Limited Purpose HRA
Summary Plan Description

Plan Number: The Plan Number, if not stated elsewhere the Plan Number is 501.

Adopting Employer/Plan Administrator:

Name:

Address:

Phone Number:

EIN Tax Number:

The Employer will accept service of process for this Plan as the Plan Administrator. The Employer has the discretionary authority to:

- Interpret the Plan in order to make eligibility and benefit determinations,
- Make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan, and
- Terminate or Amend this Plan.

Plan Year: January 1st through December 31st

Plan Benefits: Elected Maximum Eligibility Start Date

Out-of-Pocket Dental and Vision Expenses; Maximum is

Qualified Long-Term Care

Carryover Feature

Maximum is per Eligible Employee

Dental Insurance Yes ☐ No ☐

Maximum Benefit:
This is the maximum amount of benefits that will be paid out during the course of the Plan Year. Employees will be eligible to receive reimbursements from the general assets of the Employer for services incurred in a Plan Year or the remaining portion of a Plan Year in which they are enrolled.

Eligible Employees:
Employee(s) who work(s) for the Employer; provided that such Employee(s) is (are) not:

- ☐ Part-time Employees working less than 30 hours per week.
- ☐ Seasonal Employees working less than months of work per year.
- ☐ Employees less than years of age.
- ☐ Current Employees with less than days of service with Employer. NOTE: The maximum waiting period is 90 days.
- ☐ New Employees with less than days of service with Employer. NOTE: The maximum waiting period is 90 days.

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Article I. General Information

1.01 PURPOSE
The Employer adopts this plan under the terms and conditions set forth in this Plan Document. The Employer intends this Plan to be in compliance with Sections 105 and 106 of the Internal Revenue Code of 1986 (the "Code") and shall be interpreted to accomplish that objective. In accordance with the forgoing, the cost of benefits provided pursuant to this Plan are intended to be eligible for deduction by the Employer and exclusion from the Participant's gross income. This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations ("the Privacy Rule") amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH" or "Security Rule"). This Plan provides for only excepted benefits in the form of limited scope dental and/or vision benefits and is an excepted plan under the terms of the Affordable Care Act of 2010 and not subject to the health care reform provisions of that Act.

Article II. Eligibility

2.01 COVERED EMPLOYEE
An Eligible Employee shall automatically become a Participant in this Plan. There are no separate enrollment forms or requirements.

Employees who fail to meet the requirements for enrollment are not eligible to enroll in this Plan. In addition, the following persons are excluded from participating in this Plan:

- Employees who are non-resident aliens and receive no earned income from the employer which constitutes income from sources within the United States.
- Employees who are self-employed individuals as described in section 401(c) of the Internal Revenue Code including sole proprietors, or partners in a partnership.

An Employee who meets the Eligibility Criteria and is enrolled in this Plan is considered a Participant.

2.02 DEPENDENTS AND SPOUSES
For the purpose of this Plan, a Dependent is an individual who is a dependent of a Participant within the meaning of Section 152(a) of the Code, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and includes any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27. A Spouse is an individual who is legally married to a Participant but will not include an individual separated from a Participant or under a decree of legal separation.

This Plan, under certain circumstances, will provide benefits for your child, even if you do not have custody of your child or the child is not claimed on your taxes your dependent. Those circumstances must be established through a Qualified Medical Child Support Order (QMCSO). A QMCSO is a decree or order issued by a court that obligates you to provide health benefits for your child. If you incur this type of obligation as a result of a court ordered medical child support order, you must inform your Employer.

2.03 TERMINATION
A Participant will automatically cease to be a Participant on the earliest of the following dates:

- the date on which this Plan is terminated by the Employer;

- the date on which the Participant's employment with Plan Sponsor is terminated, whether termination is initiated by the Participant or the Plan Sponsor;
- The date on which the Participant no longer meets the Eligibility Criteria.

Article III. Benefits

3.01 BENEFITS
This Plan will provide reimbursements for Qualified Expenses incurred during a Plan Year by a Participant, the Participant's Spouse or the Participant's Dependents while the Participant is covered under this Plan. Dental and vision expenses are only reimbursable to the extent allowed as a deduction by the IRS. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the dental and vision expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

A Qualified Expense when indicated as covered on the first page of this Summary Plan Description is limited to dental and vision services or supplies and qualified long-term care services that are not paid by any other source such as coverage under a group or individual health plan.

