MEDICAL REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

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MEDICAL REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

This document, along with the Group Health Benefit Plan Certificates of Coverage, Subscriber Agreements and Summary Plan Descriptions and any underlying agreements of which are hereby incorporated by reference, constitute the summary plan description ("SPD") for this Medical Reimbursement Plan (the "Plan"). This SPD provides a brief explanation of the Plan. However, this summary is not the actual Plan. The actual Plan is a legal document which any employee may review and copy upon request to the Employer. In the event of any conflict between any statements in this SPD and the provisions of the Plan Document, the provisions of the Plan Document will govern.

For additional information regarding the Plan, you should refer to the official plan documents, Group Health Benefit Plan Certificates of Coverage, Subscriber Agreements and Summary Plan Descriptions - copies are available from the Employer on request.

EFFECTIVE DATE

The Plan became effective April 1, 2017.

YOUR BENEFITS UNDER THE PLAN

Your Employer is pleased to offer you 3 Options from which to choose:

Value Plan
Standard Plan
Premium Plan

The terms of which are summarized in the attached herein. Each Option is comprised of group health benefit plan coverage (the "Group Health Benefit Plan) and medical reimbursement plan coverage (the "Medical Reimbursement Plan"). The Group Health Benefit Plan component refers to the portion of your benefit that is fully-insured or self-insured, and the Medical Reimbursement Plan component refers to the portion of your benefit which is paid from the general assets of the Employer. The purpose of the Medical Reimbursement Plan component is to reimburse employees and dependents for out-of-pocket expenses resulting from the deductible and/or coinsurance, and/or co-payments required by the Group Health Benefit Plan. You will note that the level of coverage under Medical Reimbursement Plan component varies among the Options. The Group Health Benefit Plan component works in tandem with the Medical Reimbursement Plan component to provide comprehensive group health benefits.

Group Health Benefit Plan.

Please refer to your Group Health Benefit Plan insurance Certificate of Coverage and/or Subscriber Agreement and/or Plan Summary or other written materials for a complete

description of your Group Health Benefit Plan benefit, including the material terms of the benefit, eligibility requirements, an explanation of conversion rights and the name and address of the insurer or preferred provider organization.

Medical Reimbursement Plan

The purpose of the Medical Reimbursement Plan is to reimburse covered employees for out-of-pocket expenses they incur under the Group Health Benefit Plan as a result of the deductible and/or coinsurance and/or co-payments required under the Group Health Benefit Plan.

Subject to the terms of each Option, if you are covered by the Group Health Benefit Plan, you are automatically covered by the Medical Reimbursement Plan. The Medical Reimbursement Plan also covers dependents to the same extent that such individuals are covered by the Group Health Benefit Plan. The effective date of your participation under the Medical Reimbursement Plan is the date on which you become a participant in the Group Health Benefit Plan.

"Medical Expenses" which may be reimbursed under the Medical Reimbursement Plan are Medical Expenses incurred during the Plan Year which are covered under the Group Health Benefit Plan but for which you are not entitled to reimbursement or payment under the Group Health Benefit Plan because such expenses are less than the Group Health Benefit Plan's deductible limit or are required as coinsurance or co-payments. The amount of Medical Expenses for which you are entitled to reimbursement depends on the Option that you select.

Eligible Medical Expenses do not include amounts incurred during a prior Plan Year, a subsequent Plan Year or before the Plan became effective.

There are two ways that a claim can be filed for Medical Expenses under the Medical Reimbursement Plan, as follows:

(a) Provider Filed Claims Submission You must show your Group Health Benefit Plan identification card and your Medical Reimbursement Plan ID Card to the provider at the time of service. The provider must bill the Group Health Benefit Plan first and then submit any remaining balance to the Claims Administrator as a secondary payer. Note that certain providers will not accept your CBIZ Primarily Care Card. In this event, please assert your Medical Expense claim as described in the paragraph (b) below.

