INCREDIBLEBANK
GROUP SHORT TERM DISABILITY PLAN

Plan Document
and Summary Plan Description

As in Effect December 1, 2023

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PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION

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NAME OF PLAN

IncredibleBank Group Short Term Disability Plan.

PLAN SPONSOR

River Valley Bancorporation, 327 N. 17th Avenue, Wausau, WI 54401; Employer Identification Number 39-1440245.

PLAN NUMBER

501.

TYPE OF PLAN

The Plan provides short-term disability benefits in the event of personal illness or personal disability.

PLAN ADMINISTRATOR

IncredibleBank, 327 N. 17th Avenue, Wausau, WI 54401; (715) 348-1403; Employer Identification Number 39-1088977.

The Plan Administrator has the authority to make factual determinations, to determine eligibility for and entitlement to benefits under the Plan, to construe and interpret the provisions of the Plan, and to correct defects and resolve ambiguities in the Plan. The Plan Administrator also has the sole authority to delegate any power, responsibility, or duty that has been assigned to it. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

TYPE OF PLAN ADMINISTRATION

The Plan is administered by IncredibleBank and benefits are provided in accordance with this document which serves as both the plan document and summary plan description as required by the Employee Retirement Income Security Act.

AGENT FOR SERVICE OF LEGAL PROCESS

Director of Total Rewards, IncredibleBank, 327 N. 17th Avenue, Wausau, WI 54401.

Service may also be served on the Plan Administrator.

PLAN FUNDING

Benefits under the Plan are provided out of the general assets of the Employer.

COST

The Employer pays the full cost.

PLAN YEAR

January 1 - December 31.

ELIGIBILITY FOR BENEFITS

Full-time employees of IncredibleBank (the "Employer") are eligible for benefits under this Plan and become Plan Participants the first day of the month following completion of 30 consecutive calendar days of employment with the Employer. Full-time employee is defined as a common law employee of the Employer who is regularly scheduled to work at least 30 hours a week. Seasonal, temporary and part-time employees of the Employer, and employees compensated on a 100% commissioned basis (even if considered full-time) are not eligible for coverage. If the Plan Administrator determines that an individual is ineligible for the Plan because the individual is not a common law employee of the Employer, but a court or administrative agency determines that the individual was, in fact, a common law employee of the Employer, the Plan Administrator's initial determination of ineligibility shall not be altered.

BENEFITS PROVIDED BY THE PLAN

It is the intent of the Employer to provide income continuation to Plan Participants in the event personal illness, personal disability or childbirth renders them medically unable to perform all of the Substantial and Material Duties of their own position ("Disability"). In order to be eligible for Disability Benefits, you must establish a medical reason for your inability to work. The Plan Administrator may require you to furnish a doctor's certificate periodically and may require examination by a physician of its choosing, including a second opinion if the Plan Administrator determines in its discretion that one is necessary.

Pregnancy will be a Disability under the Plan if you are unable to perform the Substantial and Material Duties of your position due to the pregnancy. Disability Benefits due to a pregnancy may begin prior to the expected delivery date with a physician's certification of Disability and will continue after the birth (subject to the maximum 12 weeks of Disability Benefits described below). Adoptive parents and birth fathers are not eligible for Disability Benefits due to the mother's pregnancy.

The Substantial and Material Duties of your job are those essential tasks required by the Employer from those engaged in your particular job that cannot be modified or omitted.

Level of Benefits

Disability Benefits are equal to a percentage of Salary, which is dependent upon length of employment. The schedule of Disability Benefits is as follows:

Years of Service	Benefit
60 days to < 3 yrs.	65% of Salary
3 yrs. to < 4 yrs.	75% of Salary
4 yrs. to< 5 yrs.	85% of Salary
5 years and over	90% of Salary

Plan Participants may utilize accrued PTO by the hour to bridge the gap between his/her Disability Benefits and full Salary. Please see Paid Time Off Policy for more information on PTO.

Important Definitions

Your Salary as of any date is your regular basic weekly (or weekly equivalent) wage then in force. It does not include commissions, bonuses, tips, shift differential pay, housing or car allowances, overtime or other irregular pay. Salary also does not include contributions to an Internal Revenue Code ("Code") Section 401(k) Plan or the amount of any pre-tax contributions to a cafeteria plan under Code Section 125.

Reduction of Disability Benefits; Partial Weekly Benefit

The weekly Disability Benefit may be reduced in order to correct a prior overpayment of benefits. If the part of the week for which Disability Benefits are payable is less than a full week, the Disability Benefit paid for each day of Disability will be the weekly Disability Benefit converted to a daily benefit.

