Appendix I
Summary Plan Description
Dr. Hauschka Skin Care, Inc.
Health Reimbursement Arrangement

This Document is Effective: March 1, 2018

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INTRODUCTION

Dr. Hauschka Skin Care, Inc. (the "Employer") has established this Health Reimbursement Arrangement (the "HRA"). The purpose of this HRA is to reimburse Participants for certain unreimbursed medical expenses ("Eligible Medical Expenses") incurred by the Participant or their Covered Dependents. This HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Section 105 and 106 of the Internal Revenue Code ("Code").

This Summary Plan Description, or "SPD", describes the basic features of the HRA, including the rights and responsibilities of covered individuals, the Employer, and the Plan Administrator. Attached to this SPD is a Plan Information Appendix that provides important information specifically related to this HRA (e.g. the name of the sponsoring employer and plan administrator, the plan number, and the maximum level of reimbursement available under this particular HRA). If you do not have a Plan Information Appendix for this SPD, you should contact the Employer. The Plan Information Appendix may be replaced from time to time to reflect changes made to the HRA. You should check your Plan Information Appendix to ensure that you have the most recent Plan Information Appendix. You may contact the Employer if you have concerns that the Plan Information Appendix that you have is outdated. Other appendices may be attached to this SPD to the extent referenced in this SPD. The Plan Information Appendix and any other appendices referenced in this SPD should be considered a part of the SPD (i.e. the SPD, the Plan Information Appendix and any other applicable appendices together constitute the entire SPD).

This HRA has been established and is operated in accordance with both this SPD and the official plan document. This SPD (including the applicable appendices) has been incorporated into and made a part of the official plan document (i.e. the official plan document and this SPD together constitute the plan document for this HRA). Although the SPD has been incorporated into and made a part of the plan document, the terms of the official plan document will control if there is a conflict between this SPD and the official plan document.

This HRA is considered a component of the Employer's medical plan ("Component Medical Plan") specifically identified in the Plan Information Appendix. Both the HRA and the Component Medical Plan should be considered a single employee benefit plan (or part of the same Employee benefit plan) even though they are described in separate documents. The governing documents for this HRA are not intended to replace, supersede, modify or revise the governing documents of the Component Medical Plan. For purposes of this SPD, the Component Medical Plan and this HRA are collectively referred to as the "Plan".

PART I:
General Information about the Plan

**You will notice that certain terms and/or phrases are capitalized throughout this SPD. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined either in this SPD or in the official plan document into which this SPD is incorporated.*

Q-1. What is the HRA?

Generally, the HRA is an employer provided reimbursement account. The HRA works as follows:

- The Employer establishes a notional account called a Health Reimbursement Account ("Reimbursement Account") for each Participant (see Q-2 for more information on how to become a Participant).
- Each Plan Year, the Employer allocates a specified amount of employer contributions, called "HRA Dollars", to each Participant's Reimbursement Account for reimbursement of Eligible Medical Expenses. You generally do not contribute to the Reimbursement Account.
- Unlike Health FSA amounts, you do not necessarily forfeit HRA dollars that you do not use during a Plan Year.

Q-2. Who is eligible for this HRA?

You are eligible to participate in this HRA if you are an Employee of the Employer (including any Adopting Employer) ***and*** you also elect to participate in the Component Medical Plan identified in the Plan Information Appendix. Eligible employees who become covered under this HRA are called "Participants".

You may be permitted to enroll in the Component Medical Plan during the Component Medical Plan's initial enrollment period, the annual enrollment period, or during the Plan Year to the extent permitted by the Component Medical Plan (e.g., during a special enrollment period). The Component Medical Plan must allow you to enroll yourself if you are otherwise eligible and you declined coverage under the Component Medical Plan for yourself or your eligible dependents when first eligible because you or your dependents had coverage under another group health plan and that other group coverage is lost for reasons other than failure to pay premiums or cause. You must generally request enrollment within at least 30 days of losing the other coverage in order to be eligible for this special enrollment (although the Plan's special enrollment period may be longer than 30 days). Coverage must be effective no later than the first day of the month following the date you request for enrollment (but it may be earlier).

In addition, the Component Medical Plan must allow you to enroll yourself (and your eligible dependents) if you are otherwise eligible if you request enrollment within at least 30 days of gaining a new dependent through marriage, birth, adoption or placement for adoption. In the case of coverage resulting from a newborn or adopted child, coverage is effective as of the date of the birth. In the case of coverage resulting from a gaining a new dependent through marriage coverage must be effective no later than the first day of the month following the date you request enrollment (but it may be earlier).

