SECTION 3

SUMMARY PLAN DESCRIPTION

PLACE ALL PAGES OF THE SUMMARY PLAN DESCRIPTION AFTER TAB 3

DISTRIBUTE A COPY OF SPD TO ALL EMPLOYEES

Flagship One Inc
INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENT (ICHRA)
REQUIRED NOTICE

USE THIS NOTICE WHEN APPLYING FOR INDIVIDUAL HEALTH INSURANCE COVERAGE

04/01/2022

You are getting this notice because your employer is offering you an individual coverage health reimbursement arrangement (HRA). Please read this notice before you decide whether to accept the HRA. In some circumstances, your decision could affect your eligibility for the premium tax credit. Accepting the individual coverage HRA and improperly claiming the premium tax credit could result in tax liability.

This notice also has important information that the Exchange (known in many states as the "Health Insurance Marketplace") will need to determine if you are eligible for advance payments of the premium tax credit. An Exchange operates in each state to help individuals and families shop for and enroll in individual health insurance coverage.

You may also need this notice to verify that you are eligible for a special enrollment period to enroll in individual health insurance coverage outside of the annual open enrollment period in the individual market.

I. The Basics

What should I do with this notice?

Read this notice to help you decide if you want to accept the HRA.

Also, **keep this notice** for your records. You'll need to refer to it if you decide to accept the HRA and enroll in individual health insurance coverage, or if you turn down the HRA and claim the premium tax credit on your federal income tax return.

What's an individual coverage HRA?
An individual coverage HRA is an arrangement under which your employer reimburses you for your medical care expenses (and sometimes your family members' medical care expenses), up to a certain dollar amount for the plan year. If you enroll in an individual coverage HRA, **you must also be enrolled in** individual health insurance coverage or Medicare Part A (Hospital Insurance) and B (Medical Insurance) or Medicare Part C (Medicare Advantage) (collectively referred to in this notice as Medicare) for each month you are covered by the HRA. If your family members are covered by the HRA, **they must also be enrolled in** individual health insurance coverage or Medicare for each month they are covered by the HRA. See Schedule A of Benefits and Eligible Expenses from the ICHRA Summary Plan Description provided to you by your Employer.

The individual coverage HRA you are being offered is employer-sponsored health coverage. This is important to know if you apply for health insurance coverage on the Exchange.

Note: There are different kinds of HRAs. The HRA that's being referred to throughout this notice, and that your employer is offering you, is an **individual coverage HRA**. It is not a Individual Coverage health reimbursement arrangement (QSEHRA) or any other type of HRA.

What are the basic terms of the individual coverage HRA that my employer is offering?

This individual coverage HRA reimburses individual health insurance premium.

(1) The maximum dollar amount available for employee only in the HRA is outlined in Schedule A of this document.

Waiting Period: You are eligible to participate in the Plan on the first day of the month following completion of 30 consecutive days of active employment and if you are regularly work 30 or more hours per week as an Eligible Temp Employee once you have meet the Temp Status. You meet "Eligible Temp" Status after 12 months of service with 1560 hours of service performed during those 12 months (i.e. "measurement period")

Note that the self-only HRA amount available for the plan year, which is the amount you should tell the Exchange is available to you, is outlined in Schedule A of the Plan Document**.** If you apply for individual health insurance coverage through the Exchange, this is the amount the Exchange will use to figure out if your HRA is considered affordable. Benefits are available Monthly and Prorated Monthly for short plan years or mid-year enrollment.
(2) Your family members aren't eligible for the HRA.
(3) In general, your HRA coverage will start July 1, 2022. However, if you become eligible for the HRA less than 90 days before the beginning of the plan year or during the plan year, your HRA coverage will start July 1, 2022 or within 90 days of this date or your mid-year effective date as a new hire. Individual coverage HRA benefits become available as soon as your qualifying health insurance is effective.
(4) The HRA plan year begins on January 1 and ends on December 31.
(5) Amounts newly made available under the HRA will be made available on the first day of each month.

Note: You will need this information if you apply for health insurance coverage through the Exchange.

Can I opt out of the individual coverage HRA?
Yes. You can opt out of the HRA for yourself (and your family members, if applicable). The opt-out provision is available during annual open enrollment, when qualifying health insurance terminates, termination of employment, and during qualifying events such as the individual market's annual open enrollment period from November 1 through December 15 or during other special open enrollment periods. Upon termination all unused individual coverage HRA funds are forfeited.