(b) File a claim with the Claims Administrator. You can file for reimbursement of Medical Expenses by filing the provider's bill and the Group Health Benefit Plan's explanation of benefits with the Claims Administrator identified at the end of this SPD. You must also submit such other evidence of Medical Expenses that the Claims Administrator may require. The Claims Administrator will pay the provider directly unless you state that you have paid the provider directly in which case the Claims Administrator will pay you directly.

The minimum amount you can file for is $5.00. Any claims filed under $5.00 will be reimbursed under the discretion of the Claims Administrator or held and processed with future claims. Normally your claim will be paid within 60 days, provided you substantiate your claim as described above. Timeframe may vary based on the funding arrangement between the Claims Administrator and the Employer.

You must file for reimbursement of Medical Expenses incurred during a Plan Year no later than one year following the date of service. For purposes of the Medical Reimbursement 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. Please refer to the sections of this SPD entitled "Benefit Determinations" and "Appeals Determinations" for details regarding the timing of benefit determinations and appeal procedures.

Certain tax law requirements apply with respect to the operation of the Medical Reimbursement Plan. For example, a disproportionate amount of the total benefits under the Medical Reimbursement Plan cannot be allocated to "highly compensated" participants. The Employer has structured the Medical Reimbursement Plan in a manner that will enable you to exclude all reimbursements from your income. This may necessitate limiting the amount of nontaxable benefits payable with respect to some "highly compensated" participants.

Despite the Employer's best efforts to ensure compliance with all the applicable laws and rules, it is possible that such "highly compensated" employees could be found to have received disproportionate benefits. If such an adverse determination were made, then the "highly compensated" employees would be required to pay back taxes (with interest) on their medical expense reimbursements. Reimbursements to employees who are not "highly compensated" would not be subject to tax.

PLAN YEAR

The accounting period for the Plan is the accounting period of the underlying Group Health Benefit Plan's insurance contract(s) and/or provider agreements.

NO GUARANTEE OF EMPLOYMENT

The Plan is not an employment contract. Nothing contained in this document nor the Group Health Benefit Plan documents gives you the right to be retained in the service of the Employer or interferes with the right of the Employer to discharge you or to terminate your service at any time.

RESPONSIBILITY FOR PRODUCTS/SERVICES

The Employer does not guarantee and will not be responsible for the nature or quality of the products or services provided through any health care provider or program since these

products and services will be provided by personnel and agencies outside of the control of the Employer.

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Group Health Benefit Plan contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You should review the Group Health Benefit Plan insurance booklets. You may lose coverage under the Group Health Benefit Plan if the Employer terminates the Group Health Benefit Plan or amends it to reduce or eliminate your coverage.

FUNDING

Benefits provided through the Group Health Benefit Plan may be fully-insured or self-insured and may be funded by employer contributions, employee contributions or both. Benefits provided through the Medical Reimbursement Plan are paid from the general assets of the Employer. The Employer is at risk for the total value of reimbursements above the employee contributions.

TYPE OF ADMINISTRATION

Benefits provided under the Group Health Benefit Plan are administered by the providers/insurers through which such benefits are provided. Benefits under the Medical Reimbursement Plan are administered by the Claims Administrator identified at the end of this summary.

AMENDMENT AND TERMINATION

The Employer expects to maintain the Group Health Benefit Plan and/or Medical Reimbursement Plan indefinitely but reserves the right to amend or terminate the Group Health Benefit Plan and/or Medical Reimbursement Plan if the Employer believes the situation so requires. You will be notified in writing if there is any significant amendment or if the Group Health Benefit Plan and/or Medical Reimbursement Plan is terminated.

