Holland Enterprises, Inc.

Health Reimbursement Arrangement

(HRA) Plan

Summary Plan Description

April 1, 2020

Contents

Introduction

Your employer (the Employer) is pleased to provide the Holland Enterprises, Inc. Health Reimbursement Arrangement (HRA) Plan (the HRA Plan) for Eligible Employees. Under federal tax law, the HRA Plan is known as a "Health Reimbursement Arrangement" or "HRA" plan. The HRA Plan is integrated with the Medical Plan offered to Holland Enterprises, Inc.'s employees. Only Eligible Employees who have coverage under one of the Medical Plan options offered by the Employer can become Participants in the HRA Plan.

This booklet describes the basic features of the HRA Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the HRA Plan and a brief description of your rights as a Participant. If there is a conflict between the official, complete HRA Plan document and this booklet, the official HRA Plan document will control. Definitions of capitalized terms used in this booklet are contained in Part V.

PART I. General Information About the Plan

I-1. What is the purpose of the HRA Plan?

The purpose of the HRA Plan is to reimburse Participants, up to certain limits, for their own and their covered Spouses' and Dependents' Medical Care Expenses applied to the Medical Plan deductible or out-of-pocket maximum. Reimbursements for Medical Care Expenses paid by the HRA Plan generally are excludable from taxable income.

I-2. Who can become a participant in the HRA Plan?

If you are an Employee who is covered by one of the Medical Plan options offered by the Employer, you are an Eligible Employee and a Participant in the HRA Plan. If your employment terminates for any reason and you are not rehired within 30 days, or you fail to qualify as an Eligible Employee for any other reason for more than 30 days, your service before the loss of Eligible Employee status will be disregarded when determining whether you are entitled to Eligible Employee status at a later date.

I-3. What Benefits are offered through the HRA Plan?

The HRA will reimburse 80% of eligible Medical Care Expenses that are applied to your Medical Plan Prescription Drug cost-sharing requirements (copayment or coinsurance) or applied to your Medical Plan deductible to a maximum of $3,000 per year.

Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Expenses must first be submitted to the Employer's Medical Plan and any

secondary health insurance coverage before any Benefits are payable from this Plan. If you have elected to participate in the Employer's Health FSA, eligible expenses may be submitted first to the HRA with any additional remaining expense then payable from your FSA balance.

I-4. How will the HRA Plan work?

The HRA Plan will reimburse you for eligible Medical Care or Prescription Drug Expenses. In order to receive reimbursement, you must submit a claim by following this procedure:

- You must submit a complete claim to the Claims Administrator;
- A request for payment must relate to Prescription Drug Expenses that were covered under the Medical Plan, but for which you were responsible under that plan's cost-sharing requirements (e.g., coinsurance or copayment) or Medical Expenses that were applied to your Medical Plan deductible. Such expenses must have been incurred by you, your Spouse, or your Dependent during the time you were a Participant under this Plan; and
- A request for payment must be submitted by May 30 following the close of the Plan Year in which the Medical Care Expense was incurred, unless your coverage under the Plan has terminated in which case, requests for payment must be submitted within 60 days of the termination date;
- Claims must be submitted in writing. The Administrator may require that Participants submit claims on a form provided by the Administrator. The claim must set forth-
    - The individual(s) on whose behalf the Medical Care or Prescription Drug Expenses were incurred;
    - The date of the eligible expenses so incurred; and
    - The amount of the requested reimbursement.
- Each claim for Medical Care Expenses must be accompanied by an Explanation of Benefits (EOB) showing that the Medical Care Expenses have been incurred and applied towards your deductible. Prescription drug claims must be accompanied by a receipt from the pharmacy, which includes the information shown above. Additional information may be requested by the Claims Administrator in order to process your claim.

I-5. Are there any limitations on Benefits available from the HRA Plan?

Only Medical Care and Prescription Drug Expenses are covered by the HRA Plan. An eligible Expense is an expense that is covered under the Medical Plan, but applied towards the Medical Plan's cost-sharing requirements. Any expenses that are denied by or not submitted to the Employer's Medical Plan will NOT be eligible for HRA reimbursement.

I-6. How do I become a Participant?

If you meet the eligibility requirements described in Section I-2, you will automatically become a Participant in the HRA Plan on the effective date of your Employer Medical Plan coverage.

I-7. What if I cease to be an Eligible Employee?

If you cease to be an Eligible Employee because you are no longer covered by one of the Employer's Medical Plans, your participation will terminate when your Medical Plan coverage ends. If you cease to be an Eligible Employee for any other reason (for example, if you die, retire, or terminate employment), your participation in the HRA Plan will terminate at the end of the month in which the terminating event occurs, unless you are eligible for and elect COBRA continuation coverage as described below. In either case, you will be reimbursed for any Medical Care or Prescription Drug Expenses prior to the date your participation terminates, however any such claims must be submitted within 60 days of your termination date.

