ERISA

Hamaspik Care, Inc.

Employee Benefits Plan Document

and

Summary Plan Description

Amended:
January 1, 2020

Hamaspik Care, Inc. maintains this Employee Benefits Plan for the exclusive benefit of its eligible employees and other persons made eligible by their relationship to the eligible employee. This Plan is comprised of different benefit programs that are subject to Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document together with documents incorporated by reference constitutes the written plan document required by ERISA Section 402 and the Summary Plan Description required by ERISA Section 102.

Table of Contents

1. General Plan Information

The Hamaspik Care, Inc. Employee Benefits Plan is amended on January 1, 2020. This Plan has been in existence since January 1, 2018. This booklet contains a summary in English of participant rights and the benefits available under the Hamaspik Care, Inc. Employee Benefits Plan. If you have difficulty understanding any part of this booklet, you can contact the Human Resources Coordinator for assistance.

Plan Name	**Hamaspik Care, Inc.** **Employee Benefits Plan**
Plan Sponsor	**Hamaspik Care, Inc.** **5 Perlman Drive** **Spring Valley, NY 10977** **845-503-0802**
Plan Sponsor EIN Number	**27-4628760**
Plan Number	**501**
Plan Year – the 12 month period during which this Plan is administered	**January 1 - December 31**
Plan Administrator	**Hamaspik Care, Inc.** **5 Perlman Drive** **Spring Valley, NY 10977** **845-503-0802**
Employee Benefits Contact	**Human Resources Coordinator** **845-503-0802**
Agent for Service of Legal Process – service of process may also be made to the Plan Administrator	**Administrator** **Hamaspik Care, Inc.** **5 Perlman Drive** **Spring Valley, NY 10977** **845-503-0802**
Named Fiduciary	**Hamaspik Care, Inc.** **5 Perlman Drive** **Spring Valley, NY 10977** **845-503-0802**
Type of Plan	**This Plan is a welfare benefit plan providing various types of coverages listed under Plan Benefits below.**

If the information appearing above contradicts any term presented in the incorporated Benefit Plan Descriptions, the information above will control. For example, if a Benefit Plan Description has a different Plan Number the Plan Number above controls.

2. Plan Benefits

Employer Sponsored Benefits Plans

This Employee Benefits Plan includes the component Benefit Plan(s) identified below. Each Benefit Plan is described in full within the documents that are incorporated by reference and referred to as Benefit Plan Descriptions. This Plan is intended to comply with any applicable State mandates. The State mandates are explained in the Benefit Plan Descriptions or materials provided by the Employer.

Benefit Plan Table

Type of Benefit	Insurer or Third Party Administrator or Service Provider	Funding	Insurance Policy Contract Year
Health	**Cigna**	**Fully-Insured**	**01/01 - 12/31**
Health (MEC Plan)	**Leading Edge**	**Fully-Insured**	**01/01 - 12/31**
Dental	**Nippon Life Benefits**	**Fully-Insured**	**04/01 - 03/31**
Vision	**Nippon Life Benefits**	**Fully-Insured**	**04/01 - 03/31**
Basic Group Term Life	**Nippon Life Benefits**	**Fully-Insured**	**04/01 - 03/31**
Accidental Death & Dismemberment	**Nippon Life Benefits**	**Fully-Insured**	**04/01 - 03/31**
Long-Term Disability	**Nippon Life Benefits**	**Fully-Insured**	**04/01 - 03/31**
Health Flexible Spending Account	**Leading Edge Admin.**	**Self-Insured**	**01/01 - 12/31**

Note: The items in the funding column are described in Section 4. Funding.

