SAMPLE
Individual Coverage
Health Reimbursement Arrangement (ICHRA) Plan

SUMMARY PLAN DESCRIPTION

Effective: October 1, 2020

The SAMPLE Company

Summary Plan Description

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Summary Plan Description

Article I

INTRODUCTION

SAMPLE Company, (the "Employer") sponsors the The SAMPLE Company for Eligible Employees. Under the federal tax law, the HRA Plan is known as a "Health Reimbursement Arrangement" or "HRA" plan.

The purpose of the ICHRA Plan is to reimburse Eligible Employees, up to certain limits, for their own Medical Care Expenses. Reimbursements for Medical Care Expenses paid by the ICHRA Plan generally are excludable from taxable income.

This Summary Plan Description (SPD describes the basic features of the HRA Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the HRA Plan and is not meant to interpret or change the provisions of your Plan. A copy of the Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. In the event of any inconsistencies or conflict between the actual provisions of the ICHRA Plan Document and this Summary, the ICHRA Plan Document shall govern.

Article II

PARTICIPATION IN YOUR PLAN

How can I participate in the ICHRA Plan?
Once an Employee has met the Plan's eligibility requirements, and provided that the procedures outlined under **How do I become a Participant and when is my Entry Date?** section are followed, the Eligible Employee may participate in the Plan.

What are the Eligibility Requirements to participate in the Plan?
Employees who are enrolled in qualifying individual health insurance coverage, full time employees and are employed by a participating Employer may participate in the Plan provided that the election procedures outlined under **How do I become a Participant and when is my Entry Date?** section are followed.

Are there any Employees who are not eligible to participate in the Plan?
The following Employees are excluded from participating in the Plan:

* Self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

How do I become a Participant and when is my Entry Date?
After you satisfy the eligibility requirements described under **What are the Eligibility Requirements to participate in the Plan?,** and you have Integrated Coverage, you will automatically be enrolled and become a Participant in the ICHRA, at least annually.

Employees who actually participate in the ICHRA Plan are called "Participants." An Employee continues to participate in the ICHRA Plan until: (a) termination of the ICHRA Plan; or (b) the date on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason). However, for purposes of pre-taxing COBRA coverage for the HRA benefits, certain Employees may be able to continue eligibility in the HRA Plan for certain periods. See **What is Continuation Coverage and how does it work?,** and **What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?** for information about how termination of participation affects your Benefits.

What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?
If you cease to be an Eligible Employee, your participation will terminate immediately. If you cease to be an Eligible Employee for any other reason (for example, if you die, retire, or terminate employment), your participation in the ICHRA Plan will terminate at the end of the month in which the terminating event occurs, unless you are eligible for and elect COBRA continuation coverage as described below. In either case, you will be reimbursed for any eligible Integrated Coverage premium expense that is incurred prior to the date your participation terminates, up to your account balance in the ICHRA Account, provided that you comply with the reimbursement request procedures required under the ICHRA Plan (see **How will the ICHRA Plan work?** for more information on the reimbursement request process). Any unused portions will be not be available after termination of employment.

You will be reimbursed for any eligible Integrated Coverage premium expense that is incurred prior to the date your participation terminates, up to your account balance in the ICHRA Account, provided that you comply with the reimbursement request procedures required under the ICHRA Plan (see **How will the ICHRA Plan work?** for more information on the reimbursement request process). Any unused portions will be not be available after termination of employment.

However, if you are rehired within 30 days or less during the same Plan Year and are eligible for the ICHRA Plan, then your ICHRA Account balance will be reinstated.

If you are rehired more than 30 days after you terminated employment, you will be treated as a new hire and must re-satisfy the eligibility requirements to rejoin the Plan.

If you cease to be an Eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described under **How do I participate in the ICHRA Plan?** before again becoming eligible to participate in the Plan.

What is COBRA continuation coverage and how does it work? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the Plan?

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the ICHRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the ICHRA Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

* Your termination from employment or reduction of hours;
* Your divorce or legal separation from your Spouse;
* Your becoming eligible to receive Medicare benefits;
* Your Dependent child's ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Plan Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual, disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

FMLA and USERRA Leaves of Absence

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain ICHRA Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

Non-FMLA and Non-USERRA Leaves of Absence

If you go on a leave of absence that is not subject to the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), you will be treated as having terminated participation.

Article III

WHAT BENEFITS ARE PROVIDED UNDER THE PLAN

What Benefits are offered under the ICHRA Plan?
Once you become a Participant, the ICHRA Plan will maintain an "ICHRA Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your ICHRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from any health insurance plan before any Benefits are payable from this Plan.