No Waiting Period; Maximum Period that Disability Benefits are Payable

Disability Benefits begin retroactive to the first working day of your Disability. Disability Benefits are payable for a maximum of twelve weeks per rolling 12-month period, regardless of the number of Disabilities during such rolling 12-month period. For purposes of the Plan, the 12-month period is measured backward from the date you receive any Disability Benefits hereunder. However, in no event will Disability benefits continue beyond:

1. The date of your death;

2. The date your Disability ends;

3. The date you fail to provide any required proof of a Disability;

4. The date you fail to submit to any required medical examination or evaluation;

5. The date you cease to be under the regular and appropriate care of a physician.

6. The date the Plan terminates.

The Employer's long-term disability (LTD) plan has a recovery period (also known as an "elimination period") of 90 days before it will pay LTD benefits. However, this short-term disability (STD) plan provides Disability Benefits for 12 weeks in a rolling 12-month (measured backwards) period. As a result, if you return to work after more than 90 days while you are out on an approved STD leave, there may be a gap between your STD benefits ending and your LTD claim approval and payment.

DOCTOR'S STATEMENT REQUIRED

While it is not necessary for you to be confined to a hospital or bed, a statement by a legally licensed physician, surgeon, or chiropractor to the effect that your Disability prevents you from performing all of the Substantial and Material duties of your job is required for you to receive Disability Benefits. The Doctor's statement should indicate the expected length of time you will not be able to perform all of the Substantial and Material duties of your job. In the case of childbirth, a statement of a legally licensed physician which states that you have given birth is sufficient to document your Disability.

To avoid confusion and possible denial or delay of payment of at least part of your claim, it is recommended that you see a doctor to establish that you are under a doctor's care for that particular illness and that the illness did in fact begin as claimed. Disability Benefits will not begin until the Doctor's statement is received and approved by the Plan Administrator. Some doctors are not willing to "backdate" claim forms more than a few days prior to your visit, so it may be in your best interest to see a doctor early.

You may be required to be examined by a doctor or undergo an evaluation, at reasonable intervals, during the course of a claim. The Employer will pay for those examinations and evaluations and will choose the doctor or evaluator to perform them. Failure to attend a medical examination or cooperate with the doctor may be cause of suspension or denial of your Disability Benefits.

Prior to returning to work an additional statement is required from your doctor indicating that you are able to resume job duties and noting any limitations.

FMLA; OTHER BENEFITS

Periods of Disability run concurrent with Family/Medical Leave (FMLA) and state Leave Laws, as allowed by law, if the Plan Participant is eligible for such leave. During the Disability period, the Plan Participant will continue benefit programs they currently are enrolled in.

EXCLUSIONS

This Plan does not apply to and benefits will not be paid with respect to:

1. Disability arising out of or in the course of any employment, including self-employment, for wage or profit or Disability for which the Participant is entitled to benefits under any applicable workers' compensation or occupational disease law.

2. Disability for which the Participant is not treated by a doctor;

3. Disability caused by any act or incident of declared or undeclared war;

4. Disability occurring while the Participant is on active duty or as the result of the Participant being on active duty as a member of the armed services of any country;

5. Any self-inflicted Disability related to a suicide attempt or as the result of an intentional or impulsive act;

6. Disability resulting from committing or attempting a crime, felony or misdemeanor; and

7. Disability which starts while you are not working on a regularly scheduled basis due to lay-offs, unpaid leave of absence, or other reason.

SUBROGATION PROVISION

When a Participant receives a benefit from the Plan:

1. For a Disability; and

2. Is entitled to recover payment from any other party who may be obligated to pay for such Disability; then

the Plan is subrogated to all rights to recover:

a. Any payments to which the Participant or any other person or organization is entitled on account of such Disability; and

b. To the extent the Plan paid the benefit.

The Participant or other person receiving such payment from the Plan shall:

1. Sign and deliver all necessary papers;

2. Do whatever else is necessary to protect the Plan's rights; and

3. Not do anything before or after the Plan's payment which would prejudice the Plan's rights.

The Plan's rights of full recovery may be from a third party, any liability or other insurance covering a third party, the Participant's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault insurance or school insurance coverages that are paid or payable.

The Plan's right to subrogate will apply even if the Participant has not been made whole for the loss. The Plan's right of subrogation shall be, in first priority, to the extent of any and all benefits paid.

The Plan will not pay fees or costs associated with any claim/lawsuit without express written consent. The Plan reserves the right to independently pursue and recover paid benefits.