For a detailed description of the eligibility and enrollment rules of the Component Medical Plan, please refer to the governing documents for the Component Medical Plan (e.g. the certificate of coverage, SPD and/or insurance contract).

Q-3. Are my dependents covered under the HRA?

If you become a Participant, you may also be reimbursed for Eligible Medical Expenses incurred by your Covered Dependents. A "Covered Dependent" for purposes of this HRA is any individual who meets both of the following conditions: (i) the individual is covered as a spouse or "dependent" under the Component Medical Plan and (ii) the individual is a legal "spouse" (as determined in accordance with federal law) or a "dependent" as defined in Code Section 105(b).

You may be able to enroll your eligible dependents in the Component Medical Plan when you enroll, during annual enrollment, or during the Plan Year to the extent permitted by the Component Medical Plan. The Component Medical Plan must allow you to enroll your otherwise eligible dependents (and yourself) if you declined coverage under the Component Medical Plan for your eligible dependents when first eligible because your dependents had coverage under another group health plan and that other group coverage is lost for reasons other than failure to pay premiums or cause. You must request enrollment within the time period set forth in the Component Medical Plan documentation. Coverage must be effective no later than the first day of the month following the date your enrollment is received by the Plan Administrator (but it may be earlier).

In addition, the Component Medical Plan must allow you to enroll a new dependent if you request enrollment within the time period set forth in the Component Medical Plan documentation. In the case of coverage for a newborn or adopted child, coverage is effective as of the date of the birth. In the case of coverage for a new dependent gained through marriage coverage must be effective no later than the first day of the month following the date your enrollment is received by the Plan Administrator (but it may be earlier).

For a detailed description of dependent eligibility and enrollment rules (including special enrollment rules) under the Component Medical Plan, please refer to the governing documents for the Component Medical Plan (e.g., the Component Medical Plan SPD). You may be required to provide proof of dependent status upon request by the Plan Administrator (or its designated Third Party Administrator). Failure to provide such proof may result in a delay in coverage under this HRA.

In addition, this HRA will cover a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under this HRA. The plan administrator of the Component Medical Plan (or its designee) will notify you if a medical child support order has been received. The plan administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan's QMCSO procedures. The plan administrator will notify both you and the affected child once a determination has been made. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting either the plan administrator of the Component Medical Plan or the Plan Administrator of this HRA (as identified in the Plan Information Appendix).

Q-4. What is the effective date of coverage under this HRA?

Coverage under this HRA for an Eligible Employee and Eligible Dependent(s) begins on the applicable date identified in the "Effective Date of Coverage" section of the Plan Information Appendix. In no event will the coverage under this HRA begin before the earlier of the effective date of this HRA or the effective date of coverage under this HRA. The effective date of this HRA is identified in the Plan Information Appendix.

Q-5. When does coverage under this HRA end?

Coverage for a Participant and/or Covered Dependent ends on the same date that coverage under the Component Medical Plan ends. However, you, your covered spouse, and/or your covered child(ren) may be eligible to continue coverage under this HRA and the Component Medical Plan in accordance with federal law beyond the date that coverage would otherwise end if coverage is lost for certain reasons. Your continuation of coverage rights and responsibilities are generally described in **Q-18** herein. All HRA dollars that are not applied towards Eligible Medical Expenses incurred before your coverage termination date in accordance with Q-15 of this SPD are forfeited.

If you have lost coverage during a leave of absence that qualifies under the Family and Medical Leave Act ("FMLA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), you may have rights to reinstatement in the Plan as set forth in the Employer's internal policies and procedures established in accordance with FMLA and USERRA.

Q-6. What happens to my HRA coverage if I take a leave of absence from the Employer?

Your coverage under this HRA during a paid or unpaid leave of absence will be treated in the same manner that coverage under the Component Medical Plan is treated during a leave of absence. For a detailed summary of the continuation rights under the Component Medical Plan during a leave of absence, please refer to the governing documents of the Component Medical Plan and/or your Employee Handbook.

Q-7. What is an "Eligible Medical Expense"?

"Eligible Medical Expenses" are medical care expenses ***incurred*** by you or your Covered Dependents that satisfy all of the conditions described in the "Eligible Medical Expense" section of the Plan Information Appendix and are for "medical care" as defined in Code Section 213(d). All expenses that are not within the scope of "Eligible Medical Expenses" described in the Plan Information Appendix are excluded. "Incurred" means the date the service or treatment is provided; not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided. Also, an otherwise Eligible Medical Expense will not be reimbursed unless the requirements described in Q-15 below have been satisfied.

