HESSEL LAW OFFICES
EMPLOYEE BENEFITS PLAN &
ERISA WRAP SUMMARY PLAN DESCRIPTION

PLAN PURPOSE

Hessel Law Offices (the "Employer") maintains the **Employee Benefit(s) Plan** ("the Plan") for the exclusive benefit of its eligible employees and their eligible dependents. Benefits under the Plan are currently provided under a group health insurance contract ("the Group Health Insurance Contract") entered into between the Employer and Providence Health Plan, (Providence Health Plan).

Plan benefits, including information about eligibility, are summarized in the Certificate of Coverage, Member Payment Summary, and Provider & Facility Directory issued by Providence Health Plan, copies of which are available from your Human Resources Department, free of charge. These documents together with this document constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA"). Capitalized terms not otherwise defined in this document are defined in the Certificate of Coverage.

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As used in this Summary Plan Description (SPD), "Your" means an active Employee as described under "Who is Eligible."

SPECIFIC PLAN INFORMATION

Plan Name:	Hessel Law Offices Employee Benefit(s) Plan
Type of Plan:	A group health plan (a type of welfare benefits plan subject to the provisions of ERISA).
Plan Year:	January 1 to December 31
Effective Date:	January 1, 2018; amended January 1, 2023
Plan Number:	502
Insurance Company:	Providence Health Plan https://www.providencehealthplan.com/
Employer / Plan Sponsor:	Hessel Law Offices Aaron Hessel 17040 Pilkington Rd Ste 205 Lake Oswego, OR 97035
Plan Funding and Type of Administration:	The Plan is fully insured. Benefits are provided under the Group Health Insurance Carrier Contract between the Employer and Providence Health Plan. Claims for benefits are sent to Providence Health Plan, which is responsible for paying claims. Providence Health Plan and the Employer share responsibility for administering the Plan. Insurance premiums for employees and their eligible dependents are paid in part by the Plan Sponsor out of its general assets, and in part by employees' payroll deductions.
Plan Sponsor's Employer Identification Number:	45-3860804
Plan Administrator:	Hessel Law Offices 17040 Pilkington Rd Ste 205 Lake Oswego, OR 97035 Attention: Aaron Hessel
Named Fiduciary:	Hessel Law Offices 17040 Pilkington Rd Ste 205 Lake Oswego, OR 97035

Agent for Service of Legal Process:	Hessel Law Offices 17040 Pilkington Rd Ste 205 Lake Oswego, OR 97035 (503) 828-3656 Service of process may also be made on the Plan Administrator.
Important Disclaimer:	Plan benefits are provided under a Group Health Insurance Contract between the Employer and Providence Health Plan. If the terms of this summary document conflict with the terms of the Group Health Insurance Contract, the terms of the Group Health Insurance Contract will control, unless superseded by applicable law.

SUMMARY OF PLAN BENEFITS

The Plan provides eligible employees and their eligible dependents with health insurance. These benefits are provided under the Group Health Insurance Contract with Providence Health Plan. A summary of the benefits provided under the Plan is in the Certificate of Coverage issued by Providence Health Plan.

The Plan, through the Group Health Insurance Contract, provides benefits in accordance with the applicable requirements of federal laws, such as Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Newborns' and Mothers' Health Protection Act (NMHPA), Mental Health Parity Act (MHPA), Women's Health and Cancer Rights Act (WHCRA), Genetic Information Nondiscrimination Act of 2008 (GINA), and the Affordable Care Act (ACA).

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them.

The Plan is fully insured. Benefits are provided under the Group Health Insurance Contract entered into between the Employer and Providence Health Plan. Claims for benefits are sent to Providence Health Plan, and Providence Health Plan, not the Employer, is responsible for paying them. Providence Health Plan is also responsible for determining eligibility for and the amount of any benefits payable under the Plan and prescribing claims procedures and forms to be followed to receive Plan benefits. Providence Health Plan also has the discretionary authority to require participants to furnish it with such information as it determines is necessary for the proper administration of claims for Plan benefits.

Claims and Appeals

Providence Health Plan is responsible for evaluating all benefit claims under the Plan. Providence Health Plan will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If your claim is denied, you may appeal to Providence Health Plan for a

review of the denied claim and Providence Health Plan will decide your appeal in accordance with its reasonable procedures, as required by ERISA. See the Certificate of Coverage for complete details regarding Providence Health Plan's claims and appeals procedures.

