HEALTH REIMBURSEMENT ARRANGEMENT

Summary Plan Description

INTRODUCTION

Insert Name of Employer (the "Employer" or "Company") is pleased to announce that we have established a medical expense reimbursement program for you called the *Insert Name of Employer* Health Reimbursement Arrangement (HRA) Plan (the "Plan"). 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 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.

PART A

GENERAL INFORMATION ABOUT THE PLAN

This Section provides general information about the Plan.

1. Plan Name:

The *Insert Name of Employer* Health Reimbursement Arrangement is the name of the Plan.

2. Effective Date (select all that apply):

❑ The provisions of the Plan became effective on _____, which is called the Effective Date of the Plan.

❑ The provisions of the amended and restated Plan became effective on _____.

3. Plan Year:

Your Plan's records are maintained on a twelve-month period of time known as the Plan Year. The initial Plan Year begins on _____ and ends on _____. Future Plan Years will be based on a full twelve-month period beginning each _____ and ending each _____.

4. Plan Number:

Your Employer has assigned Plan Number _____ to your Plan.

5. Employer Information:

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

_____

_____

_____

_____

The Plan shall be governed under the laws of the State of or the Commonwealth of: _____.

6. Plan Administrator Information:

The name, address, employer identification number and business telephone number of the Plan Administrator are:

_____

_____

_____

_____

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.

7. Service of Legal Process:

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

8. Type of Administration:

The type of administration of the Plan is employer administration.

9. Eligibility Requirements:

As the sole employee you are the only person eligible to participate in this Plan.

For purposes of determining continued eligibility under the Plan, a retiree □shall/□shall not be eligible to continue participation in the Plan.

If Retirees are eligible to participate in the Plan as set forth in the paragraph above, Retirees shall only be considered as those employees who have satisfied the Employer's terms and conditions for retirement. For this Plan, "Retirement" shall be considered as being only the Sole Employees who (select only one):

□ Has reached _____ years of age

□ Has attained a combination of years of service and age, to equal _____

□ Other: _____

10. Entry Date:

The Entry Date for you shall be (select only one):

□ _____ days after the date of hire.

□ Immediately upon satisfying the Plan's eligibility requirements.

□ As of the first day of the month coincident with or next after satisfying the Plan's eligibility requirements.

11. Benefits:

The Plan shall reimburse the Sole Employee for the cost of Eligible Medical or Dental Expenses (as defined under Internal Revenue Code Section 213 and as further described below in subsection (12)), subject to an annual limit of $_____. In addition (select only one):

□ The entire portion of the 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 actual expenses incurred).

☐ Only a specified portion of the participant's remaining in an amount not to exceed $_____ may be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution.

☐ The participant's remaining account balance as of the end of the Plan Year may not be carried over to the next Plan Year.

12. Eligible Medical or Dental Expenses:

The following categories of expenses qualify for reimbursement under the Plan (select one of a), b), c) or d)):

a) ☐ Comprehensive. All medical and dental expenses not otherwise covered by a health insurance plan that covers the applicable employee on the date that the medical service is received or provided (e.g., co-pays, deductibles, co-insurance payment requirements, covered items the benefits for which are limited by the plan, etc.), except as otherwise described as follows:

_____

_____

_____

_____

_____

_____

_____

b) ☐ Bridge. Only those expenses that are covered under applicable employee's health insurance plan, but subject to a deductible or co-insurance payment obligation of the insured. Coverage will be provided for out-of-pocket costs of up to $_____ of the total deductible and co-insurance limits of the plan. Select one of the two following options:

☐ Benefits under this Plan shall be paid BEFORE the sole employee is responsible for his portion of the deductible and co-insurance limits;

☐ Benefits under this Plan shall be paid AFTER the sole employee's portion of the deductible and co-insurance limits are paid.

c) ☐ Limited. Only those expenses that are not otherwise covered by insurance (e.g., co-pays, deductibles, etc.), as further selected as follows (select all that apply):

☐ Dental Expenses;

