) ensure that adequate separation between the Plan and the Company or Plan Administrator is supported by reasonable and appropriate security measures;
 - (iii) ensure that any agent, including a subcontractor, to whom it provides information agrees to implement reasonable and appropriate security measures to protect the information (e.g., in the event the Company or Plan Administrator provides information to the broker for renewal bids); and
 - (iv) report to the Plan any security incident of which it becomes aware.

7.2 Special Enrollment Rights. This Section is intended to comply with ERISA Section 701(f) with respect to any Welfare Program that is a group health plan subject to ERISA 701(f). To the extent this Section is inconsistent with the provisions of policies, contracts, summary plan descriptions, or other written materials for such Welfare Program intended to address special

enrollment rights under ERISA Section 701(f), such provisions of such other policies, contracts, summary plan descriptions, or other written materials shall supersede this Section, to the extent such other provisions comply with Section 701(f) of ERISA.

- (a) In accordance with the HIPAA special enrollment rules, if an eligible Employee declines coverage in a Welfare Program that is a group health plan subject to the requirements of ERISA Section 701(f) for himself or herself and/or the Employee's Spouse and Dependents because of other health insurance coverage, they may be able to enroll for coverage under such Welfare Program upon loss of eligibility for the other coverage, provided that the Participant requests enrollment within 30 days after the other coverage ends.

If a Participant gains a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and the Participant's Spouse and Dependents in the group health Welfare Program provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

- (b) Employees, Spouses, and Dependents who are eligible but not enrolled in a Welfare Program that is a group health plan subject to the requirements of ERISA Section 701(f) may enroll when:
 - (i) The Employee's, Spouse's or Dependent's Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and the eligible Employee requests coverage under such Welfare Program within 60 days after the termination, or
 - (ii) The Employee, Spouse, or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the eligible Employee requests coverage under such Welfare Program within 60 days after eligibility is determined.

The special enrollment rules of this Section 7.2 do not apply to a Welfare Program that provides limited scope dental or vision benefits or certain health care flexible spending accounts (e.g., health care spending accounts that limit benefits to employee salary reduction amounts).

7.3 Qualified Medical Child Support Orders. A qualified medical child support order ("QMCSO") is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide a child or children of an Employee with health insurance coverage. The Plan Administrator (or its delegate) shall comply with the terms of any QMCSO it receives, and shall:

- (a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO as defined under Section 609 of ERISA (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);
- (b) Promptly notify the Participant and any alternate recipient of the receipt of a medical child support order, and the group health plan's procedures for determining whether the medical child support order is a QMCSO; and

- (c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Participant and each alternate recipient of such determination.

7.4 State Medicaid Programs. Eligibility for coverage or enrollment in a state Medicaid Program shall not impact an Employee's, Spouse's, or Dependent's eligibility for coverage under a Welfare Program that provides health benefits.

7.5 Coverage During FMLA Leave. This Section is intended to comply with the Family and Medical Leave Act of 1993 ("FMLA") with respect to any Welfare Program that is a group health plan subject to the FMLA. To the extent this Section is inconsistent with the provisions of policies, contracts, summary plan descriptions, or other written materials for such Welfare Program intended to comply with the FMLA, the such provisions in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this Section, to the extent such other provisions comply with the FMLA.

A Participant on a leave of absence that qualifies as leave under the FMLA may continue to receive group health plan coverage under this Plan during such leave along with his or her eligible Spouse and Dependents as if such Participant did not experience an interruption in active employment until the end of such FMLA leave period, or, if earlier, the date the Participant gives notice that he or she does not intend to return to work at the end of the FMLA period. The Participant must make any required contributions for group health plan coverage during such period in such time and manner as the Plan Administrator may require under applicable federal regulations and in accordance with the terms of any applicable Code Section 125 cafeteria plan sponsored by the Company.

If a Participant does not continue group health coverage or other types of coverage but returns to work before the expiration of FMLA leave, he or she must be reinstated in his or her benefit coverage, including group health care coverage, at the same level and under the same conditions as if the leave had not occurred.

7.6 Special Rules for Maternity and Infant Coverage. This Section is intended to comply with ERISA Section 711 with respect to any Welfare Program that is a group health plan subject to ERISA 711. To the extent this Section is inconsistent with the provisions of policies, contracts, summary plan descriptions, or other written materials for such Welfare Program intended to address compliance with ERISA Section 711, such provisions in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this Section, to the extent such other provisions comply with Section 711 of ERISA.