SPECIAL ENROLLMENT RIGHTS

If you do not enroll yourself and your dependents in the Group Health Benefit Plan after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual initially declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you initially declined coverage because you had other health care coverage that you have now lost through no fault of your own; or (ii) since declining coverage initially, you have acquired a new dependent (through marriage, or the birth or adoption of a child or placement for adoption) and wish to cover that person. In the former case, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the Group Health Benefit Plan when you declined to participate. In either case,

as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the Group Health Benefit Plan within the allowed timeframe set forth by the Group Health Benefit Plan. See the Employer for details about special enrollment.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for one parent to provide a child or children with health insurance under the Group Health Benefit Plan. Employer shall comply with the terms of any qualified medical child support order it receives, and shall:

(a) Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under Section 609 of ERISA;

(b) Promptly notify you and any alternate recipient of the receipt of any medical child support order, and the group medical plan's procedures for determining whether medical child support orders are qualified medical child support orders; and

(c) Within a reasonable period of time after receipt of such order, the Employer shall determine whether such order is a qualified medical child support order and shall notify you and each alternate recipient of such determination.

SPECIAL RULES FOR MATERNITY AND INFANT COVERAGE

Group Health Benefit plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Group Health Benefit Plans and health insurance issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

SPECIAL RULE FOR WOMEN'S HEALTH COVERAGE

The Women's Health and Cancer Rights Act of 1998 requires Group Health Benefit Plans, health insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the Group

Health Benefit Plan or coverage. For answers to specific questions regarding your particular Group Health Benefit Plan's policy, contact the Employer.

CERTIFICATE OF COVERAGE UNDER THE GROUP HEALTH BENEFIT PLAN

A certificate of coverage is a written document provided by the issuer of the Group Health Benefit Plan to show the type of health care coverage an individual had (e.g., employee only, family, etc.) and how long the coverage lasted. Under Federal law, the issuers of most group health plans must provide these certificates automatically when a person's coverage terminates. However, if you do not receive a certificate, you have the right to request one. Certificates apply to both participants and dependents. The primary purpose of the certificates is to show the amount of "creditable coverage" that you had under the Group Health Benefit Plan, because this can reduce or eliminate the length of time that any preexisting condition clause in a new plan otherwise might apply to you. The issuer of the Group Health Benefit Plan will automatically give you a certificate after you lose coverage (whether regular coverage or COBRA continuation coverage) and will make reasonable efforts to provide on the certificate the names of your dependents who were also covered. The issuer of the Group Health Benefit Plan will provide automatic certificates for your dependents when it has reason to know that they are no longer covered. In addition, the issuer of the Group Health Benefit Plan will provide a certificate for you (or your dependents) upon request if you make the request within two years (24 months) after your coverage terminates. In accordance with Federal law, the certificate of coverage will only show your coverage under the group medical plan on or after July 1, 1996. See the Employer for information about confirming any coverage you had before that date.

FAMILY AND MEDICAL LEAVE

This section applies if the Employer is subject to the requirements of the Family and Medical Leave Act of 1993 ("FMLA"), which generally exempts small employers. Small employers, however, may be subject to similar requirements imposed by state law. Please contact the Employer if you have questions about your right to coverage during a family or medical leave.

Subject to the terms of the Group Health Benefit Plan, the Plan will provide coverage during periods of approved leave that complies with the FMLA if you continue to pay your share of the premium while on leave (if applicable). Please contact the Employer regarding payment rules and regulations. When you return from FMLA leave, your Group Health Benefit Plan coverage will be reinstated, and the Employer may recover your share of any premium payments that you missed while on leave, during which your Group Health Benefit Plan coverage was continued.

UNIFORMED SERVICES REEMPLOYMENT RIGHTS

Your right to continued participation in the Group Health Benefit Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Group Health Benefit Plan participation will not be interrupted. If the absence is for more than 31 days and not more than

12 weeks, you may continue to maintain your coverage under the Group Health Benefit Plan by paying premiums in the manner specified by the Employer.

If you do not elect to continue to participate in the Group Health Benefit Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA continuation coverage (if applicable) under the Plan for the 18-month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

COBRA

(a) Extensions of Coverage This section shall apply if the Employer is subject to the requirements of COBRA. Depending on when you leave the Employer, may provide continued coverage for you and your family. You will be required to pay premiums for this continued coverage.

(b) Your Legal Rights to Continuation Coverage Under COBRA

Under COBRA, the Employer is required to offer covered employees, and dependents the opportunity to extend the Group Health Benefit Plan coverage temporarily at group rates after coverage under the Group Health Benefit Plan would otherwise ceased. This extension is called COBRA continuation coverage. Evidence of your good health is not required for this extension.