☐ Vision Expenses;

☐ Preventive Care Expenses;

☐ Prescription Drugs;

☐ Other:

_____

d) ☐ Premium Only. Only the employee's applicable premium of the following employment-related insurance coverages (select all that apply):

☐ Essential Health Benefit Plan Premiums;

Excepted Benefit Health Plan Premiums

☐ Dental Insurance Premiums;

☐ Disability Insurance Premiums;

☐☐ Other: _____

13. Contributions:

The Employer shall make all contributions for this Plan. The Employer shall make contributions to the Plan in the following manner (select only one):

☐ On an annual basis at the beginning of the Plan Year.

☐ On a quarterly basis at the beginning of each quarter within the Plan Year.

☐ On a monthly basis at the beginning of each month within the Plan Year.

☐ On a pro rata basis, coordinating with employee pay dates, within the Plan Year.

14. Minimum Reimbursement Amount:

Except for a final claim for a period of coverage, a claim for reimbursement (select only one):

☐ May be any amount, regardless of the size of claim

☐ May not be less than $_____. In order to be reimbursed, a participant's aggregate claims submitted for reimbursement must satisfy this minimum threshold.

15. Order of Benefit Payments:

If the Employer sponsors a Section 125 Health Care Flexible Spending Arrangement (Health FSA), in addition to this Plan:

- ☐ Eligible Medical and Dental Expenses must be paid under the Section 125 Plan before this Plan;

- ☐ Eligible Medical and Dental Expenses must be paid under the Section 125 Plan after this Plan;

16. Type of Plan and Funding:

The Plan is intended to qualify as an employer-provided medical reimbursement plan 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 paid for by the Employer out of the Employer's general assets.

PART B

QUESTIONS & ANSWERS

1. **What is the purpose of the Plan?**

The purpose of the Plan is to provide a source of funds to reimburse you, your spouse and your eligible dependents that are covered under the Plan for some or all of the unreimbursed medical and dental expenses you incur in the course of each year while you are employed with the Employer and the Plan remains in effect. Reimbursements for eligible expenses paid by the Plan generally are excludable from income.

2. **When did the Plan take effect?**

Please refer to Part A, "General Information About Our Plan," subsection (2), of this document for a description of the Effective Date of the Plan.

3. **Who can participate in the Plan?**

You will be eligible to join the Plan once you have satisfied the conditions for eligibility. If you are not eligible to participate in this Plan on the Effective Date of the Plan, you will be eligible to join the Plan once you have satisfied the eligibility requirements under this Plan. Please refer to Part A, "General Information About Our Plan," subsection (9), of this document for a description of the Plan's eligibility requirements.

4. **Who shall make all of the contributions to the Plan?**

Your Employer will make all of the contributions necessary to fund the Plan.

Please refer to Part A, "General Information About Our Plan," subsection (13), of this document for a description of the Plan's contribution schedule.

5. **How much of my unreimbursed medical and dental expenses may be reimbursed each year?**

Please refer to Part A, "General Information About Our Plan," subsection (11), of this document for a description of the "reimbursement amount" for the Plan. To the extent provided for in Part A, subsection (11), all or a portion of any unused amounts remaining at the end of the Plan Year may be carried over for use in future periods in which you remain eligible under the Plan.

6. **How do I become a Participant?**

Before you become a member or a "participant" in the Plan, there are certain rules which you must satisfy. First, you must meet the "eligibility requirements," as described in Q&A 3 above.

Once you have met the eligibility requirements, your entry date will be the date set forth in Part A, subsection (10).

An HRA account will be established in your name for all Employer contributions made on your behalf under the Plan.

7. **How do I receive my benefits under the Plan?**

When you incur an Eligible Medical or Dental Expense, you must submit a claim reimbursement request to the Plan Administrator within the time frames specified under Part C, Section 3 set forth below. If the Plan Administrator determines that your claim is valid, you will be reimbursed for your eligible expenses as soon as administratively feasible after it has been submitted. You may submit a claim for any Eligible Medical or Dental Expenses incurred during the Plan Year at any time after you become a participant in the Plan. Reimbursements shall be made to the extent of the amount available in your HRA account at the time the claim is processed.