If I accept the individual coverage HRA do I need to be enrolled in other health coverage too?
Yes. You (and your family members, if applicable) must be enrolled in individual health insurance coverage or Medicare for each month you (or your family members) are covered by the HRA. You may not enroll in short-term, limited-duration insurance or only in excepted benefits coverage (such as insurance that only provides benefits for dental and vision care) to meet this requirement.

II. Getting Individual Health Insurance Coverage

How can I get individual health insurance coverage?
If you already have individual health insurance coverage, you do not need to change that coverage to meet the HRA's health coverage requirement.

If you don't already have individual health insurance coverage, you can enroll in coverage through the Exchange or outside of the Exchange – for example, directly from an insurance company.

Note: People in most states use HealthCare.gov to enroll in coverage through the Exchange, but some states have their own Exchange. To learn more about the Exchange in your state, visit https://www.healthcare.gov/marketplace-in-your-state/.

If you are enrolled in Medicare Part A and B or Medicare Part C, your enrollment in Medicare will meet the HRA's health coverage requirement. For information on how to enroll in Medicare, visit www.medicare.gov/sign-up-change-plans.

When can I enroll in individual health insurance coverage?
Generally, anyone can enroll in or change their individual health insurance coverage during the individual market's annual open enrollment period from November 1 through December 15. (Some state Exchanges may provide additional time to enroll.) If your individual coverage HRA starts on January 1, you (and your family members, if applicable), generally should enroll in individual health insurance coverage during open enrollment.

In certain circumstances, such as when your individual coverage HRA starts on a date other than January 1 or if you are newly hired during the HRA plan year, you (and your family members, if applicable) can enroll in individual health insurance coverage outside of open enrollment using a special enrollment period.

If you qualify for a special enrollment period, make sure you enroll on time:

- If you are newly eligible for HRA coverage that would start at the beginning of the HRA plan year, you generally need to enroll in individual health insurance coverage within the 60 days before the first day of the HRA plan year.
- If the HRA was not required to provide this notice 90 days before the beginning of the plan year, or you are newly eligible for HRA coverage that would start mid-plan year (for example, because you are a new employee), you may enroll in individual health insurance coverage up to 60 days before the first day that your HRA can start or up to 60 days after this date. **Enroll in individual health insurance coverage as soon as possible** to get the most out of your individual coverage HRA.

Note: If you enroll in individual health insurance coverage through this special enrollment period, you may need to submit a copy of this notice to the Exchange or the insurance company to prove that

you qualify to enroll outside of the open enrollment period. For more information on special enrollment periods, visit HealthCare.gov or the website for the Exchange in your state.

Do I need to get new individual health insurance coverage each year if I want to enroll in my individual coverage HRA each year?
Yes. Individual health insurance coverage is typically sold for a 12-month period that is the same as the calendar year and ends on December 31. If your HRA starts on January 1, you will either need to get new individual health insurance coverage or re-enroll in your individual health insurance coverage. If your HRA has a plan year that starts on a day other than January 1, because your individual health insurance coverage will stay in effect until December 31, you do not need to get new individual health insurance coverage or re-enroll until the next open enrollment period.
If you are enrolled in Medicare, your Medicare coverage generally will remain in place year to year.

Do I need to substantiate my (and my family member's) enrollment in individual health insurance coverage or Medicare to the individual coverage HRA?
Yes. You must substantiate that you (and your family members, if applicable) will be enrolled in individual health insurance coverage or Medicare for the period you will be covered by the HRA. Substantiation of coverage should be submitted to Sean Krentzman on the form included with this
notice no later than the individual coverage HRA effective date.

Also, each time you seek reimbursement of a medical care expense from the HRA, you must substantiate that you had (or have) (or the family member whose medical care expense you are seeking reimbursement for, if applicable had (or has)) individual health insurance coverage or Medicare for the month during which the expense was incurred. The substantiation form is attached to this notice for your convenience.

What happens if I am (or one of my family members is) no longer enrolled in individual health insurance coverage or Medicare?
If you (or a family member, if applicable) are no longer enrolled in individual health insurance coverage or Medicare, the HRA won't reimburse you for medical care expenses that were incurred during a month when you (or your family member, as applicable) did not have individual health insurance coverage or Medicare. This means that **you may not seek reimbursement for medical care expenses incurred when you (or your family member, if applicable) did not have individual health insurance coverage or Medicare**.