As an employee covered under the Group Health Benefit Plan, you have the right to elect COBRA continuation coverage if you lose your coverage because:

- Your hours of employment are reduced;
- Your employment is terminated for reasons other than gross misconduct; or
- The Employer starts bankruptcy proceedings and you are a retired employee.

Your Qualified Beneficiary may continue coverage if he or she loses coverage under the Group Health Benefit Plan because:

- He or she loses dependent status under the Group Health Benefit Plan;
- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You and your spouse divorce or become legally separated;
- You become entitled to Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings, and you are retired.

A child born to or placed for adoption with the covered employee during the continuation coverage period is also entitled to elect COBRA continuation coverage. Such a child's coverage period will be determined according to the date of the qualifying event that gave rise to the covered employee's COBRA coverage.

Under COBRA, you (Qualified Beneficiary, if applicable) must notify the Employer within 60 days after:

- You and your Qualified Beneficiary are divorced or become legally separated; or
- One of your Qualified Beneficiary loses their dependent status under the Group Health Benefit Plan.

You (or your Qualified Beneficiary, if applicable) will then be notified of your right to elect continuation coverage and the cost to do so. The deadline for electing continuation coverage is 60 days after the date the Group Health Benefit Plan ceases to cover you or from the date you are notified, which ever is later.

If you (or your Qualified Beneficiary, if applicable) do not elect continuation coverage, your coverage will stop. If you (or your Qualified Beneficiary, if applicable) choose continuation coverage, the Group Health Benefit Plan will provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment. However, you (or your Qualified Beneficiary, if applicable) must pay the full cost of this coverage.

If the original qualifying event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or loss of "dependent status" of a dependent child under the Group Health Benefit Plan, then each Qualified Beneficiary will have the opportunity to elect 36 months of continuation coverage from the date of the qualifying event. If you (or your Qualified Beneficiary, if applicable) lose coverage under the Group Health Benefit Plan because your enrollment was terminated or your hours of employment were reduced (and not immediately followed by termination of employment), then the maximum continuation period will be 18 months from the date of the qualifying event. (If coverage is lost at a date later than the date of the qualifying event and the Group Health Plan measures the maximum coverage period and notice period from the date of coverage loss, then the maximum continuation period will be 18 months from the date of coverage loss.) If during those 18 months, another qualifying event takes place that entitles you (or your Qualified Beneficiary, if applicable) to continuation coverage, your continuation coverage (or your Qualified Beneficiary continuation coverage, if applicable) may be extended by another 18 months. However, in no event will your continuation coverage (or your Qualified Beneficiary continuation coverage, if applicable) extend for more than a total of 36 months from the date of the initial event.

Disability is a special issue. If the Social Security Administration determined that you (or your Qualified Beneficiary, if applicable) are disabled during the first 60 days of the continuation coverage period, or in the case of a child born to or placed for adoption with a covered employee during a COBRA coverage period, during the first 60 days after a child's birth

or placement for adoption, then your continuation coverage period as well as your spouse's and any dependent's continuation periods may be extended from 18 months to 29 months. To qualify, you (or your Qualified Beneficiary, if applicable) must notify the Employer or COBRA Administrator within 60 days of the date of the Social Security determination and during the initial 18 month continuation coverage period. If there is a final determination that the Qualified Beneficiary is no longer disabled, the Employer or COBRA Administrator must be notified within 30 days of the determination by the Qualified Beneficiary, and any coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

In certain circumstances, bankruptcy of the Employer under Title XI will entitle you to continuation coverage. If the qualifying event causing the loss of coverage was the bankruptcy of the employer under Title XI, then each covered retired employee will have the opportunity to receive continuation coverage until the death of the covered retired employee. Qualified Beneficiaries of the covered retired employee will have the opportunity to elect continuation coverage for a period that will terminate 36 months following the death of the retired employee or upon the death of the Qualified Beneficiary, whichever is earlier.