I-8. What is COBRA continuation coverage? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the HRA Plan?

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the Medical Plan and the HRA Plan if he or she pays the applicable premium for such coverage. In order to continue coverage under the HRA, you must also elect COBRA for the Medical Plan.

"Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours;
- Your divorce or legal separation from your Spouse;

- Your becoming eligible to receive Medicare benefits;
- Your Dependent child ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

I-9. Will I have any administrative costs under the HRA Plan?

Generally, no. The Employer is currently bearing the entire cost of administering the HRA Plan while you are an Employee.

I-10. How long will the HRA Plan remain in effect?

Although the Employer expects to maintain the HRA Plan indefinitely, it has the right to terminate the HRA Plan at any time. The Employer also reserves the right to amend the HRA Plan at any time and in any manner that it deems reasonable, in its sole discretion. An amendment or termination of the Plan could result in the reduction or elimination of HRA Account balances under this Plan.

I-11. Are my Benefits taxable?

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the HRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

I-12. What happens if my claim for Benefits is denied?

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the HRA Plan are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Administrator will make the decision based on the information that it has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Administrator will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the HRA Plan's internal and external review procedures and the time limits applicable to such procedures; and
- If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to an internal appeal and, if applicable, an external review to an independent review organization.

D. Do I have to appeal a denied claim before I can go to court?

You will not be allowed to take legal action against the Plan, the Employer, the Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your *internal* appeal rights. But you do not have to pursue *external* review in order to preserve your right to file a lawsuit. (In fact, as explained later in this summary, you may be unable to take further legal action if you pursue an external appeal because the external appeal process results in a binding determination.)

E. What are the requirements of my internal appeal?

Your internal appeal must be in writing, must be provided to the Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- The date of the notice that the Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

F. Is there a deadline for filing my internal appeal?

Yes. Your internal appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission. *If you do not file your internal appeal within this 180-day period, you lose your right to appeal.* Your internal appeal will be heard and decided by the Committee.

G. How will my internal appeal be reviewed?

Any time before the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Committee. The HRA Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the

evidence before the due date for the Administrator's notice of final internal adverse benefit determination. Similarly, if the Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Administrator's notice of final internal adverse benefit determination.

The internal appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the HRA Plan who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

If the internal appeal determination will be based on the medical judgment of a health care professional retained by the Administrator, the health care professional retained for purposes of the internal appeal will not be an individual who was consulted in connection with the determination that is being appealed or any subordinate of that individual.

H. When will I be notified of the decision on my internal appeal?

The Committee must notify you of the decision on your internal appeal within 60 days after receipt of your request for review.

I. What information is included in the notice of the denial of my internal appeal?

If your internal appeal is denied, the notice that you receive from the Committee will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial upon review;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits; and
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be

provided to you free of charge upon request;

- A statement of your right to bring an external appeal or civil action under ERISA.

J. Do I have the right to seek a review of a denied claim to an external third party?

You have the right to an external review of the Administrator's denial of your internal appeal unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the HRA Plan's eligibility requirements.

K. What are the requirements of my external review?

You must first exhaust the Plan's internal appeals procedures and then may contact the Administrator to request an external appeal from an Independent Review Organization.

L. Is there a deadline for filing my external appeal?

Yes. Your external appeal must be filed with the external reviewer within 4 months of the date you were served with the Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. For example, if you received the internal appeal decision on January 3, 2020, you must appeal the decision by May 3, 2020 (or, if that is not a business day, the next business day thereafter).

M. When will I be notified of the decision on my external appeal?

The external review process may take up to two months to complete. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

I-13. Who is the Administrator?

The Employer is the Administrator and the named fiduciary for the HRA Plan.

I-14. May I elect to permanently opt out of my HRA Account?

Yes. You may elect to permanently opt out of and waive any right to reimbursements from your HRA Account for expenses incurred after the election takes effect. This opportunity will be offered at least annually by the HRA Plan.

The Employer will reimburse you for any expenses under the HRA after any opt-out election takes effect or for any Plan Year for which you have terminated your participation in the HRA Plan.

PART II. Administrative Information

The Administrator administers the HRA Plan and has the discretionary authority to interpret all HRA Plan provisions and to determine all issues arising under the HRA Plan, including issues of eligibility, coverage, and Benefits. The Administrator's failure to enforce any provision of the HRA Plan shall not affect its right to later enforce that provision or any other provision of the HRA Plan. The Administrator may delegate some of its administrative duties to agents.