In no event will the following expenses be eligible for reimbursement:

- any expense that is not a Code Section 213(d) expense
- any expenses incurred for qualified long term care services (as defined in Code Section 106)
- expenses incurred *prior to the date* that coverage under this HRA becomes effective
- expenses incurred *after the date* that coverage under this HRA ends
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Whether an Expense is an "Eligible Medical Expense" is within the sole discretion of the Plan Administrator.

Q-8. What is a Health Reimbursement Account?

Once you become a Participant, the Employer establishes a Reimbursement Account for you. The

Reimbursement Account is a notional bookkeeping account that keeps a record of HRA dollars allocated to your account and reimbursements made to you under this HRA (except as otherwise noted in the Plan Information Appendix). You have no property rights in the Reimbursement Account.

Q-9. Who contributes to my Reimbursement Account?

While you are an active employee, the Employer allocates HRA Dollars to your Reimbursement Account. You do not contribute to the Reimbursement Account (except during COBRA). In fact, federal laws prohibit you from contributing to your Reimbursement Account with any portion of a pre-tax salary reduction made under a Code Section 125 cafeteria plan. You may, however, be required to pay the "applicable premium" for continuation of HRA coverage under COBRA (please refer to Q-18 below for more information regarding COBRA continuation coverage).

Q-10. How are HRA dollars allocated to my Reimbursement Account?

Each Plan Year, the Employer allocates a specified amount of HRA dollars to your Reimbursement Account. The maximum annual HRA Dollar amount is identified in the "HRA Dollar" section of the Plan Information Appendix. The amount of HRA Dollars allocated to your Reimbursement Account is determined in the sole discretion of the Employer and may vary depending on circumstances such as family status. Nevertheless, the annual amount of HRA Dollars allocated to each Participant's Reimbursement Account will be determined in a uniform and non-discriminatory manner in comparison to other similarly situated employees.

In addition, HRA Dollars will be allocated to your Reimbursement Account in accordance with the "HRA Dollar" section of the Plan Information Appendix (e.g. all at once at the beginning of the year or periodically throughout the year on a pro-rata basis).

Q-11. What happens if I do not use all of the HRA Dollars allocated to my Reimbursement Account during the Plan Year?

Unlike Health FSA dollars, if you do not use all of the HRA Dollars allocated to your Reimbursement Account in accordance with Q-10 of this SPD, all or a portion of the HRA Dollars may remain in your Reimbursement Account for future reimbursement of Eligible Medical Expenses. The amount of unused HRA Dollars that you may "carry over" is described in the "Carry Over" section of the Plan Information Appendix. Any funds that you are not entitled carry over in accordance with this Q-11 will be forfeited and returned to the employer.

Q-12. Is there a limit on how much can be allocated to my Reimbursement Account?

The amount in your Reimbursement Account can never exceed the Reimbursement Account Maximum identified in the "Reimbursement Account" section of the Plan Information Appendix (if any). Any HRA Dollars that you would otherwise be entitled to under the terms of this HRA will be forfeited to the extent your Reimbursement Account has reached its Reimbursement Account Maximum. If your Reimbursement Account has reached the Reimbursement Account Maximum, your Reimbursement Account will be temporarily closed until such time as your Reimbursement Account balance is less than the maximum. At such time you will be entitled to receive your share of HRA Dollars, not to exceed the Reimbursement Account Maximum, at the next regularly scheduled allocation. For example, if the HRA plan year is a calendar plan year, the annual HRA Dollars are allocated monthly and your Reimbursement Account balance goes below the Reimbursement Account Maximum in June, you will be entitled to receive an HRA Allocation in July. If HRA Dollars are allocated each January 1, and your Reimbursement Account balance goes below the Reimbursement Account maximum in July, you will

receive an HRA Dollar allocation the following January 1.

Q-13. What is the maximum amount of reimbursement that I may receive under the HRA?

The maximum reimbursement amount that you can receive is equal to your Reimbursement Account balance at the time the request for reimbursement is processed. Any portion of a claim for reimbursement that exceeds the maximum reimbursement amount will be suspended and processed when the Reimbursement Account becomes sufficient. Pended claims will be processed and, if appropriate, paid before any new claims are processed and paid.

Q-14. Can I change my level of coverage under the HRA during the Plan Year?

