<u>**HESSEL LAW OFFICES**</u>

PREMIUM ONLY PLAN

SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2023

TABLE OF CONTENTS

Plan Purpose

Who is Eligible

When you May Participate

How to Enroll

Election Changes

FMLA Leave of Absence

Non-FMLA Leave of Absence

About Social Security Taxes

About Income Taxes

Future of the Premium Only Account

Insurance Contracts

COBRA Continuation Coverage

Revised Definition of "Dependent" by WFTRA

ERISA Rights Statement

Administrative Facts

- -Plan Sponsor and Administrator
- -Plan Identification Numbers
- -Service of Legal Process
- -Classification and Funding
- -Not a Contract of Employment

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

 © Copyright all rights reserved

PLAN PURPOSE

The purpose of the Hessel Law Offices Premium Only Plan ("Plan") is to allow you to purchase coverage for health care with pretax dollars through a special type of spending account.

The advantage of this special spending account is that you pay no federal taxes on the contributions you make. This means a higher take-home pay for you than if you purchased health coverage with after-tax dollars.

The following pages explain how the Plan works.

WHO IS ELIGIBLE

If you are an employee regularly scheduled to work 25 or more hours per week for Hessel Law Offices ("Employer"), or any affiliate of the Employer which adopts the Plan ("Participating Employer"), then you are eligible to participate in the Plan.

Your spouse or dependent(s) can only receive benefits through the Plan if they are named on your qualifying policy. Your spouse or dependent(s) can not participate in the Plan independently.

Self-employed individuals are not eligible to participate in the Plan, however C Corporation owners who are also employees can participate.

WHEN YOU MAY PARTICIPATE

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

HOW TO ENROLL

To enroll in the Plan, you must complete an election form; thereafter, in order to participate, you must re-enroll during the calendar month period preceding each Plan Year. If you are a newly Eligible Employee and fail to complete an election form then you will be deemed to have elected cash compensation to the extent permissible (this means you have agreed to accept your pay after taxes have been taken out to pay for qualifying benefits). If you are already a Plan participant and you fail to complete an election form for the upcoming Plan Year, only if your Employer permits an "evergreen election" will you be able to maintain the medical and dental benefit options, if any, that you elected for the prior year.

For the purposes of this Plan, "Plan Year" means the twelve-month period commencing January 1

and ending on the subsequent December 31. Keep in mind that your choices are in effect for the entire Plan Year. Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections, see "Election Changes" in this Summary. If for any reason you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pretax payment of premiums until the new Plan Year.

ELECTION CHANGES

You usually cannot change your election to participate in the Salary Reduction Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but that will apply only for the upcoming Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule, known as “Change in Election Events.” Participants can change their elections under the Salary Reduction Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Changes in Election Event: Leaves of absence, including FMLA leave; Changes in Status; Certain Judgments, Decrees, and Orders; Medicare and Medicaid; Changes in Cost; and Changes in Coverage. In addition, the Plan Administrator can change certain elections on its own initiative. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence. A special HIPAA enrollment period of no more than 60 days is provided as of April 1, 2009 for Employees and their Dependents for loss of Medicaid or CHIPRA coverage; or upon becoming eligible for a Premium Assistance Subsidy. If the change involves a loss of your Spouse’s or Dependent’s eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. Leaves of Absence. You may change an election under the Salary Reduction Plan upon FMLA and non-FMLA leave.

 © Copyright all rights reserved

2. Change in Status. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment). "Spouse" means the person who is legally married to you and is treated as a spouse under the Internal Revenue Code ("the Code");
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). "Dependent" means your tax dependent under the Code;
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefits eligibility under a cafeteria plan (including this Salary Reduction Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid; union to non-union; or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance)*.
- a change in your, your Spouse's or your Dependent's place of residence.

3. Change in Status—Other Requirements. If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage.

Revised 2/3/2023 © Copyright all rights reserved

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For accident and health benefits a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

  However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Salary Reduction Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage.
- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Salary Reduction Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

*IRS Notice 2010-38 states that the applicable Treasury Regulations have been amended retroactively to March 30, 2010, to include Change in Status events covering children under age 27 who do not otherwise qualify as dependent children, to include becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

4. Special Enrollment Rights. In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of

Revised 2/3/2023 © Copyright all rights reserved

which was previously furnished to you. Contact the Human Resources Manager if you need another copy.) When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may change your election under the Salary Reduction Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders. If a judgment, decree, or order from a divorce, separation, annulment or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child if such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health. Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act for you or your Dependent's loss of health coverage under Medicaid or CHIP.