Benefit Plan Descriptions

The Benefit Plan Descriptions expressly incorporated by reference and listed above include the following items that are applicable to the type of coverage provided:

(1) Complete detailed schedules of benefits, and all exclusions and limitations on benefits including subrogation rights and instances where benefits will be coordinated with other sources of payment;

(2) Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services;

(3) The procedures governing claims for benefits including procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any applicable time limits, and remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of Title I of the Act). Additional detail required by law for specific claims and appeals will be furnished as separate documents without charge;

(4) Cost-sharing provisions including any deductibles, coinsurance and copayment amounts for which the participant or beneficiary will be responsible;

(5) Any annual or lifetime caps and all other limits on benefits;

(6) The extent to which preventive services are covered;

(7) Whether, and under what circumstances, existing and new drugs are covered;

(8) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;

(9) Any conditions or limits on the selection of primary care providers or providers of specialty medical care;

(10) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under a Benefit Plan;

(11) A general description of the provider networks applicable to each Benefit Plan. A complete listing of providers in a network will be furnished to participants and beneficiaries as a separate document at no charge;

(12) Any circumstances which may result in disqualification, ineligibility, denial, loss**,** forfeiture, suspension, offset, reduction, or recovery of any benefits; and,

(13) Whether and to what extent benefits under the Benefit Plan are guaranteed under a contract or policy of insurance issued by the Insurance Company, and the nature of any administrative services (e.g., payment of claims) provided by the Insurance Company or Third Party Administrator.

3. Eligibility

Eligibility for Sponsored Group Plans

A Participant's rights to enroll in and maintain coverage under the Benefit Plans are described in detail in the Benefit Plan Descriptions listed above or enrollment materials provided by the Employer. The Benefit Plan Descriptions and the enrollment materials are expressly incorporated by reference and would include the following items:

(1) Under what circumstances a spouse, dependents and other persons may be enrolled including any proof of a relationship needed to meet the eligibility requirements (note that group health plans are required to cover dependent children placed with a participant for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children);

(2) The existence of any orientation period or waiting periods and how they are applied;

(3) When enrollment is allowed and a description of the enrollment procedures;

(4) When coverage will be effective and when it will end including the events that can occur that will terminate coverage; and,

(5) Details regarding when special enrollment rights allowing individuals who previously declined health coverage for themselves and their dependents have an opportunity to enroll (regardless of any open enrollment period). The Special Enrollment Notice, a copy of which was previously furnished to each participant, also contains important information about the potential special enrollment rights including a 30 day time limit for requesting the enrollment. You can contact your Employee Benefits Contact to receive an additional copy of that notice.

(6) Details regarding when special enrollment rights for an employee who is eligible, but not enrolled for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) when either:

(a) The employee or dependent was covered under a Medicaid plan or under a State Child Health Plan (SCHIP) and that coverage is terminated as a result of loss of eligibility; or,

(b) The employee or dependent becomes eligible for premium assistance from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

The employee or dependent must request coverage under the group health plan not later than 60 days after the date the employee or dependent is terminated from the Medicaid or SCHIP Plan or determined to be eligible for such assistance.

(7) An Addendum appears on the last page of this document that provides additional general information regarding how eligibility is determined for enrollment in the Employer's Health Plan based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA).

Benefits Available While on Leave

The Family And Medical Leave Act of 1993 (FMLA) as amended requires employers with 50 or more employees for each working day in 20 or more workweeks in the current or preceding calendar year to provide unpaid leave for eligible employees under circumstances that are prescribed by FMLA. If applicable, your Employee Benefits Contact will go over the Hamaspik Care, Inc. FMLA Policy with you including the payment options available for your elected Benefit Plans while you are on leave, and whether you have rights to be reinstated in your elected Benefit Plans when you return.

Your Employee Benefits Contact will go over any additional leave policies and your options regarding your elected Benefit Plans while on an approved leave of absence.

Qualified Medical Child Support Orders

The Plan Administrator will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which

(1) relates to the provision of child support related to health benefits for a child of a Participant of a group health plan ;

(2) is made pursuant to a state domestic relations law; and,

(3) creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.