Amendment or Termination of the Plan

As Plan Sponsor, the Employer has the right to amend or terminate the Plan at any time. You have no vested or permanent rights or benefits under the Plan. Plan benefits will typically change from year-to-year and you should examine the SPD provided to you each year to determine the benefits of the Plan.

Other Materials

The Certificate of Coverage (including the Member Payment Summary, and the Provider & Facility Directory) issued by Providence Health Plan are part of the Summary Plan Description as attachments. Please refer to these materials for other important provisions regarding your participation in the Plan.

Who is Eligible

In order to be eligible for benefits you must be scheduled to work 25 or more hours per week. During the Employer Waiting Period, you must work the specified minimum required hours except for paid time off and hours you do not work due to a medical condition, the receipt of healthcare, your health status or disability. Providence Health Plan may require payroll reports from your employer to verify the number of hours you have worked as well as documentation from you to verify hours that you did not work due to paid time off, a medical condition, the receipt of healthcare, your health status or disability.

To determine whether your spouse and dependent children are eligible to participate in the Plan, please read the eligibility information contained in the Certificate of Coverage issued by Providence Health Plan.

The Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children. Also eligible is any child covered under a Qualified Medical Child Support Order (QMCSO) as

defined by applicable law and determined by your Employer under its QMCSO procedures, a copy of which is available from your Human Resources Department, free of charge.

If eligible, you must complete an application form to enroll in the Plan and Providence Health Plan (available from your Human Resources Department) or otherwise comply with your Employer's enrollment procedures.

Coverage will terminate if you no longer meet the eligibility requirements. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, etc. (See the Certificate of Coverage for more information.) Coverage for your spouse and dependents stops when your coverage stops. Their coverage will also stop for other reasons specified in the Certificate of Coverage.

Waiting Period

You are eligible to participate on the first day of the month following completion of 60 consecutive days of active employment as an Eligible Employee.

Monthly Measurement Method Used For Determining Full-Time Employee Status

On Feb. 12, 2014, the Internal Revenue Service (IRS) published final regulations on the employer shared responsibility rules. The final regulations provide two methods for identifying full-time employees for purposes of offering health plan coverage and avoiding a pay or play penalty—the monthly measurement method and the look-back measurement method.

A full-time employee is an employee who was employed, on average, at least 30 hours of service per week. The final regulations treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours per service per week.

Hessel Law Offices currently uses the monthly measurement method which involves a month-to-month analysis where full-time employees are identified based on their hours of service for each calendar month. This method is not based on averaging hours of service over a prior measurement period.

SPECIAL SITUATIONS, EXTENSION OF COVERAGE

FMLA does not apply to: (1) employers that do not employ 50 or more employees during 20 or more calendar workweeks in current or preceding calendar year; (2) employees at worksites with less than 50 employees, if the employer employs fewer than 50 employees within a 75-mile radius of that worksite. COBRA does not apply to groups with less than 20 employees in preceding year.

FMLA Leave Entitlement Family and Medical Leave Act (FMLA)

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

FMLA Benefits & Protection

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

FMLA Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting FMLA Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

FMLA Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

FMLA Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

The Plan intends to comply with all existing FMLA regulations. If for some reason the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

For more information please see: https://www.dol.gov/general/topic/benefits-leave/fmla

Military Leave Coverage

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that employers must meet for certain employees who are involved in the uniformed services

As used in this provision, "Uniformed Services" means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;
- Full-time National Guard duty,
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

1) You fail to make a premium payment within the required time;
2) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
3) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your Employer.)

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan Administrator reserves the right to administer the plan in accordance with such actual regulations.

COBRA Continuation Coverage *(only applies to groups of 20+ employees in preceding year)*

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." The following are qualifying events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your eligible dependents;
- A reduction in your hours. Coverage may continue for you and/or your eligible dependents;
- Your death. Coverage may continue for your eligible dependents;
- Your divorce or legal separation. Coverage may continue for your eligible dependents;
- Your becoming entitled to Medicare. Coverage may continue for your eligible dependents; and
- Your covered dependent child's ceasing to be a dependent child under the Plan. Coverage may continue for that dependent.
- If the Plan includes retiree coverage, Employer Bankruptcy is a qualifying event.