No Welfare Program that is a group health plan subject to ERISA Section 711 shall 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. The attending provider or physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Notwithstanding the foregoing, the Welfare Program may not require that a provider obtain authorization from the Welfare Program for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

7.7 Special Rule for Women's Health. This Section is intended to comply with ERISA Section 713 with respect to any Welfare Program that is a group health plan subject to ERISA 713. To the extent this Section is inconsistent with the provisions of policies, contracts, summary plan

descriptions or other written materials for such Welfare Program intended to address compliance with under ERISA Section 713, such provisions in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this Section, to the extent such other provisions comply with Section 713 of ERISA.

If a Welfare Program is a group health plan subject to ERISA Section 713 and provides medical and surgical benefits for mastectomy procedures, it shall provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the Welfare Program.

- 7.8 Military Leave. This Section is intended to comply with Uniformed Services Employment and Reemployment Rights Act (“USERRA”) with respect to any Welfare Program that is a group health plan subject to USERRA. To the extent this Section is inconsistent with the provisions of policies, contracts, summary plan descriptions or other written materials for such Welfare Program intended to address compliance with USERRA, such provisions in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this Section, to the extent such other provisions comply with USERRA.

A Participant’s right to elect continued participation in a Welfare Program that is a group health plan subject to USERRA (a “USERRA Welfare Program”) for himself or herself, the Participant’s Spouse, and Dependents during a leave of absence for active military duty is protected by USERRA.

- (a) Participants may elect to continue under a USERRA Welfare Program for a period of time that is the lesser of:
 - (i) the 24-month period beginning on the Participant’s first day of military leave, or
 - (ii) the period beginning on the Participant’s first day of military leave and ending on the date the Participant fails to return from military leave or apply for re-employment as required under USERRA.
- (b) If a Participant’s absence for military duty is less than 31 days, the Participant will be required to pay the regular employee share of the cost for coverage under such USERRA Welfare Program. If the Participant’s absence is for 31 or more days, the Participant will not be required to pay more than 102% of the full cost of coverage (and the Participant’s Spouse and Dependents) under such USERRA Welfare Program.
- (c) USERRA continuation coverage under a USERRA Welfare Program is considered alternative group health plan coverage for purposes of COBRA. Therefore, if a Participant elects USERRA continuation coverage, COBRA continuation coverage under such USERRA Welfare Program shall not be available.
- (d) Participants returning from military leave shall be reinstated for coverage under a USERRA Welfare Program upon re-employment, and an exclusion or waiting period shall not be imposed if such exclusion or waiting period would not have been imposed

had the Participant's coverage for a reason other than military leave. This paragraph shall not apply to illnesses or injuries determined by the Secretary of Veteran's Affairs or his or her representative to have been incurred in, or aggravated during, the performance of military service.

- (e) In no event shall benefits available under a USERRA Welfare Program during a period of USERRA qualified military leave be less generous than those benefits available during other comparable employer approved leave periods (e.g., family and medical leave).

7.9 COBRA. This Section is intended to comply with the coverage continuation requirements of the Consolidated Omnibus Budget Reconciliation Act as set forth in Part 6 of ERISA ("COBRA") with respect to any Welfare Program that is a group health plan subject to COBRA (a "COBRA Welfare Program"). To the extent this Section is inconsistent with the provisions of policies, contracts, summary plan descriptions or other written materials for such Welfare Program intended to address compliance with COBRA, such provisions in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this Section, to the extent such other provisions comply with COBRA.

- (a) Legal Rights to COBRA. The Company, to the extent required by law, shall offer a Participant, Spouse, or Dependent who, as a result of a "qualifying event," becomes otherwise ineligible to participate in a COBRA Welfare Program the opportunity to temporarily extend coverage under such COBRA Welfare Program at group rates. A domestic partner shall not be considered a Spouse for COBRA purposes and therefore shall not be entitled to COBRA continuation coverage unless otherwise required under applicable law. However, the Company may, solely in its own discretion, and solely in the manner it determines, provide continuation coverage to domestic partners who are Beneficiaries.

- (b) Qualifying Events.

- (i) A Participant who loses COBRA Welfare Program coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

- (A) A reduction of the Participant's hours of employment;

- (B) The Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct; or

- (C) Upon the Company or Participating Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is a retired Employee.