The Plan Administrator will promptly notify the participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. A participant or beneficiary can request a copy of the Plan's procedures and the Plan Administrator will provide a copy of these procedures free of charge. Within 30 days of receipt of a medical child support order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify the participant and each alternate recipient of that determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party will be treated as a claimant and the claims procedure of the Benefit Plan will be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

A Qualified Medical Child Support Order (QMCSO) must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

A QMCSO will not require the Plan to provide any type or form of benefit, or any option, that it is not already offered except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Reconciliation Act of 1993 (OBRA '93). Upon determination of a Qualified Medical Child Support Order, the Plan must recognize the QMCSO by providing benefits for the Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA"), federal continuation shall not apply to any group health plan for any calendar year if the employer employed fewer than 20 Employees on more than 50% of the work days in the prior calendar year. If you have less than 20 Employees on more than 50% of the work days in the prior calendar year then State Continuation may apply.

The following terms in this section provide general information regarding the federal right to continue under COBRA. The Benefit Plan Description has a complete description of the federal and state rights to continue coverage under a Benefit Plan.

COBRA is offered to anyone who is considered a Qualified Beneficiary under the federal law. This includes employees who lose their group health plan coverage due to termination of employment (unless due to gross misconduct) or a reduction in hours who were covered under the group health plan on the day before the event.

A spouse or dependent covered under group health plan on the day before one of the following events that *causes a loss of coverage* is a qualified beneficiary. The spouse and dependents are eligible for COBRA for a loss of coverage due to the termination of the employee's employment (other than for gross misconduct) or the reduction of the employee's hours of employment, the death of the employee, divorce (or legal separation in a state where legal separation is recognized) or loss of dependent status under the written terms of the Benefit Plan, such as reaching the limiting age. (Note: Medicare entitlement of the employee can be a qualifying event or secondary event for some retirement plans, contact your Employee Benefits Contact for details.)

A COBRA Election Notice will be sent to the last known address on file with your employer within 44 days of the loss of coverage. COBRA Election Notice deadlines are based on the date coverage is lost. To elect continuation coverage, a participant must complete the Election Form and return it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries. You have 60 days from the later of the post mark date on your COBRA Election Notice or the date coverage terminated to enroll in COBRA. When you qualify for Trade Adjustment Assistance (TAA), you may have a second chance to elect to receive COBRA benefits. If you are within the 60-day period or believe that you are eligible for this second election period, contact your Employee Benefits Contact.

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (in the case of an extension of continuation coverage due to a disability a Benefit Plan may charge 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The COBRA Election Notice will provide the premium amounts due to continue.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, or loss of dependent status under the written terms of the Benefit Plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Continuation coverage will be terminated before the end of the maximum period if:

(1) Any required premium is not paid in full on time;

(2) A qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan;

(3) A qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage; or,

(4) The Plan Sponsor ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving continuation coverage (such as fraud).

An 11-month extension of coverage may be available for all family members covered if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. See the important notice procedures below.

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available regardless of events is 36 months. The second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. See the important notice procedures below.

Notices Due From Participants

When Notice Is Required. You, your spouse or covered dependent must notify the Plan Administrator of one of the following events, in writing, in order to be offered COBRA Continuation:

(1) The occurrence of a qualifying event that is a divorce or legal separation of a covered employee from his or her spouse, or a dependent who loses eligibility under the plan;

(2) The occurrence of a second qualifying event;

(3) A qualified beneficiary has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage; and

(4) A qualified beneficiary has subsequently been determined by the Social Security Administration to no longer be disabled.

Where the Notice is Sent. The written notice must be mailed or otherwise delivered to the Plan Administrator or Employee Benefits Contact.

When Notice is Due. Each Employee or Qualified Beneficiary who lost coverage due to a qualifying event listed above under numbers 1 or 2 must deliver the notice no later than 60 days from the later of (1) The date on which the relevant qualifying event occurs; (2) The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (3) The date on which the qualified beneficiary is informed, through the furnishing of the plan's Summary Plan Description or the General Notice, of their responsibility to provide the notice and these procedures for providing the notice.

A Social Security Determination of Disability must be delivered within 60 days after the later of: (1) The date of the disability determination by the Social Security Administration; (2) The date on which a qualifying event occurs; (3) The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (4) The date on which the qualified beneficiary is informed, through the furnishing of the summary plan description or the General Notice, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator. In addition, the notice of a Social Security Determination of Disability must be delivered before the end of the 18 month COBRA continuation period.