Your right to continuation coverage (or your Qualified Beneficiary right, if applicable) under COBRA ends if:

- The Employer ceases to provide group health coverage to any of its employees;
- You (or your Qualified Beneficiary, if applicable) fail to pay the premium within 30 days after its monthly due date;
- You (or your Qualified Beneficiary, if applicable) becomes covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your Qualified Beneficiary, if applicable) becomes entitled to Medicare after the date of the COBRA election;
- You (or your Qualified Beneficiary, if applicable) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

CLAIMS PROCEDURE

The following claims procedure shall apply specifically to claims made under the Plan.

BENEFIT DETERMINATIONS

Post-Service Claims are those claims that are filed for payment of Medical Expenses after health care has been received.

If your Post-Service Claim is approved, you will receive written notice from the Claims Administrator within 60 days of receipt of the claim. Timeframe may vary based on the funding arrangement between the Claims Administrator and the Employer.

If your Post-Service Claim is pended, you will receive a written notice from the Claims Administrator within 60 days of receipt of the claim advising you of the information that is needed to process the claim. You will then have one year from the date of service to resubmit the claim.

If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 60 days of receipt of the claim. The denial notice will explain the reason for the denial and provide the claims appeal process.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of health care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. The Claims Administrator may consult with, or seek the participation of, fiscal experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for Medical Expenses.

APPEALS DETERMINATIONS

The first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Employer. Your second level appeal request must be submitted to the Employer within 60 days from receipt of first level appeal decision.

Please note that the Claims Administrator and Employer's decisions are based only on whether or not benefits are available under the Group Health Benefit Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

STATEMENT OF ERISA RIGHTS

As a covered employee under the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants are entitled to:

(i) Examine, without charge, at the Employer's office all Plan documents, including those filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.

(ii) Obtain copies of all Plan documents and other Plan information upon written request to the Employer. The Employer may make a reasonable charge for the copies.

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

(iv) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

(v) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Group Health Benefit Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Group Health Benefit Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for you and your dependents, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other covered employees and their dependents. No one, including your Employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a Medical Expense is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Claims Administrator and/or the Employer 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 Employer 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 Employer. If you have a claim for Medical Expenses, which is denied or ignored in whole or part, you may file suit in a state or 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.

If you have any questions about the Plan, you should contact the Employer. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA PRIVACY ISSUES

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA is available from the Employer.

Neither this Plan nor the Employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a Privacy Notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Privacy Notice, please contact the Employer. If you have questions about the privacy of your health information please contact the Plan Administrator. If you wish to file a complaint under HIPAA, please contact the Employer.

MISCELLANEOUS INFORMATION

Type of Plan:	Medical Reimbursement Plan
Plan Number:	503
Plan Sponsor/Employer:	Looking Upwards Maureen Russo Irongate II -438 East Main Road Middletown, RI 02842
Plan Sponsor/Employer Identification Number:	05-0376075
COBRA Administrator	Looking Upwards
Claims Administrator (Medical Reimbursement Plan only):	CBIZ Benefits & Insurance Services, Inc., DBA CBIZ Primarily Care, Inc. 75 Sockanosset Crossroad, Suite 300 Cranston, RI 02920 Tel: (401) 946-4441 Fax: (401) 946-0320
Agent for Service of Legal Process:	Looking Upwards