Note: You must report to the HRA if your (or your family member's) individual health insurance coverage or Medicare has been terminated retroactively and the effective date of the termination.

III. Information About the Premium Tax Credit

What is the premium tax credit?
The premium tax credit is a tax credit that helps eligible individuals and their families pay their premiums for health insurance coverage purchased through the Exchange. The premium tax credit is not available for health insurance coverage purchased outside of the Exchange. Factors that affect premium tax credit eligibility include enrollment in Exchange coverage, eligibility for other types of coverage, and household income.

When you enroll in health insurance coverage through the Exchange, the Exchange will ask you about any coverage offered to you by your employer, including through an HRA. Your ability to claim the premium tax credit may be limited if your employer offers you coverage, including an HRA.

The Exchange also will determine whether you are eligible for advance payments of the premium tax credit, which are amounts paid directly to your insurance company to lower the cost of your premiums. For more information about the premium tax credit, including advance payments of the premium tax credit and premium tax credit eligibility requirements, see irs.gov/aca.

If I accept the individual coverage HRA, can I claim the premium tax credit for my Exchange coverage?
No. You may not claim the premium tax credit for your Exchange coverage for any month you are covered by the HRA. Also, you may not claim the premium tax credit for the Exchange coverage of any family members for any month they are covered by the HRA.

If I opt out of the individual coverage HRA, can I claim the premium tax credit for my Exchange coverage?
It depends.

- If you opt out of the HRA and the HRA is considered **unaffordable** you **may claim** the premium tax credit for yourself and any family members enrolled in Exchange coverage if you are otherwise eligible.
- If you opt out of the HRA and the HRA is considered **affordable**, you **may not claim** the premium tax credit for yourself or any family members.

If you are a former employee, the offer of an HRA will not prevent you from claiming the premium tax credit (if you are otherwise eligible for it), regardless of whether the HRA is considered affordable and as long as you don't accept the HRA.

How do I know if the individual coverage HRA I've been offered is considered affordable?
The Exchange website will provide information on how to determine affordability for your individual coverage HRA. To find your state's Exchange, visit: https://www.healthcare.gov/marketplace-in-your-state/.

Do I need to provide any of the information in this notice to the Exchange?
Yes. Be sure to have this notice with you when you apply for coverage on the Exchange. If you're applying for advance payments of the premium tax credit, you'll need to provide information from the answer to "What are the basic terms of the individual coverage HRA my employer is offering?" on page 2 above. You will also need to tell the Exchange whether you are a current employee or former employee.

If I'm enrolled in Medicare, am I eligible for the premium tax credit?
No. If you have Medicare, you aren't eligible for the premium tax credit for any Exchange coverage you may have.

IV. Other Information You Should Know

Who can I contact if I have questions about the individual coverage HRA?
Contact: Flagship One Inc, Sean Krentzman, (516) 766-2223 OR Diversified Human Solutions (267) 948 7290 or service@diversifiedhumansolutions.com

Is the individual health insurance coverage I pay for with my individual coverage HRA subject to ERISA?
The individual health insurance coverage that is paid for with amounts from your individual coverage HRA, if any, is not subject to the rules and consumer protections of the Employee Retirement Income Security Act (ERISA). You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage.

FLAGSHIP ONE INC

INDIVIDUAL COVERAGE HRA ATTESTATION: ANNUAL COVERAGE SUBSTANTIATION REQUIREMENT

Instructions: You have been offered an individual coverage health reimbursement arrangement (HRA) to help you pay for medical care expenses. To enroll in this individual coverage HRA, you must be enrolled in individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage). You should have received a notice that describes the individual coverage HRA that you are being offered. If you have not, or if you have questions about the individual coverage HRA, contact Sean Krentzman at (516) 766-2223.

If you plan to enroll in the individual coverage HRA, you must complete this form to confirm that you will have individual health insurance coverage, Medicare Part A and B, or Medicare Part C while you are covered by the HRA. If your family members will also be covered by the individual coverage HRA, you need to fill out the applicable section of this form on their behalf.

You must sign and date the form. Your family members do not need to sign or date the form. Please return the completed form to Sean Krentzman. You must return the form by the first day you become eligible to participate in the individual coverage HRA.