Note: To choose this continuation coverage, an individual must be covered under the Plan on the day before the qualifying event. In addition, your newborn child or child placed for adoption with you during a period of continuation coverage will remain eligible for continuation coverage for the remaining period of coverage even if you and/or your spouse terminate continuation coverage following the child's birth or placement for adoption.

Notification Requirements

Under the law, you or the applicable dependent has the responsibility to inform the Plan Administrator, in writing, within 60 days of a divorce or legal separation or of a child losing dependent status under the Plan. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights.

Your Employer has the responsibility to notify the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

Subject to the Plan Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan will promptly notify you and other qualifying individual(s) of their continuation coverage rights. You and any applicable dependents must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights.

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, they you will be provided with an additional 60 day enrollment period, with continuation coverage beginning on the date of such TAA approval.

Notice of Unavailability of Continuation Coverage

If the Plan Administrator receives a notice of a qualifying event from you or your dependent and determines that the individual (you or your dependent) is not entitled to continuation coverage, the Plan Administrator will provide to the individual an explanation as to why the individual is not entitled to continuation coverage. This notice will be provided within the same time frame that the Plan Administrator would have provided the notice of right to elect continuation coverage.

Maximum Period of Continuation Coverage

The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

Cost of Continuation Coverage

The cost of continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150 percent of the Plan's cost of coverage.

Premium payments for continuation coverage for you or your eligible dependent's "initial premium month(s)" are due by the 45th day after electing continuation coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elects continuation coverage. All other premiums are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by your Employer and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

1. The date the maximum continuation coverage period expires;
2. The date your Employer no longer offers a group health plan to any of its employees;
3. The first day for which timely payment is not made to the Plan;
4. The date the qualifying individual becomes covered by another group health plan. However, if the new plan contains an exclusion or limitation for a pre-existing condition of the qualifying

individual, continuation coverage will end as of the date the exclusion or limitation no longer applies;

5. The date the qualifying individual becomes entitled to coverage under Medicare; and
6. The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. In order to be eligible to apply for such coverage from a carrier after ceasing participation in the Plan, you or your eligible dependents must elect continuation coverage under the Plan, continue through the maximum continuation coverage period (18, 29, or 36 months, as applicable), and then apply for coverage with the individual insurance carrier before a 63 day lapse in coverage. For more information about your right to such individual insurance coverage, contact an independent insurance agent or your state insurance commissioner.

Notice of Termination Before Maximum Period of COBRA Coverage Expires

If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

The Plan intends to comply with all applicable law regarding continuation (COBRA) coverage. If for some reason the information presented in this Plan differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the Plan (which is a type of employee welfare plan called a "group health plan") you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series, if applicable) 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 Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from a group health plan or a health insurance issuer when you lose coverage under a group health 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.

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 Plan. The people who operate the 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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.

GENERAL NOTICES

Benefits after Childbirth (NMHPA)

Group health plans may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, and less than 96 hours following a caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-pockets costs or to use a certain provider or facility. Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prevents discrimination by group health plans and insurance companies based on genetic information. Generally, this Plan and the insurance companies from which it has purchased coverage are not permitted to:

- Use genetic information to discriminate with respect to premiums or contributions;
- Request or require Participants and/or their Dependents to undergo genetic testing (except in specifically permitted situations);
- Collect genetic information for underwriting purposes or prior to enrollment under the Plan;
- Use genetic information to determine eligibility for coverage.

Genetic information includes any information about (i) an individual's genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual.

Women's Health & Cancer Rights Act (WHCRA)

If the Participant or Dependent have had or are going to have a mastectomy, the individual 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:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurances shown in the Benefit Description will apply.

ADDITIONAL INFORMATION

Compliance with State and Federal Mandates

With respect to the benefits and as applicable, the Plan will comply with the requirements of all applicable laws. If for some reason the information presented in this Wrap SPD differs from the actual requirements of any law, the Plan reserves the right to administer the Plan in accordance with those requirements.