If the Social Security Administration determines that a COBRA Participant is no longer disabled, that Determination must be delivered within 30 days of the later of: (1) the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled; or (2) The date on which the qualified beneficiary is informed, through the furnishing of the plan's summary plan description or the General Notice of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator.

What The Notice Must Contain. The written notice must contain at least the name of the person(s) that will be losing coverage, the event that will cause the loss of coverage (referred to as a qualifying event) and the date the qualifying event actually occurs. You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Employee Benefits Contact at the address provided in this notice. The Employee Benefits Contact may develop and make available a form which may be required to be completed to provide adequate notice.

4. Funding

The Benefit Plan Table

This Plan makes available the Benefit Plans identified under Section 2. Plan Benefits, details listed in the Benefit Plan Table, and described in the Benefit Plan Descriptions incorporated by reference. The funding for each Benefit Plan is identified on the Benefit Plan Table and described below.

If the Benefit Plan is 'Fully-Insured'. Benefits are provided under an insurance contract entered into between Hamaspik Care, Inc. and the Insurance Company identified on the Benefit Plan Table. Premiums must be paid to the Insurance Company to maintain the Benefit Plan. The premium is paid in part or whole from the general assets of Hamaspik Care, Inc.

If the Benefit Plan is 'Self-Insured'. Benefits are paid from the general assets of Hamaspik Care, Inc. Claims processing and other delegated functions for the Benefit Plan are administered by the Third Party Administrator identified on the Benefit Plan Table.

If Hamaspik Care, Inc. purchased an insurance policy that provides benefits to Hamaspik Care, Inc. in the event of excess claims, commonly referred to as Stop Loss Insurance, contributions due from a participant for coverage under the Benefit Plan will not be used to pay the premium for the Stop Loss Insurance. The Stop Loss Insurance premium will be paid from the general assets of Hamaspik Care, Inc.

If the Benefit Plan is 'Partially-Insured'. A portion of the benefits are provided as an insurance contract entered into between Hamaspik Care, Inc. and the Insurance Company identified on the Benefit Plan Table. The remaining benefits are paid from the general assets of Hamaspik Care, Inc.

If the Benefit Plan includes 'Employee Salary Reduction'. These tax advantage Plans are funded in part or in whole by an Employees' salary reduction. The Benefit Plan Description includes a list of 'change in status' events that limit the instances where an Employee can change pretax elections during the Plan Year. A Health Flexible Spending Account allows Employees to make elections for pre-tax reimbursement of medical expenses, including most services allowed under Section 213(d) of the Internal Revenue Code. A Health Flexible Spending Account is a health and welfare plan subject to ERISA and Section 105 of the Internal Revenue Code. The Health Flexible Spending Account has limited COBRA continuation rights, COBRA is only offered if the cost to continue to the end of the Plan Year is less than the available benefit and continuation is only available to the end of the current Plan Year. Claims processing and other delegated functions for the Benefit Plan are administered by the Service Provider identified on the Benefit Plan Table.

PLAN SPONSOR - EMPLOYEE CONTRIBUTIONS/SPENDING CREDITS If employee contributions are required for any Benefit Plan then Hamaspik Care, Inc. will determine and communicate the employee's required contribution and the method of payment at open enrollment and as needed throughout the Plan Year. Hamaspik Care, Inc. can change that determination at any time. These communications are expressly incorporated by reference. The Plan Sponsor may use plan assets to pay plan administrative expenses. Plan assets may be used to pay reasonable administrative expenses as needed.

Hamaspik Care, Inc. may provide additional contributions in the way of cash or spending credits that can be used for any Benefit Plan, or used in a limited manner as defined by the Plan Sponsor. The Plan Sponsor may make defined contributions to specific Benefit Plans and require that you pay a portion or all of the cost for coverage under any Benefit Plan. The enrollment materials used each Plan Year include the amount of any Plan Sponsor contributions, the rules defining how the Plan Sponsor contributions can be used by Participants, and include all limitations on the use of Plan Sponsor contributions. The enrollment materials are expressly incorporated by reference.