I attest to the following:

I, _____, am covered (or will be covered) by the following health
(insert name)

coverage:_____.
(insert name of insurance company or indicate "Medicare")

This health coverage began (or will begin) on _____.
(insert date coverage began or will begin)

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

FLAGSHIP ONE INC

INDIVIDUAL COVERAGE
HEALTH REIMBURSEMENT ARRANGEMENT (ICHRA)

SUMMARY PLAN DESCRIPTION
Effective Date: July 1, 2022
(Plan Year January 1 to December 31)

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

PLAN PURPOSE AND SPECIAL ICHRA NOTICE REQUIREMENTS

The purpose of the Flagship One Inc Individual Coverage Health Reimbursement Arrangement Plan ("ICHRA Plan") is to provide you with additional health coverage benefits. The benefits available under this Plan and other important information concerning the Plan, such as rules that must be satisfied before you become eligible and laws that protect your rights are outlined in this summary plan description.

A notice relating to the ICHRA (attached to this SPD) has been provided to you before the beginning of each plan year or no later than the date you first become eligible to participate in the ICHRA, if you are not eligible to participate at the beginning of the plan year. Non-temp Full Time Employees are not eligible for the ICHRA but will be eligible for the Quinn Business & Consulting Services, LLC Group Benefits Plan.

WHO IS ELIGIBLE

With respect to the ICHRA, if you regularly work 30 or more hours per week for the Company, or for any affiliate of the Employer which adopts the Plan ("Participating Employer"), you are eligible to participate in the HRA Plan.

WHEN YOU MAY PARTICIPATE

You are eligible to participate in the Plan on the first day of the month following completion of 30 consecutive days of active employment as an Eligible Temp Employee once you have meet the Temp Status. You become an Eligible Temp Employee after meeting the Look-Back Measurement Period requirements.

Look-Back Measurement Method Used For Determining Full-Time Employee Status

Effective January 1, 2022 the Company uses a look-back measurement method to determine who is a full-time TEMP employee for purposes of Plan coverage. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for Plan coverage determinations.

The look-back measurement method applies to all Company employees.

The look-back measurement method involves three different periods:

- A **measurement period** for counting your hours of service.
    - If you are an ongoing employee, this measurement period (which is also called the "standard measurement period") runs from January 1 to December 31 and will determine your Plan eligibility for the stability period that follows the measurement period.

- If you are a new employee who is variable hour, seasonal or part-time, the measurement period will begin on the first day of the month after date of hire and will last for twelve months.

- If you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a full-time TEMP employee who is eligible for Plan coverage based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

- A **stability period** is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are a full-time employee who is eligible for coverage during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status. The stability period last twelve months.

- An **administrative period** is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period lasts one month.

Special rules apply when employees are rehired by the Company or return from an unpaid leave.

SCHEDULE OF BENEFITS

The Individual Coverage Health Reimbursement Arrangement (ICHRA) benefits allow you to be reimbursed for certain individual health insurance premium which are incurred by you.

The maximum allowed benefit balance each year is outlined in Schedule A, plus any unused amounts from prior Coverage Periods, if any. The maximum amount that can be carried forward to a later Coverage Period is 0% of your prior Plan Year's unused balance; subject to the annual limit listed on Schedule A.

Expenses are considered "incurred" when the service is performed, not necessarily when the expense is formally billed, charged, or paid for. Any amounts reimbursed to you under the Plan may

not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage.

HOW INDIVIDUAL COVERAGE (HRAs) WORK:

Your Employer has set aside a specific amount of funds each Plan Year from which you may be reimbursed for eligible medical expenses that you have incurred during your Period of Coverage. Normally, you would pay for these expenses out of pocket, with your own after-tax income. The ICHRA Account will only be a records-keeping account with the purpose of keeping track of contributions and available reimbursement amounts. Your Employer is funding the account, and as such, there should be no tax liability to you for reimbursements received under the Plan subject to the caveats and rules listed in this summary plan description.

To receive reimbursement, you must complete a claim form and submit it along with your paid bills or other substantiation of premium expenses and/or attestation of qualified coverage to the Plan Administrator. The Plan Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the ICHRA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), you will be required to comply with substantiation procedures established by your Plan Administrator in accordance with IRS guidance. You must acquire and retain sufficient documentation to substantiate any expense paid with the debit card. Please review the list of eligible medical expenses provided on Schedule A of this Summary Plan Description, as well as the list of any ineligible expenses listed on Schedule B of this Summary Plan Description. If your request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement check soon thereafter up to the amount available in your HRA account.