No Contract of Employment

Nothing in this Plan shall be construed as a contract of employment between the Employer and any employee or Participant, or as a guarantee of any employee or Participant to be continued in the employment of the Employer, nor as a limitation on the right of the Employer to discharge any of its employees with or without cause.

Medical Loss Ratio Rebates under the Public Health Service Act

In certain circumstances under the Medical Loss Ratio Standards in § 2718 of the Public Health Service Act, rebates may be paid to this Plan based on the insurance carrier's medical loss ratio. Insurance carriers are required to provide Participants with a written notice of a rebate at the time the rebate is paid to the Plan. Any rebate received by the Employer may be retained by the Employer. Any portion of the rebate attributable to Participant contributions will be used for the benefit of the Participants. This may be done by, for example, lowering the Plan costs for those Participants who are enrolled during the next Plan Year, applying the rebate towards the cost of administering the Plan, implementing a wellness or other program to help reduce plan costs, providing additional taxable income to the Participants, or using the rebate in any other reasonable manner.

Additional Information Contained in Attached Benefit Descriptions

The following additional information about the Benefits is included in the Benefit Descriptions for the benefit (if applicable):

- Any additional procedures for enrolling in the Plan;
- A summary of benefits, though this may be provided as a separate document;
- A description of any premiums, deductibles, coinsurance or copayment amounts. The schedule of your contributions, if any, to the premium payment will be provided to you by the Employer;
- A description of any annual or lifetime caps or other limits on benefits;
- Whether and under what circumstances preventive services are covered;
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers (if any). If there is a network, the Benefit Description will contain a general description of the provider network and you will receive automatically, without charge, a list of providers in the network from the carrier or administrator;
- Whether and under what circumstances coverage is provided for any out-of- network services;
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- Any services requiring preauthorization or utilization review as a condition to obtaining a benefit service;
- A summary of the claim procedures. However, if the claims procedures are not included in the Benefit Description, a copy will be provided to you automatically, without charge from the insurance carrier or administrator;
- Provisions describing the coordination of benefits with the benefits provided under another similar plan in which you or another plan participant are enrolled;
- Any subrogation or reimbursement rights that prevent duplicate payments for your health care; and
- Any other benefit limitations and exclusions.

HESSEL LAW OFFICES

Schedule A

FORMULA FOR EMPLOYEE CONTRIBUTIONS UNDER THE PLAN

The following description of the Employee Contribution per Participant may be expressed as a percentage of monthly cost, or as a flat monthly dollar amount. If the formula for Employee contributions varies by class of Employees, the Employer Sponsor assumes full responsibility for its Employer contribution design.*

Name of Benefit Plans To Be Offered		Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
Providence Health Plan	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%

ER = Employer Contribution
EE = Employee Contribution

*An asterisk in the premium column means there are multiple rates based on age, sex, or other demographics. Please refer to specific insurance carrier premium rate sheets for individual maximum elective contribution.

In no event shall the existence of any Employer contributions for monthly premium costs, as indicated above, be construed to require the Employer to pay or otherwise be liable for any deductible, coinsurance, co-payment or other cost-sharing amounts related to the applicable medical care coverage option elected by the Participant.

PROVIDENCE Health Plans

Oregon 2023 Small Group Rates

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Balance Plans (Providence Signature Network)

Plan	Medical						Prescription Drug						Rates			
✓= Deductible Waived	PCP Copay	Spec Copay	In-Network Coinsurance	Out-of-Network Coinsurance	Deductible	Out-of-pocket Maximum	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	EE Tier	ES Tier	EF Tier	EC Tier
Balance 8000 Bronze	$75✓	$100✓	50%	50%	$8,000	$9,100	$0✓	$35✓	50%	50%	50% with $200 per script cap	50%	$419.00	$838.00	$1,194.15	$775.15
Balance 6000 Silver	$40✓	$60✓	35%	50%	$6,000	$9,100	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$455.25	$910.50	$1,297.45	$842.20
Balance 4000 Silver	$40✓	$65✓	40%	50%	$4,000	$9,100	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$470.70	$941.40	$1,341.50	$870.80
Balance 2500 Gold	$40✓	$60✓	20%	50%	$2,500	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$513.25	$1,026.50	$1,462.75	$949.50
Balance 1500 Gold	$30✓	$50✓	20%	50%	$1,500	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$565.80	$1,131.60	$1,612.55	$1,046.75
Balance 750 Gold	$30✓	$50✓	20%	50%	$750	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$604.70	$1,209.40	$1,723.40	$1,118.70