Looking Upwards, Inc.	Blue Cross Blue Shield RI Base Plan - (Not Offered)	Value PPO	
		Bi-Weekly Per INDIVIDUAL	[illegible]
		Bi-Weekly Per FAMILY	[illegible]
Effective April 1, 2017 through March 31, 2018	Deductible Accumulation: All deductible amounts paid count towards the family deductible amount, one or all can meet it.	Looking Upwards Pays	You Pay
Variable Hour Employees		Deductible Accumulation: No one person will pay more than the individual deductible.	
Calendar Year Deductible per Individual	$3,000	$1,750	$1,250
Calendar Year Deductible per Family	$6,000	$3,500	$2,500
Coinsurance	0%	0%	0%
Calendar Year Out-of-Pocket Maximum per Individual (Copays, Deductible and Coinsurance included in BCBS maximum)	$6,000	$1,750	$1,250 plus all copays
Calendar Year Out-of-Pocket Maximum per Family (Copays, Deductible and Coinsurance included in BCBS maximum)	$12,000	$3,500	$2,500 plus all copays
Physician Office Visits, Outpatient Laboratory & Radiology - Present BCBS Card AND CBIZ Primary Care Card			
Preventative Care Services; Personal Care Physician Office Visits(PCP-Annual Physical), Annual GYN Exam, Well Child Care, Lab, X-Ray or other preventive tests	$0		$0
Primary Care Office Visits	100% after deductible	Balance of deductible	$30 copay
Specialist Office Visits (e.g., Dermatologists, Allergists, Cardiologists)	100% after deductible	Balance of deductible	$50 copay
Eye Exams (One Routine per Calendar Year - No Limits for Medically Necessary)	100% after deductible	Balance of deductible	$50 copay
Chiropractic Visits (12 visits per calendar year)	100% after deductible	Balance of deductible	$50 copay
Outpatient Mental Health & Substance Abuse	100% after deductible	Balance of deductible	$50 copay
Preventative lab, X-ray and imaging	$0		$0
Diagnostic lab, x-ray, imaging and machine tests	100% after deductible	Balance of deductible	$0
Retail Prescription Drugs: Present BCBS Card Only			
Prescription Drug Deductible: (Drug deductible is separate from the medical deductible) $100 per person deductible, max 3 per family, applied to Tier 2, Tier 3 and Tier 4 drugs			
Prescription Drug Tier 1	$10		$10
Prescription Drug Tier 2	$35 after $100 deductible		$35 after $100 deductible
Prescription Drug Tier 3	$60 after $100 deductible		$60 after $100 deductible
Prescription Drug Tier 4	$100 after $100 deductible		$100 after $100 deductible
Mail Order Pharmacy (2 1/2 copays)	$25/ $87.50 / $150 / NA		$25 / $87.50 / $150 / NA
Emergency Room & Urgent Care Services: Present BCBS Card AND CBIZ Primarily Care Card			
Urgent Care (i.e. Walk-In Treatment Centers)	100% after deductible	Balance of deductible	$50 Copay
Emergency Room (Waived if Admitted)	100% after deductible	Balance of deductible	$150 Copay
The following services are subject to the Deductible. Present BCBS Card AND CBIZ Primarily Care Card			
Inpatient Services - Your Portion of Deductible Applies			
In Patient Hospital Stays - (Facility Fees, Doctor Fees, Lab Tests, etc.)	100% after deductible	Balance of deductible	$0 after deductible
Inpatient Mental Health	100% after deductible	Balance of deductible	$0 after deductible
Inpatient Substance Abuse	100% after deductible	Balance of deductible	$0 after deductible
Outpatient Services - Your Portion of Deductible Applies			
Short-Term Rehabilitation Therapy (Physical / Occupational Therapy)	100% after deductible	Balance of deductible	$0 after deductible
High-end radiology services (MRI/CAT/PET), nuclear medicine and sleep studies	100% after deductible	Balance of deductible	$0 after deductible
Surgery and Related Anesthesia	100% after deductible	Balance of deductible	$0 after deductible
Outpatient Radiation & Chemo-Therapy	100% after deductible	Balance of deductible	$0 after deductible
Durable Medical Equipment (Wheel Chairs, C-PAP's, Diabetic Supplies) & Prosthetic Devices (including Leg and Arm Braces)	100% after deductible	Balance of deductible	$0 after deductible
Home Health Care , including Hospice Care	100% after deductible	Balance of deductible	$0 after deductible
Ground Ambulance Services	100% after deductible	Balance of deductible	*$50*
* Infertility (See carrier for Covered, Eligible Services)	100% after deductible	Balance of deductible	$0 after deductible
Out-of-Network Services - Employer does NOT reimburse Out of Network services. Be sure to stay in the Network			
The out-of-network deductible is separate from and in addition to in-network deductible. You are entirely responsible for all out-of-network deductible and coinsurance expenses.			
Annual Deductible per Individual	$6,000.00	$0.00	$6,000.00
Annual Deductible per Family	$12,000.00	$0.00	$12,000.00
Out-of-Network coinsurance maximum separate from and in addition to in-network coinsurance maximum.			
Coinsurance	30%	0%	30%
Out-of-pocket maximum per Individual (Copays, Deductible and Coinsurance included in BCBS maximum)	$12,000.00	$0.00	$12,000.00
Out-of-pocket maximum per Family (Copays, Deductible and Coinsurance included in BCBS maximum)	$24,000.00	$0.00	$24,000.00