To have your claims processed as soon as possible, please refer to the claims procedures set forth in Part C of this summary. Please note that it is not necessary that you have actually paid an amount due for an Eligible Medical or Dental Expense. Instead, you only have to have incurred the expense and such expense is not being paid for or reimbursed from any other source. For purposes of the Plan, you are considered to have "incurred" an expense when the health care services are rendered for which you are seeking a reimbursement, and not when you have actually paid the bill.

8. **What is an "eligible expense?"**

An "eligible expense" means any expense identified as an Eligible Medical or Dental Expense that is further described under subsection (12) of Part A. However, you may not submit a claim for an amount that has been deducted on your prior year's personal tax return or that was

incurred prior to the time that you became a participant under the Plan, nor shall you be entitled to submit a claim for any other expenses that have been paid through any other health insurance plan, Section 125 "cafeteria" plan, or other similar medical expense reimbursement arrangement. Please contact the Plan Administrator for a complete list of Eligible Medical or Dental Expenses.

9. **When must the expenses be incurred that I may be reimbursed for?**

Eligible expenses must have been incurred after the Effective Date of the Plan (see Part A, subsection (2)). You may not be reimbursed for any expenses arising before the Plan became effective, or prior to the time you became covered under the Plan, if later.

10. **Does the Plan also provide benefits for my family?**

The Plan provides reimbursement for expenses incurred for you, your spouse, and any other person you could claim as a dependent on your federal income tax return, except that an individual's status as a dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of Internal Revenue Code Section 152. The Plan will also provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order ("QMCSO"). You may obtain a copy of the Plan's QMCSO procedures at no charge from the Plan Administrator.

11. **What happens if my claim for benefits is denied?**

You will be notified in writing by the Plan Administrator within 30 days of the date you submitted your claim if the claim is denied. If you do not receive notification of the denial of a claim within the 30 day period, and if the claim is not otherwise paid, it will be deemed denied. The notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. The Plan Administrator will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 180-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Plan Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review. See Part C, below, for more information regarding your rights to appeal any adverse claim determination.

12. **Does my coverage under this Plan end when my employment terminates or I am no longer an eligible employee?**

Generally, yes. Your normal participation will cease at the end of the last day before your employment with the Company terminates or your eligibility ceases. However, you may still receive reimbursement of any Eligible Medical or Dental Expenses, as otherwise provided for under the Plan, as long as such reimbursement requests are made prior to the expiration of 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. Under all circumstances, coverage ends upon the earlier of your death or the date the Plan terminates.

13. **Does my coverage continue while I am absent on duty in the uniformed services?**

The Plan will continue to reimburse you or your family for Eligible Medical or Dental Expenses (except for any illness or injury suffered by you in connection with duty in the uniformed services) for the first 30 days of your absence. However, coverage after that period will be suspended while you are on approved military service leave. No re-entry requirements will be imposed if you return to active employment with the Employer within 30 days of completing a period of absence from employment with the Employer for duty in the uniformed services.

The "uniformed services" are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

14. **Which Plan pays first if I am already enrolled in a Flexible Spending Account?**

Please refer to Part A, "General Information About The Plan," in subsection (15) of this document, to determine the order of benefit payments, if the Employer sponsors a Section 125 Health Care Flexible Spending Arrangement in addition to this Plan.

15. **How long will the Plan remain in effect?**

Although the Company expects to maintain the Plan indefinitely, it has the right to amend or terminate the Plan at any time.

If the Plan is terminated, credits to your HRA account will be used to provide benefits through the end of the Plan Year in which termination occurs. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

PART C

ADDITIONAL PLAN INFORMATION

1. **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.

2. **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;

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, 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.

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.

3. **Claims Process**

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 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.

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.

4. 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.

5. 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.

PART D

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.