- (ii) A Spouse or Dependent who loses COBRA Welfare Program coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

- (A) A Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct, or reduction of hours of employment;
 - (B) The death of a Participant;
 - (C) The divorce or legal separation of the Participant and Spouse;
 - (D) Loss of dependent status under the COBRA Welfare Program;
 - (E) Enrollment in Medicare (Part A or B) by the Participant; or
 - (F) The Company or Participating Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.
- (c) Qualified Beneficiary. A Qualified Beneficiary is a Participant, Spouse, or Dependent who on the day before a qualifying event is covered under the COBRA Welfare Program. Qualified Beneficiary includes children born to, adopted by, or placed for adoption with the Participant during his or her COBRA continuation coverage period. Such child's coverage period shall be determined according to the date that the Participant's COBRA continuation coverage period began. A domestic partner is not a Qualified Beneficiary for COBRA purposes and therefore shall not be entitled to COBRA continuation coverage as described in this Article VII unless otherwise required under applicable law.
- (d) Notices. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of divorce or legal separation must notify the Plan Administrator within 60 days after such divorce or legal separation. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of the loss of Dependent status under the COBRA Welfare Program available under the Plan must notify the Plan Administrator within 60 days of such loss of Dependent status.
- The Qualified Beneficiary shall be notified of his or her right to elect continuation coverage and the cost to do so. Continuation coverage must be elected within 60 days after the later of the date coverage under the COBRA Welfare Program ceases or the date the Qualified Beneficiary is notified of the right to elect continuation coverage.
- If the Qualified Beneficiary does not elect continuation coverage, coverage under the COBRA Welfare Program shall cease. If the Qualified Beneficiary chooses continuation coverage, such COBRA Welfare Program shall provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period.
- (e) Cost. The Qualified Beneficiary must pay the full cost of such coverage to the Plan for a similarly situated active employee. The Plan may charge a 2% administrative fee. The COBRA premium may increase to 150% of the total premium during a disability extension as described in paragraph (f)(iv).

(f) Maximum Continuation Period.

- (i) A Qualified Beneficiary who loses COBRA Welfare Program as a result of the death of the Participant, the Participant's eligibility for Medicare, divorce, legal separation or loss of Dependent status under such COBRA Welfare Program and elects COBRA continuation coverage shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred.
- (ii) A Qualified Beneficiary who loses COBRA Welfare Program coverage as a result of the Participant's termination of employment or reduction of hours and elects COBRA continuation coverage shall be entitled to receive up to 18 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred. If a second qualifying event occurs during such 18-month period, the COBRA continuation coverage period may be extended by an additional 18 months for each Qualified Beneficiary (other than a covered Employee). The Qualified Beneficiary must notify the Plan Administrator within 60 days of a second qualifying event to receive the additional 18 months of continuation coverage. A second qualifying event is an event that occurs during the initial 18-month period that would have resulted in a loss of coverage under the COBRA Welfare Program for the Qualified Beneficiary in the absence of the first qualifying event. In no event, however, shall any Qualified Beneficiary's COBRA continuation coverage period exceed 36 months.
- (iii) A Qualified Beneficiary (other than the Participant) who loses COBRA Welfare Program coverage as a result of the Participant's termination of employment or reduction of hours and such event occurs within 18 months following the Participant's enrollment in Medicare, shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date the Participant enrolled in Medicare.
- (iv) If a qualifying event occurs that is the Participant's termination of employment or reduction of hours, any Qualified Beneficiary who is deemed to have been disabled, as determined by the Social Security Administration, at any time during the first 60 days of COBRA continuation coverage shall be eligible to extend the COBRA continuation coverage period to 29 months. In the case of a child born to or adopted by a Participant during the Participant's COBRA continuation coverage period, such 60-day period will begin from the date of birth or placement of adoption. Such extension shall apply to the Qualified Beneficiary's covered family members. Such Qualified Beneficiary must notify the Plan Administrator of the disability in writing within 60 days of the date of the Social Security Administration determination and before the end of the 18-month continuation coverage period. A Qualified Beneficiary receiving extended COBRA continuation coverage due to disability must inform the Plan Administrator within 30 days of receiving a final determination that he or she is no longer disabled.
- (v) In the case of a qualifying event that is the bankruptcy of the Company or the Participating Employer, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired

covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse, or Dependent of the retired covered Employee ends on the earlier of – (A) The date of the Qualified Beneficiary's death; or (B) The date that is 36 months after the death of the retired covered Employee.