This comparison is for descriptive purposes only. Please consult detailed plan literature for actual benefit levels. If this summary and actual plan literature disagree, the benefits described in plan literature will apply. Call CBIZ Primarily Care (800) 395-1300 with Questions.

Looking Upwards, Inc. — Effective April 1, 2017 through March 31, 2018	Blue Cross Blue Shield RI Base Plan - (Not Offered)	Value PPO		Standard PPO		Premium PPO	
		Bi-Weekly Per INDIVIDUAL	[illegible]	Bi-Weekly Per INDIVIDUAL	[illegible]	Bi-Weekly Per INDIVIDUAL	[illegible]
		Bi-Weekly Per FAMILY	[illegible]	Bi-Weekly Per FAMILY	[illegible]	Bi-Weekly Per FAMILY	[illegible]
	Deductible Accumulation: All deductible amounts paid count towards the family deductible amount, one or all can meet it.	Looking Upwards Pays	You Pay	Looking Upwards Pays	You Pay	Looking Upwards Pays	You Pay
		Deductible Accumulation: No one person will pay more than the individual deductible.		Deductible Accumulation: No one person will pay more than the individual deductible.		Deductible Accumulation: No one person will pay more than the individual deductible.	
Calendar Year Deductible per Individual	$3,000	$1,750	$1,250	$2,250	$750	$2,750	$250
Calendar Year Deductible per Family	$6,000	$3,500	$2,500	$4,500	$1,500	$5,500	$500
Coinsurance	0%	0%	0%	0%	0%	0%	0%
Calendar Year Out-of-Pocket Maximum per Individual (Copays, Deductible and Coinsurance included in BCBS maximum)	$6,000	$1,750	$1,250 plus all copays	$2,250	$750 plus all copays	$2,750	$250 plus all copays
Calendar Year Out-of-Pocket Maximum per Family (Copays, Deductible and Coinsurance included in BCBS maximum)	$12,000	$3,500	$2,500 plus all copays	$4,500	$1,500 plus all copays	$5,500	$500 plus all copays
Physician Office Visits, Outpatient Laboratory & Radiology - Present BCBS Card AND CBIZ Primarily Care Card							
Preventative Care Services; Personal Care Physician Office Visits/PCP-Annual Physical), Annual GYN Exam, Well Child Care, Lab, X-Ray or other preventive tests	$0		$0		$0		$0
Primary Care Office Visits	100% after deductible	Balance of deductible	$30 copay	Balance of deductible	$30 copay	Balance of deductible	$30 copay
Specialist Office Visits (e.g., Dermatologists, Allergists, Cardiologists)	100% after deductible	Balance of deductible	$50 copay	Balance of deductible	$50 copay	Balance of deductible	$50 copay
Eye Exams (One Routine per Calendar Year - No Limits for Medically Necessary)	100% after deductible	Balance of deductible	$50 copay	Balance of deductible	$50 copay	Balance of deductible	$50 copay
Chiropractic Visits (12 visits per calendar year)	100% after deductible	Balance of deductible	$50 copay	Balance of deductible	$50 copay	Balance of deductible	$50 copay
Outpatient Mental Health & Substance Abuse	100% after deductible	Balance of deductible	$50 copay	Balance of deductible	$50 copay	Balance of deductible	$50 copay
Preventative lab, X-ray and imaging	$0		$0		$0		$0
Diagnostic lab, x-ray, imaging and machine tests	100% after deductible	Balance of deductible	$0	Balance of deductible	$0	Balance of deductible	$0
Retail Prescription Drugs: Present BCBS Card Only							
Prescription Drug Deductible: (Drug deductible is separate from the medical deductible) $100 per person deductible, max 3 per family, applied to Tier 2, Tier 3 and Tier 4 drugs.							
Prescription Drug Tier 1	$10		$10		$10		$10
Prescription Drug Tier 2	$35 after $100 deductible		$35 after $100 deductible		$35 after $100 deductible		$35 after $100 deductible