TERMINATION OF BENEFITS

Your coverage under this Plan will terminate:

1. As of the day you are no longer employed by the Employer in an eligible class of employees under the Plan.

2. As of the day your employment is terminated, or you are no longer a full-time employee of the Employer.

3. As of the day you retire.

4. As of the day the Plan is terminated by the Employer.

AMENDMENT OR TERMINATION OF THE PLAN

The Employer has reserved the right to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time for any reason without advance notice to Participants. No Participant will be vested in any way as to Disability Benefits under the Plan.

CLAIMS PROCEDURE

Requesting Benefits

The following procedure should be used to help ensure prompt and correct payment of Disability Benefits:

1. Report in writing illness or injury as soon as possible to Human Resources.

2. If you are entitled to Disability Benefits, payments will be made through the normal payroll process.

3. A return to work slip from the doctor for the period of your Disability must be presented to Human Resources who will notify your supervisor of your return to work.

A request for benefits under the Plan must be submitted to Human Resources in accordance with these requirements no later than the first anniversary of the date you experience a Disability. You will lose the right to any benefits under the Plan if you do not meet this deadline.

Formal Claim Process

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. The Plan Administrator will provide you with written or electronic notification of any Plan adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan Administrator. This period may be extended by the Plan Administrator for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan Administrator and notifies you, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If, prior to the end of the first 30 day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan Administrator, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies you, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which the Plan Administrator expects to render a decision. In the case of any such extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

The Plan Administrator's written or electronic notification of any adverse benefit determination must contain the following information:

1. The specific reason or reasons for the adverse determination.

2. Reference to the specific Plan provisions on which the determination is based.

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

4. Appropriate information as to the steps to be taken if you or your beneficiary want to submit your claim for review.

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in

making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

If your claim has been denied, and you want to submit your claim for review, you must follow the Claims Review Procedure.

What is the Claims Review Procedure?

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Plan Administrator. YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 180 DAYS AFTER YOU HAVE RECEIVED WRITTEN OR ELECTRONIC NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION.

You may submit written comments, documents, records, and other information relating to your request for a review of your claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. In addition:

1. Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan ("Appeals Plan Administrator") who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

2. In deciding an appeal of any adverse benefit determination that is based in whole or part on medical judgment, the Appeals Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

3. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

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

The Plan Administrator (or Appeals Plan Administrator, if applicable) will provide you with

written or electronic notification of the Plan's benefit determination on review. The Plan Administrator must provide you with notification of this denial within 60 days after the Plan Administrator's receipt of your written claim for review, unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. In no event will such extension exceed a period of 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Appeals Plan Administrator expects to render the determination on review. In the case of an adverse benefit determination, the notification will set forth:

1. The specific reason or reasons for the adverse determination.

2. Reference to the specific Plan provisions on which the benefit determination is based.

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

If you have a claim for benefits which is denied upon review, in whole or in part, you may file suit in a state or Federal court.

STATEMENT OF ERISA RIGHTS

Participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants be entitled to the following with respect to the Plan:

Examine, without charge, in the Human Resources Department, all plan documents and copies of all documents filed by the Plan Administrator with the United States Department of Labor, such as annual reports.

Obtain copies of all Plan documents and other Plan information upon written request. The Plan Administrator may make a reasonable charge for these copies.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and

beneficiaries. No one may be fired or otherwise discriminated against in any way to prevent anyone from obtaining a benefit or exercising rights under ERISA. If a benefit claim is denied in whole or in part, a written explanation of the reason for the denial must be given to the employee. Each employee has the right to have Plan review and to have the claim reconsidered. Under ERISA, there are steps to be taken to enforce the above rights.

For instance, if an employee requests materials from the Plan and does not receive them within thirty days, suit may be filed in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the employee up to $110 a day until the employee receives the materials, unless the materials were not sent because of reasons beyond its control. If a claim for benefits is denied or ignored, in whole or in part, the employee may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the employee is discriminated against for asserting the employee's rights, assistance may be sought from the U.S. Department of Labor, or a suit filed in a federal court. The court will decide who should pay court costs and legal fees. If the employee is successful, the court may order the person sued to pay these costs and fees. If the employee loses, the court may order the employee to pay these costs and fees, for example, if it finds the employee's claim is frivolous. If there are any questions about the Plan, contact Human Resources. If there are any questions about this statement or about employee rights under ERISA, contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

DISCLAIMER

The Plan Administrator has tried to make the description of benefits in this Summary easier to understand than the formal legal Plan document that contains the actual Plan language and describes the Plan operation in full. In the translation from legal to everyday language, it has done its best to explain Plan provisions correctly. However, if any of the information in this Summary should conflict with the governing Plan documents, those Plan documents will be the final authority. No rights are or are intended to be created by this Summary if those rights or benefits are not created by the formal Plan document which formally establishes the Plan.