You may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each Plan Year.

FUTURE OF THE ICHRA

The Plan is based on the Employer's understanding of the current provisions of the IRS, DOL, and HHS jointly issued regulations. 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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

(Applicable to any size group) A Participant who takes an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA Leave"), may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the USERRA leave commences, as other Plan Participants.

NON-FMLA AND NON-USERRA LEAVES OF ABSENCE

A Participant who goes on a leave of absence that is not subject to FMLA or USERRA will be treated as having terminated participation.

ADMINISTRATIVE FACTS

Plan Sponsor and Administrator

The ICHRA Plan is sponsored by Flagship One Inc, 19 Wilbur St. Lynbrook NY 11563 - Phone: (516) 766-2223. The Flagship One Inc Federal Tax ID Number is 80-0244828. Flagship One Inc 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. If an Employee covered under the Plan has any questions about the Plan, the Employee should contact the Plan Administrator.

General Information

Flagship One Inc Individual Coverage Health Reimbursement Arrangement is the name of the Plan.

Your Employer has assigned Plan Number 501 to this Plan.

The provisions of this Plan became effective on July 1, 2022. The Plan Year is January 1 to December 31 with the initial year of 2022 being a short plan year.

Service of Legal Process

The Employer is the Plan's agent for service of legal process.

Classification and Funding

This Employee benefit is a Health Reimbursement Arrangement as defined by Section 105 of the Internal Revenue Code. This Health Reimbursement Arrangement is funded solely by the Employer.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and a Participating Employer. Flagship One Inc'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.

Your Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), defines **Protected Health Information (PHI)** as information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment of the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The HIPAA definition of PHI applies to this plan, and it restricts a Plan Administrator's use and disclosure of PHI. The Plan Administrator shall have access to PHI from the Plan only as permitted under this plan or as otherwise required or permitted by HIPAA, subject to the conditions of permitted disclosure and after obtaining written certification. The Plan may disclose PHI to the Plan Administrator, provided that the Plan Administrator uses or discloses the PHI for Plan administration purposes only. Plan Administration Purposes include administrative functions performed by the Plan Administrator on behalf of the Plan, such as, claims processing, auditing, and monitoring.

The Plan may disclose to the Plan Administrator information on whether the individual is participating in the plan, or is enrolled in or has disenrolled from the Plan.

With respect to PHI disclosed by the Plan to the Plan Administrator, the Plan Administrator shall:

1. Not use or disclose the PHI other than is permitted or required by the Plan or by law.
2. Not use or disclose the PHI for employment-related actions and decisions.
3. Ensure that any agents, or subcontractors to whom PHI is provided, agrees to the same privacy restrictions and conditions that apply to the employer and the Plan Administrator.
4. Report to The Plan any use or disclosure of PHI that is any violation of the HIPAA Privacy Rule.
5. Make available PHI to comply with the HIPAA right to access in accordance with the law.
6. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
7. Return or destroy all PHI received from the Plan that the Employer or Plan Administrator still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, if feasible.
8. Satisfy the requirement of adequate separation between the Plan and the Employer. The Employer shall allow Sean Krentzman and no other persons, access to PHI. These specified Employees, or classes of Employees, shall only have access to and use PHI to the extent necessary to perform the Health Reimbursement Arrangement Plan administration functions that the Plan Administrator performs for the Plan. Any of these specified Employees who do not comply with the provisions of this Section, shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's Employee discipline and termination procedures.

ERISA Rights Statement

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to help assure that all employer-sponsored group benefit programs 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, 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. The Plan Administrator is required by law to furnish each Participant with a copy of this summary 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 the 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 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.

Under ERISA, there are steps the Employee covered under the 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 Employer'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 the Plan fiduciaries misuse the Plan's money, or if the Employee covered under the 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 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 claims to be frivolous.

If you have any questions about the Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration (PWBA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

The rights reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, are subject to the applicable provisions of the Plan.

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 the Flagship One Inc Individual Coverage Health Reimbursement Arrangement 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.