Prescription Drug Tier 3	$60 after $100 deductible		$60 after $100 deductible		$60 after $100 deductible		$60 after $100 deductible
Prescription Drug Tier 4	$100 after $100 deductible		$100 after $100 deductible		$100 after $100 deductible		$100 after $100 deductible
Mail Order Pharmacy (2 1/2 copays)	$25 / $87.50 / $150 / NA		$25 / $87.50 / $150 / NA		$25 / $87.50 / $150 / NA		$25 / $87.50 / $150 / NA
Emergency Room & Urgent Care Services: Present BCBS Card AND CBIZ Primarily Care Card							
Urgent Care (i.e. Walk-In Treatment Centers)	100% after deductible	Balance of deductible	$50 Copay	Balance of deductible	$50 Copay	Balance of deductible	$50 Copay
Emergency Room (Waived if Admitted)	100% after deductible	Balance of deductible	$150 Copay	Balance of deductible	$150 Copay	Balance of deductible	$150 Copay
The following services are subject to the Deductible: Present BCBS Card AND CBIZ Primarily Care Card.							
Inpatient Services - Your Portion of Deductible Applies							
In Patient Hospital Stays - (Facility Fees, Doctor Fees, Lab Tests, etc.)	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
Inpatient Mental Health	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
Inpatient Substance Abuse	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
Outpatient Services - Your Portion of Deductible Applies							
Short-Term Rehabilitation Therapy (Physical / Occupational Therapy)	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
High-end radiology services (MRI/CAT/PET), nuclear medicine and sleep studies	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
Surgery and Related Anesthesia	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
Outpatient Radiation & Chemo Therapy	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
Durable Medical Equipment (Wheel Chairs, C-PAP's, Diabetic Supplies) & Prosthetic Devices (including Leg and Arm Braces)	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
Home Health Care, including Hospice Care	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
Ground Ambulance Services	100% after deductible	Balance of deductible	$50	Balance of deductible	$50	Balance of deductible	$50
* Infertility (See carrier for Covered, Eligible Services)	100% after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible	Balance of deductible	$0 after deductible
Out-of-Network Services - Employer does NOT reimburse Out Of Network services. Be sure to stay in the Network							
The out-of-network deductible is separate from and in addition to in-network deductible. You are entirely responsible for all out-of-network deductible and coinsurance expenses.							
Annual Deductible per Individual	$6,000.00	$0.00	$6,000.00	$0.00	$6,000.00	$0.00	$6,000.00
Annual Deductible per Family	$12,000.00	$0.00	$12,000.00	$0.00	$12,000.00	$0.00	$12,000.00
Out-of-Network coinsurance maximum separate from and in addition to in-network coinsurance maximum.							
Coinsurance	80%	0%	20%	0%	20%	0%	20%
Out-of-pocket maximum per Individual (Copays, Deductible and Coinsurance included in BCBS maximum)	$12,000.00	$0.00	$12,000.00	$0.00	$12,000.00	$0.00	$12,000.00
Out-of-pocket maximum per Family (Copays, Deductible and Coinsurance included in BCBS maximum)	$24,000.00	$0.00	$24,000.00	$0.00	$24,000.00	$0.00	$24,000.00

This comparison is for descriptive purposes only. Please consult detailed plan literature for actual benefit levels. If this summary and actual plan literature disagree, the benefits described in plan literature will apply. Call CBIZ Primarily Care (800) 365-1300 with Questions.