Health Reimbursement Arrangement
Summary Plan Description

Purpose of the HRA Plan

_____ (the "Employer" or "Company") is pleased to announce the establishment of the _____ Health Reimbursement Arrangement ("Plan" or "HRA"), a medical expense reimbursement program for you and other eligible employees. Under the Plan, you will be able to receive reimbursement for the cost of eligible medical, dental and other similar expenses without taxation to you individually. The purpose of this Summary Plan Description ("SPD") is to briefly describe the basic features of the Plan, the expenses that qualify for reimbursement and other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

However, one of the most important features of the Plan is that the cost of all benefits being offered to you under this Plan is entirely paid for by your Employer, at no additional cost to you or your family.

Read this Summary Plan Description carefully so that you understand the provisions of the Plan and the benefits you are entitled to receive. You should direct any questions you have to the Plan Administrator. There is a Plan document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan document, the Plan document will control. Also, to the extent there are any type of insurance contracts that exist to provide any portion of benefits under this Plan, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract would control.

Name of the Plan

_____ Health Reimbursement Arrangement is the name of the Plan. _____ has assigned Plan Number 001 to this Plan. The provisions of this Plan became effective on _____ and the Plan Year is defined as a calendar year, January 1 to December 31.

Plan Sponsor and Plan Administrator

The Plan is sponsored by _____, who is also serving as the Plan Administrator. The Plan Administrator keeps the records for the Plan and is responsible for the Plan. The Plan Administrator will also answer any questions you may have about the Plan. You may contact the Plan Administrator for any further information about the Plan.

Company Name:		
Street:		
City:	ST:	Zip:
Phone:		
Federal Employer ID #		

Service of Legal Process

The Plan Administrator is the Plan's agent for services of legal process.

Eligibility Requirements

Eligible Employees of the HRA are those employees who are regularly scheduled to work at least 5 hours per week for the Company. Eligible Employees may participate in the Plan beginning on the first day of the month coincident with or next after satisfying the Plan's eligibility requirements.

Schedule of Benefits

The Plan shall reimburse eligible employees for the cost of Eligible medical or Dental Expenses, as defined under Internal Revenue Code Section 213, subject to an annual limit per eligible employee of $_____. In addition, the entire portion of a participant's remaining account balance as of the end of the Plan Year can be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution. None of this amount may be paid in cash or other form of distribution, other than through reimbursement of eligible medical expenses.

Medical Care Expenses are considered "incurred" when the service is performed, not necessarily when it is reimbursed. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your individual income tax return nor reimbursed to you by any other health plan.

All qualified medical and dental expenses as defined under Internal Revenue Code Section 213 not otherwise covered by insurance or other group health plans are eligible for reimbursement under the Plan except those listed below:

Select any of the following that apply:

- ☐ Health Insurance Premiums
- ☐ Dental Insurance Premiums
- ☐ Long-term Care Insurance Premiums
- ☐ Dental Expenses
- ☐ Vision Expenses
- ☐ Preventative Care Expenses
- ☐ Prescription Drugs
- ☐ Other:

OR

☐ None

Type of Plan and Funding

The Plan is intended to qualify as an employer-provided medical reimbursement plan as authorized under Internal Revenue Code Section 105 and the regulations issued thereunder and as a health reimbursement arrangement as defined in IRS Notice 2002-45. The plan is funded soley by the Employer from the Employer's general assets.

Plan Accounting

The Plan Administrator shall periodically furnish you with a statement of your HRA account for you to use in determining how much additional benefits remain in your account prior to the end of the Plan Year. This statement will also assist you in budgeting for expense reimbursement needs in future Plan Years. You may also make a written request to receive a copy of your HRA account from the Plan Administrator at any time.

Your Rights under ERISA

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

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of documents filed by the Plan with the U.S. Department of Labor or Internal Revenue Service, such as detailed annual reports and plan descriptions;

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series) (if required) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies); and

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

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of this Plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have an affirmative duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the Plan or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court if you have exhausted the claims procedures available to you under the Plan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claims Processing

You should submit reimbursement claims during the Plan Year, but in no event later than 60 days after the end of the Plan Year in which the claim was incurred. For a terminated employee or any participant who is no longer eligible under the terms of this Plan, claims will still be reimbursed but only if such reimbursement requests are made by the earlier of 1) 30 days following the date that you ceased your employment or eligibility; or (2) the end of the 60-day period following the close of the Plan Year in which the expense was incurred. Any claims submitted after that time will not be considered.

You are entitled to notification of the decision on your claim within 30 days after the Plan Administrator's receipt of the claim. This 30 day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Plan Administrator. The Plan Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Plan Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Plan Administrator will make the decision based on the information that it has.

If your claim is denied, the notice that you receive from the Plan Administrator will include the following information:

(a) The specific reason for the denial;

(b) A reference to the specific Plan provision(s) on which the denial is based;

(c) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA § 502(a) following a denial on review;

(e) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(f) If the Plan Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

You have the right to appeal the Plan Administrator's denial of your claim. Your appeal must be in writing, must be provided to the Plan Administrator, and must include the following information:

(a) Your name and address;

(b) The fact that you are disputing a denial of a claim or the Plan Administrator's act or omission;

(c) The date of the notice that the Plan Administrator informed you of the denied claim; and

(d) The reason(s), in clear and concise terms, for disputing the denial of the claim or the Plan Administrator's act or omission.

You should also include any documentation that you have not already provided to the Plan Administrator. Your appeal must be delivered to the Plan Administrator within 180 days after receiving the denial notice or the Plan Administrator's act or omission. If you do not file your appeal within this 180-day period, you lose your right to appeal.

Anytime before the appeal deadline, you may submit copies of all relevant documents, records, written continents, and other information to the Plan Administrator. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the fiduciary will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination. You will receive notification of the decision on your appeal within 60 days after receipt of your request for review. If special circumstances require an extension of time for processing the appeal, a decision shall be rendered not later than 120 days after receipt of a request for review. If an extension is necessary, you will be given written notice of the extension prior to the expiration of the initial 60 day period.

If your appeal is denied, the notice that you receive will include the following information:

(a) The specific reason for the denial upon review;

(b) A reference to the specific Plan provision(s) on which the denial is based;

(c) A statement providing that you are required 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;

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

(e) A statement of your right to bring a civil action under ERISA § 502(a).

No action may be brought against the Plan, the Employer, the Plan Administrator, or any other entity to whom administrative or claims processing functions have been delegated until you first follow the above claim procedures and receive a final determination on appeal.

The Plan Administrator and the fiduciary reviewing a denied claim on appeal have the right to review and interpret the appropriate Plan provisions. Decisions of the Plan Administrator and such fiduciary are conclusive and binding.

Non-Discrimination Requirements

To the extent that the Plan is treated as a self-insured medical expense plan under Treasury Regulation Section 1.105-11, it must comply with the non-discrimination requirements as set forth under Section 105(h) of the Internal Revenue Code. If you are deemed to be a "highly compensated employee," the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Your own circumstances will dictate whether contribution limitations on "highly compensated employees" will apply. You will be notified of these limitations if you are affected.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

A Participant who takes an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA Leave), may revoke his or her election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator, in their sole discretion. Upon such Participant's return from USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the USERRA leave commences, as other Plan Participants.

No Employment Rights Conferred

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our goal with the Plan is to allow you to have a greater portion of your allowable medical expense costs reimbursed to you without increasing the amount of taxes you pay; thereby increasing the amount of money you keep at the end of each pay period. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Plan Administrator.