FLAGSHIP ONE INC INDIVIDUAL COVERAGE
HEALTH REIMBURSEMENT ARRANGEMENT PLAN (ICHRA)
QUESTIONS AND ANSWERS

INTRODUCTION

As a part of our efforts to keep your medical benefit costs as affordable as possible, Flagship One Inc (referred to in these questions and answers as the "Company"), is pleased to sponsor the Flagship One Inc Individual Coverage Health Reimbursement Arrangement (ICHRA).

The Plan provides each Eligible Employee with the opportunity to receive from the Company reimbursement for specific premium.

Following are commonly asked questions and answers describing the basic features of the Plan and how it operates. Please review these questions and answers carefully, and do not hesitate to ask questions. This is your benefit, and it is important that you understand how it works and how it can help you. However, you should note that the questions and answers address only the key parts of the Plan. Consult the Plan document or summary plan description for more details.

QUESTIONS AND ANSWERS

1. What is the purpose of the Plan?

The Individual Coverage Health Reimbursement Arrangement, or ICHRA allows you to be reimbursed for allowable individual coverage expenses up to the plan limits listed in Schedule A.

The ICHRA falls under the Affordable Care Act (ACA). This means that to participate, you must maintain qualifying health insurance coverage through the entire plan year. Failure to do so may result in tax implications and an ACA penalty.

Reimbursements from an ICHRA are not subject to income tax so long as qualifying health insurance coverage is maintained. However, should you fail to maintain said coverage, reimbursements received under the ICHRA may become taxable income to you and also result in a penalty under the ACA. Before your employer can release any funds to reimburse your qualifying medical expenses through the ICHRA, you must provide proof of health insurance coverage.

Please read the *Individual Coverage Health Reimbursement Arrangement Required Notice* at the beginning of this Summary Plan Description. You will be required to submit a copy of this notice to

qualify for coverage on the ACA exchange. While applying for an insurance policy on the ACA exchange, you must inform the exchange of your ICHRA eligibility and benefit amount. If you are eligible for a premium subsidy through the exchange, the amount of that subsidy will be reduced by the amount available in your ICHRA. You do have the right to decline the ICHRA benefit and under certain circumstances this may be the better option. See the attached Required Notice for more details.

2. What benefits are offered through the Plan?

An Individual Coverage Health Reimbursement Arrangement (ICHRA), which is explained in more detail below.

3. Who may participate in the Plan?

With respect to the ICHRA, if you regularly work 30 or more hours per week for the Company, and you have completed 30 consecutive days of active employment with the Company, you are eligible to participate in the HRA Plan.

4. How does the ICHRA benefit help me?

It is likely that you will have some medical expenses that you will have to pay for in the coming year. For example, you may have insurance premium expenses you have to pay yourself. Normally, you would pay for these expenses with out of pocket, after-tax income. And, because taxes reduce the value of a dollar, you would have to earn more than $100 to pay for $100 of expenses.

The ICHRA under the Plan permits your Employer to contribute to a health reimbursement arrangement account on your behalf. The HRA will reimburse you for specific medical expenses from funds contributed by your Employer.

5. How much will my employer contribute to my ICHRA account?

Your Employer will contribute a maximum amount outlined in Schedule A of the Summary Plan Description, plus unused amounts from prior Coverage Periods, if any. The maximum amount that can be carried forward to a later Coverage Period is 0% of your prior year's unused balance subject to the annual limit. The ICHRA Account balance can never exceed the maximum allowed benefit.

6. How much will I be able to contribute to my ICHRA account?

Employees are not permitted to contribute to their HRA accounts. The accounts must be completely Employer funded.

7. What is an "eligible expense" under the HRA?

An "eligible expense" means any item covered under IRS Code Section 213 for which you have not otherwise been reimbursed from some other source, or any items that have been

excluded from reimbursement by the Employer. Participants who are enrolled in HSA Plans will have three HRA options with limited "eligible expenses" as explained in this Summary Plan Description. It is specifically the Employee's responsibility regarding Health Reimbursement Arrangement (HRA) reimbursements not to request anything that could violate the terms of the Employee's Health Savings Account (HSA). Schedules A and B of your Summary Plan Description list the types of expenses that are included and excluded as eligible expenses for your plan.

8. How do I receive eligible expense reimbursements under the Plan?

To receive a reimbursement for an eligible expense, you must complete a claim form and attach any other information or substantiation that the Plan Administrator requires. The Plan Administrator will instruct you as to how to file the form. When the claim is approved, you will be reimbursed for your eligible medical expense, up to the amount of funds available in your HRA account.