- (g) Termination of COBRA Continuation Coverage. COBRA continuation coverage shall cease upon the occurrence of any of the following events:
- (i) The Company or Participating Employer ceases to provide group health plan coverage to any of its Employees;
 - (ii) The Qualified Beneficiary fails to pay the premium or required Participant Contribution within 30 days after its due date.
 - (iii) The Qualified Beneficiary becomes covered, after the date of the COBRA continuation coverage election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such Qualified Beneficiary (other than an exclusion or limitation that may be disregarded under the law);
 - (iv) The Qualified Beneficiary becomes enrolled in Medicare after the date of the COBRA continuation coverage election;
 - (v) The Qualified Beneficiary has extended COBRA continuation coverage due to a disability and is subsequently determined by the Social Security Administration to be no longer disabled;
 - (vi) The maximum required COBRA continuation coverage period expires; or
 - (vii) For cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employee.
- (h) Second Election Period. A Participant and his or her Spouse or Dependents may be eligible to elect continuation coverage during a second election period if such Participant:
- (i) is receiving trade adjustment assistance benefits under the Trade Act of 2002 (or would be eligible to receive trade adjustment assistance benefits but has not exhausted unemployment benefits);
 - (ii) lost health coverage due to termination of employment that resulted in eligibility for trade adjustment assistance benefits under the Trade Act of 2002; and
 - (iii) did not elect COBRA continuation coverage during the initial COBRA election period.

The second election period is the 60-day period beginning on the first day of the month in which the Participant becomes eligible for such second election period, but only if the election is within the six-month period after the Participant initially lost coverage.

COBRA continuation coverage begins on the first day of the second election period. Such coverage is not retroactive to the date the Participant initially lost coverage.

- 7.10 Genetic Information Nondiscrimination Act of 2008. This Section is intended to comply with the Genetic Information Nondiscrimination Act of 2008 (“GINA”) with respect to any Welfare Program that is subject to GINA (a “GINA Welfare Program”). To the extent this Section is inconsistent with the provisions of policies, contracts, summary plan descriptions or other written materials for such Welfare Program intended to address compliance with GINA, such provisions in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this Section, to the extent such other provisions comply with GINA.
- (a) Unless otherwise permitted, the Company or Participating Employer may not request or require any genetic information from an Employee or family member of the Employee.
 - (b) “Genetic information” as defined by GINA includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
 - (c) The Company or Participating Employer shall not request any genetic information when requesting health-related information. However, with respect to any wellness program available under the Plan, the Company or Participating Employer may request, but may not require, an Employee to provide genetic information in accordance with Equal Employment Opportunity Commission regulations.
 - (d) The Company or Participating Employer will not request, require or purchase genetic information in violation of GINA. If the Company or Participating Employer intentionally or unintentionally obtains genetic information pertaining to an Employee or a family member of the Employee, the Company or Participating Employer will not use such genetic information in violation of GINA. Any genetic information received by the Company or Participating Employer that pertains to an Employee or a family member of the Employee, shall be maintained on forms and in medical files that are separate from personnel files, and shall be treated as confidential medical records.
- 7.11 Health-Related Factors. No Welfare Program that is a group health plan will discriminate against any Participant, Spouse, or Dependent in terms of eligibility to participate in such Welfare Program based on a health-related factor. In addition, benefits provided under any such Welfare Program will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. Such Welfare Program may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.
- 7.12 Mental Health Parity Act. This Section is intended to comply with the coverage continuation requirements of the Mental Health Parity and Addiction Equity Act of 2008, as set forth in

ERISA Section 712 (the “MHPAEA”) with respect to any Welfare Program that is a group health plan subject to the MHPAEA (an “MHPAEA Welfare Program”). To the extent this Section is inconsistent with the provisions of policies, contracts, summary plan descriptions or other written materials for such Welfare Program intended to address compliance with the MHPAEA, such provisions in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this Section, to the extent such other provisions comply with the MHPAEA.

An MHPAEA Welfare Program must generally comply with the provisions of the MHPAEA, including that the MHPAEA Welfare Program’s financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) that are applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

ARTICLE VIII

Amendment and Termination

- 8.1 Amendment. The Company may amend the Plan and any Welfare Program, and may transfer any Welfare Program from the Plan to a separate plan, at any time.
- 8.2 Termination. The Company may, in its sole and absolute discretion, discontinue or terminate the Plan and any Welfare Program, in whole or in part, at any time.

ARTICLE IX

Miscellaneous

- 9.1 Exclusive Benefit. Plan fiduciaries will discharge their duties with respect to the Plan for the exclusive purposes of providing benefits to Participants, Spouses, Dependents, or Beneficiaries in accordance with the terms of the Welfare Programs, and defraying reasonable expenses of administering the Plan.
- 9.2 Non-Alienation Benefits. No benefit, right, or interest of any Participant, Spouse, Dependent, or Beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment, or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, as permitted under the terms of this Plan or a Welfare Program.
- 9.3 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:
- (a) Give any person any legal or equitable right against the Company or Participating Employer except as expressly provided herein or required by law, or
 - (b) Create a contract of employment with any Employee, obligate the Company or Participating Employer to continue the service of any Employee, or affect or modify the terms of an Employee’s employment in any way.