- A balance of cost saving features and first dollar coverage for the most commonly used services
- Broadest provider network access with Providence Signature Network
- No referrals required
- No deductible for in-network doctor and specialist visits, urgent care and vision. Express Care Virtual covered in full.
- Separate in-network and out-of-network deductibles and out-of-pocket maximums
- Pharmacy included, no deductible for most prescriptions; Mail order maintenance medications have a 2 copay for 90 day benefit
- Chiropractic manipulation & acupuncture included, no deductible, $25 copay to in-network providers, visit limits of 20 (chiropractic) and 12 (acupuncture) per calendar year
- Pediatric dental, and pediatric and adult vision (12/24/24) included
- SHOP certified; dental plans cannot be purchased with SHOP certified plans if the employer is applying for the small business tax credit

Tier Key: EE = Employee Only, ES = Employee + Spouse, EF = Employee + Spouse + Child(ren), EC = Employee + Child(ren)

PROVIDENCE Health Plans

Oregon 2023 Small Group Rates

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Dental Plans

Plan	Benefits							Rates			
	Deductible	*Annual Benefit Maximum*	*In-Network Preventive*	*In-Network Basic*	*In-Network Major*	*OON Reimbursement*		*EE Tier*	*ES Tier*	*EF Tier*	*EC Tier*
Essential Dental	$50	$1,000	Covered In Full✓	20%	50%	MAC		$34.00	$67.00	$95.00	$60.00
Essential Access Dental	$50	$1,000	Covered In Full✓	20%	50%	90th UCR		$40.00	$80.00	$114.00	$72.00
Advantage Access Dental	$25	$1,500	Covered In Full✓	20%	50%	90th UCR		$45.00	$89.00	$127.00	$80.00
Preventive Dental	$0	N/A	Covered In Full✓	Not Covered	Not Covered	MAC		$11.00	$22.00	$33.00	$22.00

- No waiting periods
- Preventive Services do not apply to the annual maximum benefit
- Endodontics, periodontics and oral surgery are covered under Class II Basic Services
- Broad in and out-of-network provider access
- Ortho is not a covered service

Tier Key: EE = Employee Only, ES = Employee + Spouse, EF = Employee + Spouse + Child(ren), EC = Employee + Child(ren)

Hessel Law Offices
Premium Contribution Summary
Monthly Pay Cycle
12 Pay Periods Per Year
1/1/23 - 12/31/23

Providence Health Plan Balancd 2500 Gold			
	Total	Employer monthly	Employee monthly
	Premium	Contribution	Contribution
Single	$513.25	$256.63	$256.62
Single + Spouse	$1,026.50	$256.63	$769.87
Family	$1,462.75	$256.63	$1,206.12
Single + Children	$949.50	$256.63	$692.87

Providence Health Plan Advantage Access 1500			
	Total	Employer monthly	Employee monthly
	Premium	Contribution	Contribution
Single	$45.00	$22.50	$22.50
Single + Spouse	$89.00	$22.50	$66.50
Family	$127.00	$22.50	$104.50
Single + Children	$80.00	$22.50	$57.50

Some monthly employee premium contributions are not divisible by two, so a .01 rounding is included in employer cost

This page is provided as a guide to employee premium contributions. Confirm rates used with carrier contracted rates

Employee contributions may be taken on a pre-tax basis provided compliance and eligibility criteria are met

Employer pays 50% for employee only and 0% for dependents for the medical and dental plan

HESSEL LAW OFFICES

Schedule B

PARTICIPATING AFFILIATED EMPLOYERS

(Companies under common ownership)

The following organizations and entities shall be Participating Employers under the Plan:

Name of Participating Employer

Hessel Wealth Management, LLC 81-0999712

SECTION 3

HEALTH INSURANCE CERTIFICATE OF COVERAGE

PLACE CERTIFICATE OF COVERAGE AFTER TAB 3

SECTION 4

ANCILLARY BENEFIT PLANS

PLACE ANCILLARY BENEFIT BROCHURES AFTER TAB 4