CEDARCREST, Inc. Individual Coverage Health Reimbursement Arrangement (ICHRA) Plan Summary Plan Description

Introduction

Your employer (the Employer) is pleased to provide the CEDARCREST, Inc. Individual Coverage Health Reimbursement Arrangement (**ICHRA**) Plan (the **ICHRA** Plan) for Eligible Employees. Under federal law, the **ICHRA** Plan is known as an "Individual Coverage Health Reimbursement Arrangement" or "**ICHRA**" plan. The **ICHRA** Plan is integrated with individual health insurance coverage, Medicare Parts A and B, or Medicare Part C ("Integrated Coverage"). Only Eligible Employees who have Integrated Coverage can become Participants in the **ICHRA** Plan and receive credits to their **ICHRA** Accounts.

This Summary describes the basic features of the **ICHRA** 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 **ICHRA** Plan and a brief description of your rights as a Participant. If there is a conflict between the official, complete **ICHRA** Plan document and this Summary, the official **ICHRA** Plan document will control. Definitions of capitalized terms used in this Summary are contained in Part V.

Participants will also receive a notice about the **ICHRA** Plan with additional details. The notice is attached to the back of this Summary for your convenience. You should refer to the notice for additional information about the **ICHRA** Plan. *[**Editor's Note:** Attach employer's **ICHRA** notice to the end of this document or delete this paragraph if the employer will not do so.]*

PART I. General Information About the Plan

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

The purpose of the **ICHRA** Plan is to reimburse Participants, up to certain limits, for their own and their covered Spouses' and Dependents' premiums for Integrated Coverage. Reimbursements from the **ICHRA** Plan generally are excludable from taxable income.

I-2. When did the ICHRA Plan take effect?

The **ICHRA** Plan became effective January 1, 2023.

I-3. Who can become a participant in the ICHRA Plan?

If you are an Employee who has been employed by the Employer for a period of at least 30 consecutive calendar days, and you have Integrated Coverage, you are an Eligible Employee and may become a Participant in the ICHRA Plan. To participate, you must provide substantiation on a form provided by the Administrator that you (and your Spouse and Dependents, if applicable) are or will be enrolled in Integrated Coverage for the Plan Year (or the portion of the Plan Year during which you or other individual(s) are covered by the **ICHRA**, if applicable).

I-4. What Benefits are offered through the ICHRA Plan?

Once you become a Participant, the **ICHRA** Plan will maintain an "**ICHRA** Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible premiums for Integrated

Coverage. Your **ICHRA** 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.

Before the start of each Plan Year, the Employer will determine a maximum annual amount that may be credited during that Plan Year to the ICHRA Account of a Participant in the ICHRA Plan. For each calendar month that you are a Participant, your ICHRA Account will be credited with a pro rata portion of the maximum annual amount, so long as you have Integrated Coverage and have provided satisfactory proof of such coverage, as determined by the Administrator or its designee. For example, if the maximum annual amount is determined by the Employer to be $6,157.32 for the Plan Year, your account will be credited with $513.11 at the beginning of each calendar month during which you are a Participant, but no credit will be given for a month if you do not have Integrated Coverage or otherwise fail to qualify as an Eligible Employee on the first day of that month. Your ICHRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Integrated Coverage premiums incurred by you, your Spouse, or your Dependents. The amount available for reimbursement of eligible Integrated Coverage premiums as of any given date will be the total amount credited to your ICHRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

After the end of the Plan Year, the unused amount (if any) in your ICHRA Account will not remain available in the next Plan Year, provided you are still a Participant (and subject to any election you may make to waive or opt out of participation in the Plan).

I-5. How will the ICHRA Plan work?

The ICHRA Plan will reimburse you for eligible Integrated Coverage premiums to the extent that you have a positive balance in your ICHRA Account. The following procedure should be followed:

- You must submit a claim to the Administrator, along with substantiation on a form provided by the Administrator that the individual on whose behalf the reimbursement is requested is (or was) enrolled in Integrated Coverage for the month during which the expense was incurred, and any additional information requested by the Administrator;
- A request for payment must relate to Integrated Coverage premiums 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 March 31 following the close of the Plan Year in which the Integrated Coverage premium expense was incurred.

Claims must be submitted in writing (or electronically according to a procedure established by the Administrator). 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 Integrated Coverage premium expenses were incurred;
- The nature and date of the expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that the expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party showing that the Integrated Coverage premium expenses have been incurred and showing the amounts of such expenses, along with any additional documentation that the Administrator may request. Generally, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement total at least $25, although there is an exception made for the final reimbursement claim for a Plan Year.