7. Eligibility for Premium Assistance Subsidy. Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act if you become eligible for a Premium Assistance Subsidy.

8. Change in Cost. If the cost charged to you for your Medical Insurance Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefits package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefits package option provides similar coverage.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of Medical Insurance benefits.

Revised 2/3/2023 © Copyright all rights reserved

9. Change in Coverage. You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Medical Insurance Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefits package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefits package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage)
- *Addition or Significant Improvement of Salary Reduction Plan Option.* If the Salary Reduction Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Salary Reduction Plan permits you to

 © Copyright all rights reserved

make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.
For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Salary Reduction Plan to replace the dropped coverage.

10. Modifications Required by the Plan Administrator. The Plan Administrator may modify your election(s) downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Code), if necessary to prevent the Salary Reduction Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Salary Reduction Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

FMLA LEAVES OF ABSENCE *(Applicable to groups of 50+ employees)*

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Medical Insurance Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Medical Insurance Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis). If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Medical Insurance Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation,

 © Copyright all rights reserved

including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Medical Insurance Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to. If your Medical Insurance Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

NON-FMLA LEAVES OF ABSENCE

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply.

ABOUT SOCIAL SECURITY TAXES

Social Security taxes are not deducted from the amount you pay in premiums on a pretax basis. This could result in a small reduction in the Social Security benefit you receive at retirement. This is because Social Security benefits are based on what you earned while you were working, up to the Taxable Wage Base (TWB). If your salary is above the TWB, your Social Security benefit is not likely to be affected. If you are below the TWB, the benefit would be reduced.

The tax advantages you gain through this Plan may offset any possible reduction in Social Security benefits.

ABOUT INCOME TAXES

If you cover dependent children under medical plan(s) sponsored by Hessel Law Offices and your family's adjusted income is $41,646 or less, you may be eligible to receive the Supplemental Earned Income Credit for Health Insurance Premiums (based on the tax code as of January 1, 2008). However, the amount of your contributions for health coverage, which are paid on a pretax basis, would reduce the amount of this tax credit. You should, therefore, review whether it is more advantageous for you to take the full tax credit or to elect to have your medical and dental contributions paid on a pretax basis.

FUTURE OF THE PREMIUM ONLY ACCOUNT

The Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code. The Employer reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

INSURANCE CONTRACTS

Any moneys refunded to the Employer or a participating Employer, due to actuarial error in the rate calculation, will be the property of and retained by the Employer or the Participating Employer. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

Revised 2/3/2023 © Copyright all rights reserved

COBRA CONTINUATION COVERAGE

If you terminate employment, under Federal law, you, your spouse, and/or your covered dependents lose coverage under this Plan. You, your spouse, and/or your covered dependents may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if we (and any related companies) employed twenty (20) or more employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three (3) years for any of the other reasons given in (b) and (c) below. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, coverage under another employer's plan (whether as an employee or otherwise, provided the other employer's health plan does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary unless the pre-existing condition limit does not apply to, or is satisfied by, the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act), termination of our health plan, a "for cause" termination of coverage for reasons such as fraud, or you (or the person entitled to continued coverage) become enrolled in Medicare. However, if you become enrolled in Medicare, your covered dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a "similarly situated" employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

(a) If you would otherwise lose your health plan coverage under this Plan because of a termination of employment or a reduction in hours, you may continue the health plan coverage provided under this Plan. However, this will not be a tax-deductible expense to you, absent unusual

circumstances.

(b) Your spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.

(c) Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a dependent child under the Plan.

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is our responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, the Employer's bankruptcy, or Medicare eligibility.

"*Medicare*" means the Health Insurance For the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

REVISED DEFINITION OF "DEPENDENT" BY WFTRA

An individual is considered a "Dependent" under Section 152 of the Code and the Working Families Tax Relief Act of 2005 if he or she is a qualifying child or qualifying relative of the taxpayer.

The following four criteria must be met to be a qualifying child:

1) The individual has a specific family type relationship to the taxpayer
2) The individual does not provide more than half of his or her own support
3) The individual has the same place of residence as the taxpayer for more than half of the year
4) The individual does not turn age 19 (24 if a full-time student)*, by the end of the Plan Year

In addition the following four criteria must be met to be a qualifying relative:

1) The individual has a specific family type relationship to the taxpayer
2) The individual is not a qualifying child of any other taxpayer
3) The individual receives more than half of his or her support from the taxpayer
4) The individual's annual gross income is less than the Section 151 limit (this criteria does

 © Copyright all rights reserved

not apply to health plans)

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3)) at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by Employer dependent children may be covered by either spouse, but not by both.