Before the start of each Plan Year, the Employer will determine a maximum annual amount that may be credited during that Plan Year to the ICHRA Account of each Participant in the ICHRA Plan. At the beginning of each Plan Year that you are a Participant, your ICHRA Account will be credited with See ICHRA Model Notice for maximum monthly premium reimbursement amounts based on employee age. For example, if the maximum annual amount is determined by the Employer to be $1,200 for the Plan Year and credited on an annual basis, your account will be credited with $1,200 at the beginning of the plan year in which you are a Participant. Your ICHRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses. The amount available for reimbursement of Medical Care Expenses as of any given date will be the total amount credited to your ICHRA Account as of such date, reduced by any prior reimbursements made to you as of that date. If the initial Plan year is a short plan year, your HRA account will be prorated based on the remaining number of months.

After the end of the Plan Year, the unused amount, if any, in your ICHRA Account will be forfeited.

If a Participant enters the ICHRA mid-year, then the Participant's maximum reimbursement dollar limit will be prorated based on a percentage of the Plan Year remaining.

How will the ICHRA Plan work?
The ICHRA Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your ICHRA Account. The following procedure should be followed:

* You must show proof of qualifying individual health insurance coverage with either an attestation or third-party documentation, such as an insurance card or an explanation of benefits;
* You must submit a claim to the Plan Administrator and provide any additional information requested by the Plan Administrator;
* A request for payment must relate to Medical Care Expenses incurred by you during the time you were a Participant under this Plan;
* A request for payment must be submitted within 0 days following the close of the Plan Year in which the Medical Care Expense was incurred;

Claims must be submitted in writing. The Plan Administrator may require that Participants submit claims on a form provided by the Plan Administrator. The claim must set forth:

* The individual(s) on whose behalf the Medical Care Expenses were incurred;
* The amount of the requested reimbursement; and
* A statement that the expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred and showing the amounts of such Medical Care Expenses, along with any additional documentation that the Plan Administrator may request.

Are there any limitations on Benefits available under the ICHRA Plan?
The Plan will reimburse Medical Care Expenses, including, individual health insurance coverage purchased on or off the Exchange, Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), or Medicare Part C (Medicare Advantage) (collectively referred to as Medicare) not purchased through the employer, that meet the definition of minimum essential coverage (as defined in Code section 5000A(f)), for each month the Participant is are enrolled in individual coverage and covered by the ICHRA up to the unused amount in the Participant's ICHRA Account.

For purposes of the ICHRA and Coverage Options, "Spouse" means the person who is legally married to you and is treated as a spouse under the Code. For purposes of the new income exclusions under Code sections 105(b) and 106, the term "child" includes adult children under the age of 26 that is the employee's son, daughter, stepson, stepdaughter, legally adopted individual (or an individual placed with the employee for adoption), and eligible foster child. Under Notice 2010-38, such a child does not have to satisfy the age limits, residency, support and other tests described in Section 152 of the Code in order to be considered an employee's child for purposes of these new income exclusions.

When must the Medical Care Expenses be incurred for the ICHRA?
For Medical Care Expenses to be reimbursed to you from your ICHRA Account for the Plan Year, they must have been incurred during that Plan Year. The Plan Year for the ICHRA is a 12-month period beginning on January 1st and ending on December 31st.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the ICHRA Plan became effective, before your Enrollment Form became effective, for any expense incurred after the close of the Plan or after a separation from service (except for Continuation Coverage, as described under **What is "Continuation Coverage" and how does it work?).**

Will I pay any administrative costs under the ICHRA Plan?
No. The cost of the plan includes administrative expenses and is paid entirely by the Employer.

Are my Benefits taxable?
The ICHRA Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the ICHRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

How long will the ICHRA Plan remain in effect?
Although the Employer expects to maintain the ICHRA Plan indefinitely, it has the right to amend or terminate all or any part of the ICHRA Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the ICHRA Plan be amended accordingly.

Article IV

CLAIMS PROCEDURE

What happens if my claim for benefits is denied?
If (a) a claim for reimbursement under the ICHRA Plan is wholly or partially denied, or (b) you are denied a benefit under the ICHRA due to an issue germane to your coverage under the ICHRA Plan (for example, a determination of a Change in Status; or eligibility and participation matters under the ICHRA Plan document), then the claims procedure described below will apply. If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

* Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
* The specific reason for the denial;
* A reference to the specific ICHRA Plan provision(s) on which the denial is based;
* Any denial code (and its corresponding meaning) that was used in denying the claim;
* 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;
* A description of the ICHRA Plan's internal and external 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; and
* If the 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.

Appeals
If your claim is denied in whole or part, then you (or your authorized representative) have the right to an internal appeal and, if applicable, an external review to an independent review organization. You may request review upon written application to the "Appeals Committee" for an internal review.

You will not be allowed to take legal action against the Plan, the Employer, the Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your internal appeal rights. But you do not have to pursue external review in order to preserve your right to file a lawsuit. In fact, as explained later in this summary, you may be unable to take further legal action if you pursue an external appeal because the external appeal process results in a binding determination.