- 9.4 Governing Laws and Jurisdiction and Venue. The Plan shall be construed and enforced according to the laws of the State of Wisconsin to the extent not preempted by federal law, which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Plan or any of the Welfare Programs shall be in any court of appropriate jurisdiction in the State of Wisconsin.
- 9.5 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.
- 9.6 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge, or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.
- 9.7 Titles. The titles of the Articles and Sections are included for convenience only and shall not be construed as part of the Plan or in any respect affecting or modifying its provisions. Such words in this Plan as “herein” and “hereunder” refer to this Plan as a whole and not merely to the Article, Section, or subdivision in which those words appear.
- 9.8 Expenses. Subject to the terms of the Welfare Programs, any expenses incurred in the administration of the Plan shall be paid by the Plan and/or by the Company, according to the Company’s determination.
- 9.9. Registered Agent. The designated agent for service of legal process for the Plan is NAME, ADDRESS. Service may also be made on the Plan Administrator or the trustee under any applicable Welfare Program.
- 9.10 Not Legal Advice. This Plan is for informational purposes and does not constitute legal advice, nor should it be relied upon as such.

ARTICLE X

Participating Employers

- 10.1 Adoption of the Plan. This Plan may be adopted by a Participating Employer, by action of an authorized officer of the Participating Employer, provided the Company approves such adoption.
- 10.2 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Company and the Plan Administrator to act for the Participating Employer in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Company and/or the Plan Administrator.
- 10.3 Termination of Participation. Each Participating Employer, by action of an authorized officer of the Participating Employer, may cease to participate in the Plan or in any individual Welfare Program with respect to its Employees or former Employees, provided the Company approves

cessation. The Company, in its sole discretion, may terminate at any time a Participating Employer's participation in the Plan or in any individual Welfare Program with respect to the Participating Employer's Employees and former Employees and the Spouses, Dependents, and Beneficiaries of such Employees and former Employees.

ARTICLE XI

Effective Date

The original effective date of the plan is/was 08/01/2017. If this date is different from the effective date specified in the introduction section of this plan document, the Plan has been amended and restated. The effective date of the most recent amendment and restatement is stated in the Introduction section. The Plan may have been amended several times since its original effective date.

* * * * *

IN WITNESS WHEREOF, the Company has caused this instrument to be duly executed in its name and on its behalf as of the date set forth below.

Tri City National Bank Company.

By: _____

Date: _____

ATTEST:

APPENDIX A

Tri City National Bank COMPANY HEALTH AND WELFARE PLAN

WELFARE PROGRAMS

The following Welfare Programs shall be treated as part of the Plan pursuant to Section 2.14 and as defined in Section 2.16:

Welfare Programs

Tri City National Bank **Group Health Plan—Medical Benefits**

Carrier's or Program Administrator's Name: Anthem Blue Cross Blue Shield

1st of month following date of hire

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company Group Health Plan—Prescription Drug Benefits**

Carrier's or Program Administrator's Name: Anthem Blue Cross Blue Shield

1st of month following date of hire

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company Dental Plan**

Carrier's or Program Administrator's Name: Delta Dental

1st of month following date of hire

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company Group Life and AD&D Plan**

Carrier's or Program Administrator's Name: The Hartford

1st of month following 60 days

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company Long-Term Disability Plan**
Carrier's or Program Administrator's Name: The Hartford

1st of month following 60 days

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company Short-Term Disability Plan**
Carrier's or Program Administrator's Name: The Hartford

1st of month following 60 days

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company Group Vision Plan**
Carrier's or Program Administrator's Name: Superior Vision

1st of month following date of hire

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company Flexible Spending Plan**
Carrier's or Program Administrator's Name: Diversified Benefits Services

1st of month following date of hire

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company Salaried Employee Severance Plan**
Carrier's or Program Administrator's Name: none

none

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company Health Reimbursement Arrangement (HRA)**
Carrier's or Program Administrator's Name: none

none

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Tri City National Bank **Company [Other] Plan**
Carrier's or Program Administrator's Name: none

none

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

APPENDIX B

Tri City National Bank _____ COMPANY HEALTH AND WELFARE PLAN

PARTICIPATING EMPLOYERS

In addition to Tri City National Bank Company the following Participating Employers have adopted the Plan pursuant to Section 10.1:

- none

There are no other Participating Employers in the Plan.