Multi-Employee No Limit Plan
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 Plan Administrator. The Plan Administrator 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

Carry Over:
This is the amount of unused benefits that can be carried over from one Plan Year to the next Plan Year. See the Carry Over terms below.

Maximum Benefit: $0
This is the maximum amount of benefits that will be paid out during the course of the Plan Year. Employees enrolled in a Group Health Plan 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.

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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). This Plan must be integrated with a group health plan that satisfies the requirements of Section 2711 of the Public Health Service Act (a "Group Health Plan"). This Plan must be integrated with a group health plan that satisfies the requirements of Section 2711 of the Public Health Service Act (a "Group Health Plan") and satisfies Section 2713 (preventative health services with no cost sharing) of the Public Health Service Act.

1.02 PLAN DISCRIMINATION AND RECISSION

This Plan does not discriminate for determining eligibility (including continued eligibility) of any individual to enroll or for coverage allowed under this Plan, based on any of the following health status-related factors:

- Health status;
- Medical condition (including both physical and mental illnesses);
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability (including conditions arising out of acts of domestic violence);
- Disability; or,
- Any other health status-related factor determined appropriate by future applicable federal regulations.

Employee participation in this Plan will not be rescinded for any reason except for instances when a Participant commits a fraudulent act or an intentional misrepresentation to the Plan, Plan Administrator, Plan Sponsor or other entity that is assigned to administer any term of the Plan.

Article II. Eligibility

2.01 COVERED EMPLOYEE

An Employee shall automatically become a Participant in this Plan upon successful enrollment in the Group Health Plan sponsored by the Employer or another Employer (example, the Employee Spouse's Group Health Plan sponsored by her employer.

There are no separate enrollment forms or requirements. The Employee must be enrolled in and remain covered under the Group Health Plan. Any event that terminates coverage under the Group Health Plan will automatically terminate coverage under this Plan. The Employer reserves the right to change the Group Health Plan at its discretion.

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

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- 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.

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 the Participant’s coverage terminates under the Group Health Plan;
- 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.

Article III. Benefits

3.01 PLAN BENEFITS
This Plan will provide reimbursements for medical 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. Medical 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 medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

This Plan can only reimburse medical expenses that are not covered under any other benefit program. Thus, co-payments, deductibles, certain excluded services, expenses for prescriptions or medical supplies that are not paid for by insurance can be considered expenses that can be reimbursed under this Plan.

Examples of expenses eligible for reimbursement under this Program would include: hospitalization and clinical care; prescription and over the counter drugs; transportation expenses (such as an ambulance) incurred to get medical services; home improvement costs that are recommended by a doctor and necessary for treatment or rehabilitation only to the extent such improvement does not increase the value of your home; accident and health insurance premium (unless those premium costs could be paid on a tax free basis under a Cafeteria Plan offered by the Employer); and Qualified long term care insurance premium. You can obtain a complete list of covered services at no charge by contacting your Employer.

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3.02 OVER-THE-COUNTER MEDICINE CHANGE
A medicine or drug that is available for purchase without a prescription is considered an over-the-counter medicine. Under new federal law, an over-the-counter medicine obtained on or after January 1, 2011 can only be reimbursed tax free if a Participant obtains and submits a Prescription with their claim for reimbursement. A Participant must submit a ' Prescription' that meets all state law requirements of the state in which the Prescription was written. The person who wrote the Prescription must be allowed to prescribe drugs under applicable state law. A Medicine is any over the counter item that the IRS determines is purchased for the primary purpose of applying the drug or biological contained in the item. Insulin will be reimbursed without a Prescription.

3.03 SERVICES NOT COVERED
The following examples would usually not qualify as expenses eligible for reimbursement even though recommended by a doctor: Insurance premium for long term care plans that are not considered “qualified” by the IRS; fixed indemnity plan, fixed indemnity cancer policies, hospital indemnity insurance premium; 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.

3.04 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 Plan. 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.

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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

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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.

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