Requirements for an Internal Appeal
Your internal appeal must be in writing, must be provided to the Administrator, and must include the following information:

* Your name and address;
* The fact that you are disputing a denial of a claim or the Administrator's act or omission;
* The date of the notice that the Administrator informed you of the denied claim; and
* The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

Deadline for Filing an Internal Appeal
Your internal appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission. If you do not file your internal appeal within this 180 day period, you lose your right to appeal. Your internal appeal will be heard and decided by the Committee.

Decision on Review of Internal Appeal
Any time before the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Committee. The ICHRA 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 internal appeal, the Administrator 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.

If the Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Administrator's notice of final internal adverse benefit determination. Similarly, if the Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Administrator's notice of final internal adverse benefit determination.

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim

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

* Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
* The specific reason for the denial upon review;
* A reference to the specific Plan provision(s) on which the denial is based;
* Any denial code (and its corresponding meaning) that was used in denying the claim;
* 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;
* 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
* A statement of your right to bring an external appeal or a civil action under ERISA §502(a), where applicable.

You have the right to an external review of the Administrator's denial of your internal appeal unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the Plan's eligibility requirements.

Requirements for an External Appeal
You may request an external appeal by completing the form provided to you by the Administrator which must include the following information:

* Your name, address, daytime telephone number and email address; and

* A brief description of why you disagree with the decision, along with any additional information, such as a physician's letter, bills, medical records, or other documents to support your claim.
* Return the Request for External Review and your denial notice as instructed on the form. You should also include any documentation that you have not already provided to the Administrator.

Deadline for filing an External Appeal

Your external appeal must be filed with the external reviewer within four (4) months of the date you were served with the Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. For example, if you received the internal appeal decision on January 3, 2012, you must appeal the decision by May 3, 2012 (or, if that is not a business day, the next business day thereafter).

The plan must complete a preliminary review within five (5) business days upon receipt of your external review request to determine if you were covered under the plan, you provided all of the necessary information to process the external review and that you have exhausted the internal appeals process. The plan must provide you with a written notice of its preliminary review determination within one (1) business day after completing its review. If your request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide you with the Employee Benefits Security Administration (EBSA) contact information. If your request is incomplete, the notice must describe the information or materials needed to complete the request. The plan must permit you to "perfect" (i.e., complete) the external review request within the four-month filing period or, if later, 48 hours after receipt of the notice.

Decision on Review of External Appeal

The plan must assign an accredited Independent Review Organization to perform the external review. The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

Duty of Beneficiary/Third Party Recoveries

Any Beneficiary under the Plan that receives a payment, whether by lawsuit, settlement, or otherwise, from third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party must reimburse the Plan to the extent the Beneficiary has received payments from the Plan for such sickness or injury. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

The Plan further requires covered Beneficiaries promptly advise the Plan Administrator of third-party claims and to execute any assignments, liens, or other documents the Plan Administrator requests. The Plan may withhold Benefits until such documents are received.

Subrogation/Acts of Third Parties

The Plan Administrator, on behalf of the Plan, has the right to recover any payments made to Beneficiaries, whether by lawsuit, settlement, or otherwise, by third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

Article V

GENERAL INFORMATION

General Plan Information

* Name: The SAMPLE Company
* Plan Number: 501
* Effective Date: October 1, 2020
* Plan Year: October 1st to December 31st . Your Plan's records are maintained on this 12-month period of time, except in the case of a short plan year representing the initial Plan Year beginning October 1, 2020 and ending on December 31, 2020.
* Type of Plan: Welfare Plan
* Your plan shall be governed by the Laws of the State of Ohio

Employer/Plan Sponsor Information

* Name and Address: The SAMPLE Company
* 123 Main Street
* Anytown, USA 123456
* 888-555-1212
* Federal Employer Tax Identification Number (EIN): 34-9999999

Plan Administrator Information

Name, address, and business telephone number:

The SAMPLE Company
123 Main Street
Anytown, USA 123456

Attention: Benefits Administrator
888-555-1212

The Plan Administrator appoints the Benefits Administrator to keep the records for the Plan and to be responsible for the administration of the Plan. However, the Appeals Committee acts on behalf of the Plan Administrator with respect to appeals. The Benefits Administrator will answer any questions that you may have about our Plan. You may contact the Benefits Administrator at the above address for any further information about the Plan.

Funding and Type of Plan Administration

The ICHRA is a group health plan and is self-funded by the Employer.

All of the amounts payable under this Plan may be paid from the general assets of the Employer.

Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Named Fiduciary

The named fiduciary for the ICHRA Component is:

The SAMPLE Company

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

The SAMPLE Company
123 Main Street
Anytown, USA 123456
888-555-1212