Provided Hamaspik Care, Inc. is subject to FMLA, then Plan Sponsor contributions will continue to be provided while on an approved FMLA leave to the same extent provided to an Employee actively at work.

Refunds and Medical Loss Ratio Rebates Under Health Care Reform

In certain circumstances under the Medical Loss Ratio Standards in section 2718 of the Patient Protection and Affordable Care Act of 2010 (PPACA), rebates may be paid to this Plan. The federal law requires that the issuer of the rebate (the insurance company) provide you a written notice of a rebate, at the time the rebate is paid to the Plan. The rebate will be prorated between the amount attributable to Plan costs paid by the Plan Sponsor and Plan costs paid by participants. The participant portion of the rebate will be used for the benefit of the Plan participants. This can be done by a number of actions, including but not limited to lowering the Plan costs for the participants for the next Plan Year, applied towards the cost of administering the Plan, paid as taxable income to the participants, or in any manner that allocates the rebate to Participants based on each Participant's actual contributions, or to apportion it on any other reasonable basis.

All refunds from Insurance Policies paid to the Plan will be disbursed within 90 days of receipt by the Plan Administrator. When the Plan Administrator determines that the Medical Loss Ratio Rebates will be paid to participants, these payments will be disbursed within 90 days of receipt.

5. Plan Administration

Plan Administrator

The Plan Administrator is responsible for the administration of this Plan. Should you need to see any records or have any questions regarding any Benefit Plan, contact the Plan Administrator. The Plan Administrator has final discretionary authority to interpret the Plan and make factual determinations as to whether any individual is eligible for coverage and entitled to receive any benefits under the Plan. The Employee Benefits Contact has been appointed to assist you in answering questions and providing information to you regarding your benefits and elections. The Plan Administrator may delegate any of the responsibilities to the Insurance Company or Third Party Administrator identified in the Benefit Plan Table. The Plan Administrator is not responsible for any Benefit Plan identified as 'Individual' on the Benefits Plan Table.

The Plan Administrator will have the following rights, duties and powers to:

(1) Interpret the terms of any Benefit Plan, to determine the amount, manner and time for payment of any benefits, and to construe or remedy any ambiguities, inconsistencies or omissions, and correct any administrative errors or omissions;

(2) Adopt and apply any rules or procedures to ensure the orderly and efficient administration of any Benefit Plan;

(3) Determine the rights of any participant, spouse, dependent or beneficiary to benefits under any Benefit Plan;

(4) Develop appellate and review procedures for any participant, spouse, dependent or beneficiary to benefits under any Benefit Plan;

(5) Provide the Plan Sponsor with such tax or other information it may require in connection with any Benefit Plan;

(6) Employ any agents, attorneys, accountants or other parties (who may also be employed by the Plan Sponsor) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of any Benefit Plan, provided that such allocation or delegation and the acceptance thereof is in writing; and,

(7) Report to the Plan Sponsor, or any party designated by the Plan Sponsor, after the end of each Plan year regarding the administration of the Plan, and to report any significant problems as to the administration of any Benefit Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might ensure the efficient administration of any Benefit Plan.

Subject to applicable State or Federal law, any interpretation of any provision of this Plan made in good faith by the Plan Administrator and any determination by the Plan Administrator as to any Participant's rights or benefits under this Plan is final, shall be binding upon the parties and shall be upheld on review, unless it is shown that such interpretation or determination was an abuse of discretion (*i.e.,* arbitrary and capricious).

The Federal Privacy Rule

Plan Sponsors who receive Protected Health Information are subject to the federal privacy rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described below.

Protected Health Information ("PHI") means: information that is created or received by the Plan Sponsor and relates to the past, present, or future physical or mental health or condition of any participant; or, the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant. The test is whether there is a reasonable basis to believe the information can be used to identify the participant. PHI includes information of persons living or deceased. PHI as used in this document includes data that is transmitted or stored electronically.