Name of Plan: Holland Enterprises, Inc. Health Reimbursement Arrangement

Sponsoring Employer: Holland Enterprises, Inc.

Plan Administrator: Holland Enterprises, Inc.

Contact Person: Karla Bancroft, Safety Director

Plan Administrator's Telephone Number: (701) 373-7929

Plan Administrator's Employer Identification Number (EIN): 45-0419854

Plan Number: 501

Plan Year: April 1-March 31

Agent for Service of Process: Service may be made on the Administrator at the address listed above.

Type of Plan: The HRA Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45.

Type of Administration: The Administrator pays applicable Benefits from the general assets of the Employer through a third-party Claims Administrator.

Claims and COBRA Administrator: ConnectYourCare, LLC

Funding: The HRA Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which Benefits are paid.

PART III. HIPAA Privacy Rights

Group health plans, including the HRA Plan, are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer that outlines its health privacy policies, including with regard to electronic PHI.

PART IV. Definitions

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

- *Administrator*. The Employer.
- *Benefits*. The reimbursement benefits for Medical Care Expenses described in the HRA Plan.
- *COBRA*. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- *Code*. The Internal Revenue Code of 1986, as amended.
- *Compensation*. The wages or salary paid to an Employee by the Employer.
- *Dependent*. A dependent is a Participant's child as defined in Code §152(f)(1) who has not attained age 26, or a dependent as defined in Code §105(b); provided, however, that any child to whom Code §152(e) applies shall be treated as a dependent of both parents. Note that the Code §105(b) definition is similar to the Code §152 definition that is used to determine your tax dependents, except that an individual's status as a Dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of Code §152. The HRA Plan will provide Benefits in accordance with the applicable requirements of any court of state agency order, even if the child does not meet the definition of Dependent.
- *Eligible Employee*. An Employee who works full-time for the Employer and participates in one of the Medical Plan options offered by the Employer.
- *Employee*. An Employee of the Employer who receives Compensation from the Employer. The term shall not include (1) any individual employed by the Employer at a location outside the United States; (2) an independent contractor; and (3) self-employed individuals.
- *Employer*. Holland Enterprises, Inc. or its successor(s).
- *ERISA.* The Employee Retirement Income Security Act of 1974, as amended.
- *HIPAA*. The Health Insurance Portability and Accountability Act of 1996, as amended.
- *HRA Plan*. The Holland Enterprises, Inc. Health Reimbursement Arrangement (HRA) Plan, as amended or restated from time to time.
- *Medical Care Expenses*. See Section I-3 for a description of Medical Care Expenses.
- *Medical Plan*. The Medical Plan offered by the Employer to Eligible Employees.
- *Participant*. An Eligible Employee who has become and not ceased to be a Participant in the Plan.
- *Plan Year*. The 12-month period ending on March 31.
- *Spouse*. An individual who is treated as a spouse for federal tax purposes.

PART V. Miscellaneous

Effect of the HRA Plan on Your Employment Rights

The HRA Plan is not to be construed as giving you any rights against the HRA Plan except those expressly described in this document. The HRA Plan is not a contract of employment between you and the Employer.

Prohibition Against Assignment of Benefits

No Benefit payable at any time under the HRA Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Overpayments or Errors

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA Plan.

If you do not refund the overpayment or erroneous payment, the HRA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.

PART VI. ERISA Rights

As a Participant in the HRA Plan, you may be entitled to certain rights and protection under the Employee Retirement Income Security Act (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the Administrator's office and at other specified locations (such as worksites and union halls) all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the HRA Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as detailed annual reports;
- Obtain copies of all plan documents and other plan information upon written request to the Administrator (the Administrator may charge a reasonable amount for the copies); and
- Receive a summary of the HRA Plan's annual information report (the Administrator is required by law to furnish each Participant with a copy of this summary annual report).

You are entitled to continue health care coverage under COBRA 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, your Spouse, or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the HRA Plan for the rules governing your COBRA continuation rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your HRA Plan, called “fiduciaries” of the HRA Plan, have a duty to do so prudently and in the interest of the HRA Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may discriminate against you in any way to prevent you from obtaining a Benefit from the HRA Plan or from exercising your rights under ERISA.

If your claim for a Benefit is ignored or denied 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 materials from the HRA 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 HRA 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 HRA Plan Administrator. If you have a claim for Benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the HRA Plan, then you may file suit in state or federal court. In addition, if you disagree with the HRA Plan's decision or lack thereof regarding 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 HRA 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 that your claim is frivolous).

If you have any questions about the HRA Plan, you should contact the HRA Plan Administrator. If you have any questions about this part of the Summary Plan Description or about your rights under ERISA, or if you need assistance in obtaining documents from the HRA 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, 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.