- Vision services are allowed when substantially all services are for treatment of the eye;
- Dental services are allowed when substantially all services are for treatment of the mouth (including any organ or structure within the mouth).

The term "qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are:

- Required by a chronically ill individual as defined in §7702B, and
- Provided pursuant to a plan of care prescribed by a licensed health care practitioner.

A Qualified Long-Term Care Policy is subject to state insurance laws and covers only qualified long-term care services as defined above or based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

3.02 SERVICES NOT COVERED
All services other than those defined above for dental and visions services are excluded. The following examples would usually not qualify as expenses eligible for reimbursement even though recommended by a doctor: expenses for cosmetic procedures or cosmetic items; items that are for the general wellbeing of a Participant; items that would have been purchased by a Participant even if the Participant did not have a medical condition such as a toothbrush; vacation and travel expenses even if for rehabilitation or prescribed by a doctor; and, long-term care expenses that are not for actual medical care.

3.03 CARRY OVER AND FORFEITURE
There is carryover of any unused benefit from one Plan Year to another as indicated on the first page of this Summary Plan Description. No cash outs are allowed. If an Employee's participation in the Plan ends, the period of coverage ends on the day of the terminating event. Any expenses incurred after that date are ineligible for reimbursement. If the Employee has not incurred Qualified Expenses equal to the amounts allocated on their behalf under this Plan before that date, the unused amount is forfeited to the Employer. All forfeited amounts become the property of the Employer. The Employer can use forfeited amounts for the payment of administrative expenses under this Plan, or to assign to future allocations that are not dependent on a Participants prior reimbursement experience.

Article IV. Administration

4.01 PLAN RECORDS
The Employer will maintain records in connection with the proper administration of the Plan and can amend or terminate this Plan.

The Employer, or any of its agents, will collect employment records of Participants under the Plan. These records will include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Employer may need for the proper administration of the Plan. A Participant will furnish the Employer the data the Employer reasonably requests to insure the proper and efficient administration of the Plan, with documentation for items such as proof of relationship as needed.

4.02 EMPLOYER CONTRIBUTIONS
The Employer will contribute amounts necessary to meet its obligations under the Plan out of its general assets. There are no segregated funds established to collect or maintain the contributions.

4.03 PARTICIPANT COOPERATION
Participants shall provide the Employer with such information and evidence, and shall sign such documents, as may be requested reasonably from time to time for the purpose of administering the Plan.

4.04 DISCRIMINATION TESTING
The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, allocations and benefits, in accordance with applicable provisions of the Code. The Employer may take such actions as amending the Plan, excluding certain highly compensated Employees from participation in the Plan, if, in the Employer's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

4.05 FUNDING
Benefits under this Plan shall be made from the Employer’s general assets. Annual allocations designated by the Employer shall be monitored for each enrolled Participant in a manner deemed appropriate by the Employer. There are no segregated funds or Plan assets required or established to maintain this Plan.

4.06 EMPLOYER DISCRETION
Subject to applicable State or Federal law, and the provisions, any interpretation of any provision of this Plan made in good faith by the Employer as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

4.07 ADVERSE DETERMINATIONS AND REVIEW
In cases where the Plan Administrator denies a benefit under this Plan for any Participant eligible to receive benefits under the Plan (Employee or a covered Dependent), the Plan Administrator will furnish in writing to the Participant the reasons for the denial of benefits. The Plan Administrator will establish and maintain a procedure that allows for a full and fair review of any adverse benefit determination as specified by the Department of Labor under 29 CFR 2560-503.1. This Plan is not subject to the external

review requirements under Section 2719 Patient Protection and Affordable Care Act of 2010.

Article V. Statement of ERISA Rights

As a Participant in any Plan that is subject to Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections under ERISA. In general, the welfare benefit plans sponsored by your Employer such as but not limited to the Plan are subject to ERISA. ERISA provides that you are entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office all documents governing the ERISA Plan, including insurance contracts. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts. The administrator may make a reasonable charge for the copies.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an ERISA Plan. The people who operate an ERISA plan, called ``fiduciaries" have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

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

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 ERISA 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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, for example, if it finds your claim is frivolous.

You must first file an appeal within the time limits stated in Part IV, with the Plan Administrator, in order to bring a lawsuit in federal court for an item that can be appealed under this Plan.

Assistance with Your Questions. If you have any questions about your ERISA 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 Pension Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or contact 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.