Access To PHI: The Plan Sponsor's access to PHI is restricted to the minimum information necessary to administer the Benefit Plan. This includes obtaining Participant elections and enrollment for payroll and Benefit Plan administration. The Plan Sponsor may have access to PHI that was submitted for claims reimbursement when that claim is on an appeal from an adverse decision. Only the Employee Benefits Contact and employees trained in the federal privacy rule will have access to the PHI.

Permitted And Required Uses And Disclosures Of PHI By The Plan Sponsor: The Plan Sponsor can only use and disclose PHI for plan administration functions as permitted and required by this Plan Document, or as required by law. The Plan Sponsor will not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan. When necessary, the Employee Benefits Contact will disclose the PHI to consultants and experts as required by the Department Of Labor for a full and fair review or to perform plan non-discrimination

testing as required by law. All other disclosures of PHI will only be made pursuant to a valid authorization from the Participant that meets the requirements of 45 CFR §164.508.

The Plan Sponsor, on behalf of the Plan, may disclose Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance or modifying, amending or terminating the Plan. Summary Health Information means information that summarizes claims history and expenses which meets the federal requirements that remove all data fields that can be used to identify an individual participant.

Complaints: If a Participant has any complaints regarding the way that the Plan Sponsor has handled PHI they can complain to the Employee Benefits Contact. No response from the Employee Benefits Contact is required. A copy of this complaint procedure shall be provided to the Participant upon request. The Employee Benefits Contact will keep a copy of the complaint, applicable documentation, and disposition if any, for a period of 6 years from the end of the plan year in which the act occurred.

No Retaliation: No Employer will intimidate, threaten, coerce, discriminate against, or take other retaliatory action against Participants for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under the federal Privacy Rule.

Firewall: The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the protected health information that it creates, receives, maintains, or transmits on behalf of the group health plan; and ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

Plan Sponsor will: 1) Ensure that any subcontractors or agents to whom the Plan Sponsor provides PHI agree to the same restrictions described above, 2) report to the health plan any use or disclosure that is inconsistent with this Plan Document or the federal Privacy Rule, 3) make the PHI information accessible to the Participants, 4) allow Participants to amend their PHI, 5) provide an accounting of its disclosures of PHI as required by the Privacy Rule, 6) make its practices available to the Secretary for determining compliance, and, 7) return and destroy all PHI when no longer needed, if feasible.

The Federal Security Rule

This Term is intended to bring the Plan into compliance with the "HIPAA Security Rule" as published on February 20, 2003 by the United States Department of Health and Human Services (HHS), and amended, including the final Security Standards under the Health Insurance Portability and Accountability Act of 1996 and the HITECH Act (Health Information Technology for Economic and Clinical Health Act) of 2009.

The Electronic Media contemplated by the HIPAA Security Rule includes:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

In order to send and receive Protected Health Information ("PHI" as defined in the Plan Document) necessary for Plan administration by Electronic Media, the Plan Sponsor will:

(1) Implement reasonable and appropriate safeguards for electronic PHI created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the group health plan;

(2) Ensure that electronic "firewalls" are in place to secure the electronic PHI;

(3) Ensure that all agents and subcontractors with access to electronic PHI comply with the security requirements; and

(4) Report to the group health plan any security incident of which it becomes aware.

Right to Truthful and Complete Information

Benefits are conditioned on the Participants cooperation in providing such information and documentation necessary to verify eligibility for coverage and substantiate claims submitted. This may include Participant medical records, a physical examination during the pendency of any claim to the extent allowed by law, and an autopsy in the case of death except when forbidden by law.

If a Participant intentionally makes a false statement or submits false documents in support of coverage or in support of a claim for benefits, or a Participant intentionally fails to send correct information when the participant knows or should have known the information submitted was incorrect, the Plan Administrator may, without the consent of any person, and to the fullest extent permitted by law, terminate the person's Plan coverage and may refuse to honor any claim for benefits under the Plan including claims for Participants related to the person submitting the falsified information. Such person shall be responsible, to the fullest extent permitted by applicable law, to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

Termination and Amendment of Plan

The Plan Sponsor expects to maintain the Plan indefinitely as an employee benefit. However, the Plan Sponsor has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time. In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan automatically will terminate unless it is continued by the successor to the Plan Sponsor.