*NOTE: the Internal Revenue Service (the "IRS") Notice 2010-38 (the "Notice") provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year. Treasury regulations have been amended retroactively to March 30, 2010, to allow both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid by (or reimbursed to) the employee for such coverage to be excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. The Notice provides important guidance and further clarifications with regard to these issues.

ERISA RIGHTS STATEMENT

The Employee Retirement Income Security Act of 1974 ("ERISA") was enacted to help assure that all employer-sponsored group Medical Insurance Benefits conform to standards set by Congress. An employee who is a Participant in the Plan is entitled to certain rights and protections under ERISA which provides that all Participants will be entitled to (1) examine, without charge, at the Plan Administrator's office and at other appropriate locations, all Plan documents and copies of documents filed with the U.S. Department of Labor, if any, such as detailed annual reports and Plan descriptions; (2) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report (*generally only applicable to Health FSA plans and employer sponsored self-funded health and welfare benefit plans with more than 100 participants that are required to file a Form 5500 annual report)*. Plan records are kept on a Plan Year basis.

In addition to creating rights for plan participants, ERISA imposes duties upon those responsible for the operation of a plan who are called “fiduciaries" and who have a duty to operate the Plan prudently and in the interest of Participants and Beneficiaries. If a claim for a benefit under the Plan is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Within 180 days of receipt of a notice denying a claim you or your duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator, or by an appeals committee appointed by the Employer for that purpose (“Committee”). The Plan Administrator may extend the 180-day period where the nature of the benefit involved or other attendant circumstances make such extension appropriate.

Under ERISA, there are steps an Employee covered under a plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require the company to provide the materials and pay the person up to $110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the company’s control.

If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan’s money, or if an Employee covered under this Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If an Employee covered under the Plan has any questions about the Plan, the Employee should contact the Manager of Personnel of the Employer. If an Employee has any questions about this statement of the Employee’s rights under ERISA, the Employee should contact the nearest Area office of the U.S. Labor-Management Services Administration, Department of Labor.

Special Note: This is a Summary Plan Description only. Your specific rights to benefits under the Plan are governed solely, and in every respect by your Employer's Premium Only Plan document, a copy of which is available from the company upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan document, the language of the Plan document shall govern.

Revised 2/3/2023 © Copyright all rights reserved

ADMINISTRATIVE FACTS

Plan Sponsor and Administrator

The Plan is sponsored by Hessel Law Offices, 17040 Pilkington Rd Ste 205, Lake Oswego, OR 97035. Hessel Law Offices also acts as Plan Administrator. The Plan Administrator manages the overall operations of the Plan and decides all questions that come to it on a fair and equitable basis for participants and their Beneficiaries. The Plan Administrator has appointed the person in charge of benefits of Hessel Law Offices located at Hessel Law Offices, 17040 Pilkington Rd Ste 205, Lake Oswego, OR 97035, to be responsible for the day-to-day operation of the Plan.

Plan Identification Numbers

The Employer Identification Number ("EIN") assigned to Employer by the Internal Revenue Service ("IRS") is 45-3860804. The Plan Number ("PN") assigned to the Premium Only Plan by the Company is 501. You should refer to these numbers in any correspondence about the Plan.

Service of Legal Process

Hessel Law Offices has designated the Plan Administrator as its agent for service of legal process in connection with claims under the Plan. Such process may be served on the Company by directing the process to the Plan Administrator at the Hessel Law Offices address.

Classification and Funding

This Plan is classified as a Code section 125 welfare benefits plan by the Department of Labor and is funded by Employer and Employee contributions.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and the Employer. The Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Revised 2/3/2023 © Copyright all rights reserved

HESSEL LAW OFFICES

Schedule A

MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN*:

NAME OF COVERAGE

Group Health Insurance
Dental Insurance
Vision Insurance

*The Employee contributions necessary to obtain the coverage options set forth in this Schedule A above will be communicated by the Employer to Eligible Employees at the time of Enrollment and in Schedule B. The required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option above. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

Revised 2/3/2023 © Copyright all rights reserved

HESSEL LAW OFFICES

Schedule B

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
	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	$/%	$/%	$/%	$/%

*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.

ER = Employer Contribution
EE = Employee Contribution

 © Copyright all rights reserved

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

PROVIDENCE Health Plans

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)

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

Schedule C

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

 © Copyright all rights reserved