I-6. Are there any limitations on Benefits available from the ICHRA Plan?

Only Integrated Coverage premium expenses are covered by the ICHRA Plan. An Integrated Coverage premium expense for these purposes is a premium payment for coverage for you, your Spouse, or a Dependent under an individual health insurance policy, or under Medicare Part A, B, or C. However, it does not include expenses for individual health insurance coverage that consists solely of excepted Benefits. Your Employer or Administrator can provide you with more information about which expenses are eligible for reimbursement.

I-7. How do I become a Participant?

If you meet the eligibility requirements described in Section I-3, you will become a Participant in the ICHRA Plan on the first day of the calendar month following your submission of a properly completed enrollment form, or the first day of the later month indicated on your enrollment form, in accordance with procedures established by the Employer, but only if you are an Eligible Employee on that day.

I-8. What if I cease to be an Eligible Employee?

If you cease to be an Eligible Employee because you no longer have Integrated Coverage, your participation will terminate immediately. 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 ICHRA 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 eligible Integrated Coverage premium expense that is incurred prior to the date your participation terminates, up to your account balance in the **ICHRA** Account, provided that you comply with the reimbursement request procedures required under the **ICHRA** Plan (see Section I-5 for more information on the reimbursement request process). Any unused portions will be not be available after termination of employment. However, if you are rehired within 30 days after your termination, your **ICHRA** Account balance will be reinstated.

I-9. What is COBRA continuation coverage? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the ICHRA 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 **ICHRA** Plan. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual has Integrated Coverage and coverage under the **ICHRA** Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA to elect to continue his or her coverage under the **ICHRA** Plan if he or she pays the applicable premium for such coverage. (COBRA would not typically apply to the Integrated Coverage.) "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 coverage under the ICHRA Plan. A Qualifying Event could include 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; and
- 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-10. Will I have any administrative costs under the ICHRA Plan?

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

I-11. How long will the ICHRA Plan remain in effect?

Although the Employer expects to maintain the **ICHRA** Plan indefinitely, it has the right to terminate the **ICHRA** Plan at any time. The Employer also reserves the right to amend the **ICHRA** 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 **ICHRA** Account balances under this Plan.

I-12. Are my Benefits taxable?

The **ICHRA** Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the **ICHRA** 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. *[**Editor's Note:** Employers should confirm the effect of applicable state tax laws on ICHRA Plan Benefits.]*

I-13. 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 ICHRA 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 claim amount and the name of the Integrated Coverage provider, to the extent such information is available;
- The specific reason for the denial;
- A reference to the specific ICHRA 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 ICHRA Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under **ERISA §502(a)** following a denial on review; 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.

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 ICHRA 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 ICHRA 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.

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 claim amount and the name of the Integrated Coverage provider, to the extent such information is available;
- The specific reason for the denial upon review;
- A reference to the specific ICHRA 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;
- 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; and
- A statement of your right to bring an external appeal or a civil action under **ERISA §502(a).**

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

You have the right to request 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 ICHRA Plan's eligibility requirements.

K. What are the requirements of my external review?

The external review may be conducted according to either a state process or a federal process (which may be a federally administered process or a private accredited independent review organization (IRO) process meeting specified federal standards). For information about which process applies to your plan, including information about how to request an external review, contact the Administrator. *[**Editor's Note:** As a practical matter, external review is unlikely to apply in this context. For more information about the external review requirements and process, see **Section XV** of Health Care Reform for Employers and Advisors (Thomson Reuters/Tax & Accounting, 2010-present).]*

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

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

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

The external reviewer must notify you and the Administrator of its decision on your claim within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies (which may include judicial review) are available.

I-14. Who is the Administrator?

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

I-15. May I elect to temporarily or permanently opt out of my ICHRA Account?

Yes, you can opt out of the ICHRA Plan for yourself, your Spouse, or your Dependents, as applicable. You may elect to opt out of your ICHRA Account for a future Plan Year by submitting a form to the Administrator before the beginning of that Plan Year. Your opt-out election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to opt out for a Plan Year, you agree to permanently forgo reimbursements from your ICHRA Account for Integrated Coverage premium expenses incurred during that Plan Year. Integrated Coverage premium expenses incurred in the Plan Year before that Plan Year may be reimbursed, so long as there was no opt out in effect for that prior Plan Year. You must apply for reimbursement, by submitting an application in writing to the Administrator, no later than March 31 following the close of the Plan Year in which the Integrated Coverage premium expense was incurred.