9. What happens to the money in my HRA account if I terminate my employment?

You may submit claims for expenses incurred before the date of your termination, up until three months after you leave, unless your employer provides otherwise.

10. What happens to the unused funds in my HRA account at the end of the Plan Year?

Unused funds remain the property of the Employer.

11. How long do I have after the Plan Year ends to submit my claims?

You will have three months after the Plan Year ends to submit claims on expenses incurred in that Plan Year, unless you terminate your employment. A terminated Employee has three months from his/her date of termination to submit claims incurred in that Plan Year.

12. Are my Plan benefits taxable?

Under current law, the benefits you receive under the Plan are not currently taxable to you, nor are the benefits subject to federal income tax withholding and Social Security withholding taxes.

13. Can I change my covered dependents during the Plan Year?

Yes, you may make changes under your ICHRA account during the Coverage Period.

14. Who holds the funds that are set aside under the Plan?

Amounts your Employer contributes to your ICHRA will be retained by the Company. Separate bookkeeping entries will be maintained to keep track of your HRA benefits.

15. When will my participation in the Plan cease?

Your participation will continue until you separate from service with the Company; no longer meet the definition of Eligible Employee; or if the Plan is terminated by your Employer; or when you fail to maintain the required health insurance coverage in force.

16. Will I have any administrative costs under the Plan?

No, the Company will pay the entire cost of administering the Plan.

17. How long will the Plan remain in effect?

The Company has the right to modify or terminate the program at any time, or to elect not to continue sponsorship of the Plan.

18. Will the claims information I submit to my plan administrator be kept private?

Yes, the HIPAA Privacy Rules require that all Protected Health Information (PHI) given to the plan administrator be kept completely confidential.

19. 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 Plan 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:

- The specific reason for the denial;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- 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 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 appeal the Plan Administrator's denial of your claim.

D. What are the requirements of my appeal?

Your appeal must be in writing, must be provided to the Plan 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.

E. Is there a deadline for filing my appeal?

Yes. Your 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 appeal within this 180-day period, you lose your right to appeal.

Your appeal will be heard and decided by the Committee.

F. How will my appeal be reviewed?

Anytime before the appeal deadline, you may submit copies of all relevant documents, records, written comments, 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 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 in the initial determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the HRA Plan who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial

determination.

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

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

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

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

- The specific reason for the denial upon review;
- A reference to the specific ICHRA Plan provision(s) on which the denial is based;
- 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 a civil action under ERISA § 502(a).

No action may be brought against the Plan, the Employer, the Plan Administrator, or any other entity to whom administrative or claims processing functions have been delegated until you first follow the above claim procedures and receive a final determination from the Plan Administrator.

I. Can I request an external review of the denial of my claim?

If the denial of your claim is not related to your (or your beneficiary's) failure to meet the requirements for eligibility under the terms of your employer's HRA, you may be eligible to request an external review. View current procedures and timeline relevant to the external review request at http://www.dol.gov/ebsa or call the Employee Benefits Security Administration, 866-444 EBSA (3272).

Schedule A

SCHEDULE OF BENEFITS AND ELIGIBLE EXPENSES

Medical Expenses That Are Reimbursable

Flagship One Inc will reimburse each Eligible Employee up to $100 per month towards health insurance obtained through the New York Health Insurance Exchange (or likewise ACA complaint exchange). The website for the New York Health Insurance Exchange is: https://nystateofhealth.ny.gov/

- individual, nonexcepted benefit coverage purchased in the individual market that complies with health care reform's prohibition on lifetime and annual dollar limits (PHSA §2711) and its preventive services mandate (PHSA §2713) or Medicare (Parts A and B or Part C)

The Flagship One Inc ICHRA Plan document contains the general rules governing what expenses are reimbursable. This Schedule A, as referenced in the Plan document, specifies certain expenses that are reimbursable, if they meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

Schedule B

SCHEDULE OF INELIGIBLE EXPENSES

Medical Expenses That Are Not Reimbursable

All IRS Code 213(d) medical, dental and vision expenses found in Publication 502 not listed on Schedule A are excluded from reimbursement.

The Flagship One Inc ICHRA Plan document contains the general rules governing what expenses are reimbursable. This Schedule B, as referenced in the Plan document, specifies certain expenses that are not reimbursable, even if they meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.