Participant Summary Plan Description

Your employer has established a Section 105, Health Reimbursement Arrangement Plan. This Summary Plan description describes the benefits, terms and conditions of the Plan as it applies to eligible employees on or after their effective date.

PLAN ADMINISTRATOR/EMPLOYER:

MISSY KIRKSEY
NORTHWEST OTOLARYNGOLOGY
12277 DEPAUL DR #502
BRIDGETON MO 63044

Note to Employer: This Summary Plan Description lists the benefits available to your employee(s). The Department of Labor requires that this summary or a copy of it be given to each employee.

PLAN YEAR DATES: 1/1/2017 - 12/31/2017
RUNOUT IN DAYS: 90
TAX ID NUMBER: 43-1172884

CLIENT ID: WP62

ADMINISTRATION AGENT: TASC HRA
A Service of Total Administration Services Corporation
2302 International Lane
Madison WI 53704
608-241-1900 / 800-422-4661

AGENT FOR SERVICE OF LEGAL PROCESS: Missy Kirksey
Northwest Otolaryngology
12277 DePaul Dr #502
Bridgeton MO 63044
(314) 291-5307

PLAN BENEFITS: Benefit types allowed for reimbursement under the Plan:
Uninsured Medical, Medical Deductible, Co-pay, Coinsurance, Prescription Medication, Dental,

Orthodontia & Vision Expenses

Reimbursement limit will be applied to the Employee and Family in Aggregate.

EE Only Plan:
Employer is responsible for 100% of the first $2,000.00.

ELIGIBILITY REQUIREMENTS: Eligibility requirements include participation in UHC health insurance Plan.

PLAN FEATURE ELECTION: Claim ConneX ☒ Not Elected
Benefit Card ☒ Elected

PLAN DEFINITION AND FUNDING

This is a Section 105 Accident and Health Plan, as classified by the Internal Revenue Code. This benefit plan is classified as a welfare plan by the Department of Labor. The employer funds this Plan.

EMPLOYEE TERMINATION

You will automatically cease to be a participant on the earliest of the following dates:

1. Your death;
2. The date the Plan terminates;
3. The date the sponsor determines you made fraudulent or improper use of a plan, certificate or identification.

PLAN TERMINATION

The Plan or any portion of the Plan can be amended or terminated, in whole or in part at any time, by your employer in the same manner as the plan was adopted. Consent of any Participant, employee or any other person referenced in the Plan is not required to terminate the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

For procedures governing QMCSO, you or a beneficiary may obtain a copy of such procedures from the Administering Agent.

CONTINUATION OF COVERAGE, COBRA (applicable to employers with 20 or more employees)

Continuation Coverage means your right, or your spouse and dependents' right to continue to be covered under this Medical Expense Reimbursement Plan if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." Duration of coverage will depend upon the qualified event, and will be either 18, 29 or 36 months. Qualifying Event is:

- Termination of your employment (other than for gross misconduct), or reduction of your work hours below eligibility requirements
- Your death
- Your divorce or legal separation from your spouse
- Your becoming eligible to receive Medicare benefits
- Your dependent ceases to be a dependent

It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated **premium costs** for the remainder of the Plan Year. The notification you will receive will explain other terms and conditions of the continued coverage.

CLAIM APPEALS

If your claim is denied in whole or in part, you will be notified in writing within 30 days after the date your claim is received. (This time period may be extended for an additional 15 days for matters beyond our control, including in cases where a claim is incomplete.) TASC will provide written notice of any extension, including the reasons for the extension and the date by which a decision is expected. When 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 effectively suspend the time for a decision on your claim until the specified information is provided.)

Appeals. If your claim is denied in whole or part, then you (or your authorized representative) may request review. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision on Review. Your appeal will be reviewed and determination made within a reasonable time, defined as not later than 60 days after receipt of your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a

description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

- a statement of your right to bring suit under ERISA §502(a) (where applicable).

ERISA RIGHTS

As a participant in the welfare benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan Documents including insurance contracts, and to obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Administrator in turn may apply a reasonable charge for copies. You are also entitled to receive a summary of the Plan's financial report, if applicable. Finally, the Plan Administrator is required by law to furnish each participant with a copy of the summary annual report, with certain expectations. You are entitled to continue health care coverage under the Plan for yourself, spouse or dependents if there is a loss of health insurance coverage as a result of a qualifying event.

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 Plan participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or from exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, and must receive a written explanation of the reason for denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, you can take steps to enforce the above rights. For instance, if you require materials from the Plan and do not receive them within 30 days, you may file suit in 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 Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in state or federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for assuming your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in state or 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 the costs and fees.

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have questions about this statement or about your rights under ERISA, you may also obtain certain publications with your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, or by contacting the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (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 NW., Washington, DC 20210.