Participants in the Plan have no Plan benefits after a Plan termination or a partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial termination and except as otherwise expressly provided, in writing, by the Plan Sponsor.

No Continued Employment

No provisions of the Plan or this Summary shall give any employee any rights of continued employment with the Plan Sponsor or shall in any way prohibit changes in the terms of employment of any Employee covered by the Plan.

Non-Assignment of Benefits

Except as may be required pursuant to a "Qualified Medical Child Support Order" which provides for Plan coverage for an alternate recipient, other applicable law, or electronic payment made directly to a health care provider, no Participant or beneficiary may transfer, assign or pledge any Plan benefits.

Excess Payments

Upon any benefit payment made in error under the Plan, the Plan Sponsor will inform you that you are required to repay the amount that has been paid under this Plan in error. This includes and is not limited to amounts over your annual election, amounts for services that are determined not to be qualified expenses, or when you do not provide adequate documentation to substantiate a paid claim upon request. The Plan Sponsor may take reasonable steps to recoup such an amount including withholding the amount from future salary or wages, and reducing the amount of future benefit reimbursements by the amount paid in error.

Nondiscrimination

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

If your employer has multiple 'Medical, Surgical, Hospital Care' Benefit Plans as identified on the Plan Benefits Table in Section 2, where necessary in order to satisfy plan nondiscrimination requirements, these Benefit Plans may be disaggregated for testing purposes in order to ensure each Benefit Plan satisfies the nondiscrimination requirements provided under federal law and regulation.

Misstatements

Any misstatement or other mistake of fact will 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 will be made by the Plan Administrator as he considers equitable and practicable.

No Guarantee of Tax Consequences

The Plan Sponsor does not guarantee the tax status of employee contributions to any Benefit Plan, nor the tax free status of any benefit paid by or from any Benefit Plan.

6. Federal Notices

Newborns' Act Disclosure

This Plan does not 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. Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Additional information including State Rights required are described in detail in the applicable Benefit Plan Descriptions.

Notice of Rights Under the Women's Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits, under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

(1) All stages of reconstruction of the breast on which the mastectomy was performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) Prostheses; and,

(4) Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and co-insurance particulars that are applicable to other medical and surgical benefits provided under this Plan. Hamaspik Care, Inc. has provided the detailed information regarding deductible and co-insurance for the Hamaspik Care, Inc. Group Health Plan. For more information or to get a copy of the Summary Plan Description containing these details contact your Plan Sponsor Representative.

The Genetic Nondiscrimination Act of 2008 (GINA)

GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group. GINA prohibits a group health plan from requesting or requiring an individual or a family member of an individual to undergo genetic tests. Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual or a family member of the individual. The term genetic information includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo. Genetic information does not include information about the sex or age of any individual.

Compliance with Applicable Laws

The Plan Sponsor will administer the Benefit Plans in compliance with federal and state laws. Any interpretation of this document or the Benefit Plan Description incorporated by reference that is prohibited by federal or state law is void and will not be relied on for the administration of this Plan. The Plan Sponsor will administer the Benefit Plans in compliance with:

(1) The Mental Health Parity Act (MHPA) and The Mental Health Parity and Addiction Equity Act (MHPAEA) ERISA § 712, requiring parity in certain mental health and substance use disorder benefits;

(2) The Women's Health and Cancer Rights Act of 1998 (WHCRA) ERISA § 713(a), imposing requirements for coverage of reconstructive surgery and other complications in connection with mastectomy;

(3) ERISA § 609(c) coverage for adopted children;

(4) ERISA § 609(d) coverage of costs of pediatric vaccines;

(5) The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);

(6) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (applies to any group health plan sponsored by the Plan Sponsor);

(7) The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);

(8) The Genetic Information Nondiscrimination Act (GINA);

(9) The Health Information Technology for Economic and Clinical Health Act (HITECH);

(10) Michelle's Law; and,

(11) The Family and Medical Leave Act of 1993 (FMLA).