In lieu of a single-Plan-Year opt-out, you may elect to permanently opt out of and waive any right to reimbursements from the **ICHRA** Plan for expenses incurred after the election takes effect. This opportunity will be offered at least annually.

The Employer will not contribute to your **ICHRA** Account after any opt-out election takes effect or for any Plan Year for which you have opted out.

PART II. Administrative Information

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

Name of Plan _ **Cedarcrest, Inc. Individual Coverage Health Reimbursement Arrangement (ICHRA) Plan**

Sponsoring Employer _Cedarcrest, Inc._____

Plan Administrator __Cedarcrest, inc._____

Contact Person ___Human Resources_____

Plan Administrator's Telephone Number __603-358-3384_____

Plan Administrator's Employer Identification Number (EIN) 02-0441832_____

Plan Number _____

Plan Year___January 1, 2023_____ through ____December 31, 2023_____

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

The financial records of the ICHRA Plan are kept on a Plan Year basis. The Plan Year ends on each

_December 31.

Type of Plan: The ICHRA Plan is intended to qualify as an employer-provided medical reimbursement plan under **Code §§105** and **106** and the regulations issued thereunder, as a health reimbursement arrangement as defined under **IRS Notice 2002-45,** and as an individual coverage health reimbursement arrangement as defined under 26 CFR 54.9802-4 and other relevant guidance.

Type of Administration: The Administrator pays applicable Benefits from the general assets of the Employer.

Funding: The ICHRA 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. ERISA Rights

As a Participant in the ICHRA 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 ICHRA 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 ICHRA 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 ICHRA 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 ICHRA 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 ICHRA Plan, called "fiduciaries" of the ICHRA Plan, have a duty to do so prudently and in the interest of the ICHRA 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 ICHRA 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 ICHRA 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 ICHRA 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 ICHRA 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 ICHRA Plan, then you may file suit in state or federal court. In addition, if you disagree with the ICHRA 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 ICHRA 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 ICHRA Plan, you should contact the ICHRA 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 ICHRA 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.

PART IV. HIPAA Privacy Rights

Group health plans, including the ICHRA 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 V. 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 Integrated Coverage premium expenses described in the ICHRA Plan.
- *COBRA*. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- *Code*. The Internal Revenue Code of 1986, as amended.

- *Committee*. The Benefit Plan Committee of the Employer, or such other person or Committee as may be appointed by the Employer to supervise the administration of the Plan or decide appeals.
- *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 ICHRA Plan will provide Benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of Dependent.
- *Eligible Employee*. An Employee who works for the Employer continuously for a period of 30 consecutive days and who has Integrated Coverage.
- *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*. CEDARCREST, 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.
- *ICHRA Account*. The recordkeeping account established in your name by the Employer on the basis of which your eligible Integrated Coverage premium expenses will be paid or reimbursed.
- *ICHRA Plan*. The CEDARCREST, Inc. Individual Coverage Health Reimbursement Arrangement (ICHRA) Plan, as amended or restated from time to time.
- *Integrated Coverage*. Integrated Coverage means individual health insurance coverage that is subject to and complies with the requirements in Public Health Service Act Sections 2711 and 2713 and 26 CFR §§54.9815-2711(a)(2) and 54.9815-2713(a)(1). All individual health insurance coverage, except for coverage that consists solely of excepted benefits (e.g., insurance that only covers dental or vision care), is treated as being subject to and complying with Public Health Service Act §§2711 and 2713. In addition, coverage under Medicare Parts A and B or Medicare Part C shall constitute Integrated Coverage. A Participant, Spouse, and Dependents need not all have the same type of coverage for each to be deemed to have Integrated Coverage.
- *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 December 31.
- *Spouse*. An individual who is treated as a spouse for federal tax purposes.

PART VI. Miscellaneous

Effect of the ICHRA Plan on Your Employment Rights

The ICHRA Plan is not to be construed as giving you any rights except those expressly described in this document. The ICHRA 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 ICHRA 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 ICHRA Plan. If you do not refund the overpayment or erroneous payment, the ICHRA 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.

Document Title: CEDARCREST, Inc. Individual Coverage Health Reimbursement Arrangement (ICHRA) Plan Summary Plan Description
Checkpoint Source: Consumer-Driven Health Care Sample Documents