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage under the Hamaspik Care, Inc. Group Health Plan, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Plan Sponsor -sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for a Plan Sponsor -sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your Plan Sponsor's health plan is required to permit you and your dependents to enroll in the plan as long as you and your dependents are eligible, but not already enrolled in the Plan Sponsor's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

You can contact your Plan Administrator for any questions regarding your Special Enrollment Rights.

7. Statement of ERISA Rights

Your Rights

As a participant in 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 shall be entitled to:

Receive Information About Your Plans and Benefits

Examine, without charge, at Hamaspik Care, Inc.'s principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Human Resources Coordinator of Hamaspik Care, Inc., copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). Hamaspik Care, Inc. may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Hamaspik Care, Inc., as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

A complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by Participants and Beneficiaries. You may also request whether a particular Employer is a Plan Sponsor.

If this plan is maintained pursuant to one or more collective bargaining agreements, a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by all Participants and Beneficiaries.

COBRA and HIPAA Rights

Continue health care coverage for yourself, your spouse, or your 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 SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 the employee benefit 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, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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, 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the 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 Hamaspik Care, Inc., as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan 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.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Human Resources Coordinator of Hamaspik Care, Inc. 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 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.

Plan Adoption

By signing this Plan Document, the Employer identified below represents that it has formally adopted this Employee Benefits Plan.

Hamaspik Care, Inc.

By: _____

Printed: _____

Title: _____

ADDENDUM

Your Health Plan Eligibility and the Affordable Care Act (ACA)

Your rights to enroll in and maintain coverage under the Benefit Plans are described in detail in the Benefit Plan Descriptions or enrollment materials provided by the Employer as stated in this document under Section 3. Eligibility. This addendum provides you with additional general information regarding how eligibility is determined for enrollment in your Employer's Health Plan based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA).

For you to be eligible to participate in the Employer's Health Plan, you must be a full-time employee as defined in the regulations. In general, you are a full-time employee if you average at least **30 hours of service per week (or 130 hours of service in a calendar month)**. As a full-time employee you may also elect coverage for your dependent children up to age 26. Please refer to the applicable Benefit Plan Descriptions, Insurance Contracts or enrollment materials provided by the Employer and incorporated by reference in this document for information on other individuals (e.g., your spouse) that may be eligible for coverage.

If you are hired as a regular full-time non-seasonal employee your Employer has hired you to perform 30 or more hours of service per week (or 130 hours of service in a calendar month). Your eligibility and the eligibility of your dependents and other individuals (e.g., your spouse) for coverage under the health plan is set forth in the Benefit Plan Description(s) or enrollment materials as provided by your Employer and incorporated by reference in this document. These materials will address any waiting period, enrollment procedures and other pertinent information. You will continue to be treated as a Full-time employee as long as you maintain hours of service in keeping with the Full-time definition outlined above.

If you are not hired as regular full-time non-seasonal employee, but are hired as a variable hour, part-time or seasonal employee, your Employer will use a Monthly Measurement Method to determine if you are a full-time employee for purposes of Plan coverage. If you are determined in a given month to be a full-time employee, i.e., an employee with 30 hours or more of service per week, you must be offered health coverage to begin no later than the first day following the period of three full calendar months beginning with the first full calendar month in which you were determined to be a full time employee. (For example, if you are determined to be a full-time employee for the month of January, you will be offered health coverage effective no later than April 1st.) This three month period is the maximum time period set forth in the regulations; please check with your employer for further details. Your continued eligibility for health coverage will thereafter be determined on a monthly basis and will continue so long as you continue to meet the requirements as a full-time employee.

Special rules apply when an employee is rehired by the Employer or returns from an unpaid leave.

The rules for the monthly measurement method are very complex. Keep in mind that this is just a general overview of how the rules work. More complex rules may apply to your situation. The Company intends to follow the IRS final regulations (including any future guidance issued by the IRS) when administering the monthly measurement method. If you have any questions about this measurement method and how it applies to you, please contact your Human Resources Coordinator.