If you change your level of coverage under the Component Medical Plan during the Plan Year (e.g. single to family/family to single or part-time to full-time/full-time to part-time) and there is a different HRA Dollar allocation associated with the new level of coverage, your annual HRA Dollar allocation may be adjusted to the extent described in the "Changing Coverage" section of the Plan Information Appendix. All adjustments (if any) will be applied prospectively only.

Q-15. How do I receive reimbursement under the HRA?

When you incur an Eligible Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

- Name of person receiving service
- Name and address of service provider
- Nature of service or supplies
- Amount of reimbursable expense under the plan
- Date(s) of service

If the Plan only reimburses expenses that are otherwise covered by the Component Medical Plan but for a limitation (e.g. a deductible, coinsurance), then you must submit the applicable Evidence of Benefits ("EOB") from the Component Medical Plan administrator that identifies the expenses otherwise covered by the Plan and the amount for which you are liable. To the extent chosen by the Employer, the Component Medical Plan administrator may submit the EOB directly to the Third Party Administrator. The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Expense, you will receive notification of this determination. You must submit all claims for reimbursement during the Plan Year or during the applicable Run-Out Period. The Run-Out Period is described in the Plan Information Summary.

Your claim is deemed filed when the Third Party Administrator receives it. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Any unclaimed reimbursement amounts (e.g., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) by the "Payment Claim Date" identified in the Plan Information Appendix. If your claim for reimbursement is denied, in whole or in part, you will be notified in accordance with the HRA's claims review procedures described in Q-16

below.

Q-16. What happens if my claim for benefits is denied?

If you are denied a benefit under the Plan, you should proceed in accordance with the following claims review procedures:

Step 1: *Notice is received from Third Party Administrator*. If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible as but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal*. If you do not agree with the decision of the Third Party Administrator, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. If the Plan has established only one level of review, you should file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you should file your appeal with the third party administrator. The notice of denial reference in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, you should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer*. If the claim is again denied, you will be notified in writing. If the plan has established two levels of appeal, as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the third party administrator. Otherwise, notice of the denial will be sent no later than 60 days after the Plan Administrator receives the appeal.

Step 5: *Review your notice carefully*. You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third party administrator.

Step 6 (if there is a second level of appeal as indicated in the notice of denial): *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator*. If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the third party

administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Q-17. What happens if I received overpayments or reimbursements are made in error from this HRA?

If it is later determined that you and/or your Covered Dependent(s) received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense under the HRA that is later paid for by the Component Medical Plan or some other medical plan), you will be required to refund the overpayment or erroneous reimbursement to the HRA.

If you do not refund the overpayment or erroneous payment, the Plan reserves 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. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which have tax implications for you. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this HRA (and to the extent permissible, under the Component Medical Plan).

Q-18. What is "Continuation Coverage" and how does it work?

A federal law called "COBRA" requires most Employers sponsoring group health plans to offer covered Employees and certain covered family members the opportunity for a temporary extension of health care coverage (called "Continuation Coverage") in certain instances where coverage under the group health plan would otherwise end. These rules apply to coverage under the Component Medical Plan and the HRA unless the Employer is a small Employer as defined under applicable law (generally less than 20 employees during the current year). The Plan Administrator will tell you whether the Plan is subject to these rules. Below is a description of your rights and responsibilities under the federal COBRA rules and regulations.

<u>Who May Continue Coverage Under COBRA?</u>
Since this HRA and the Component Medical Plan are considered a single Plan, you cannot continue coverage under this HRA unless you elect to continue coverage under the Component Medical Plan. Nevertheless we have generally described your rights to continue coverage under the Plan pursuant to federal COBRA. You should also refer to the governing documents for the Component Medical Plan for additional continuation of coverage information.

Federal COBRA requires group health plans to provide "Qualified Beneficiaries" an opportunity to temporarily continue group health coverage when that coverage is lost (or should be lost) as a result of certain "Qualifying Events". A "Qualified Beneficiary" is the employee, Spouse, or Dependent Child covered under the Plan immediately preceding the Qualifying Event. A child born to or adopted by (including a child placed for adoption with) a covered employee during the covered employee's COBRA

period is also considered a "Qualified Beneficiary" if properly enrolled.

When May Coverage Be Continued Under COBRA?

Coverage may only be continued if coverage is lost as a result of certain Qualifying Events. You have the right to COBRA continuation coverage if you lose coverage under the Plan as a result of a termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment.

Your spouse has the right to COBRA continuation coverage under the Plan if your spouse loses coverage under the Plan as a result of any one of the following four events:

- you terminate employment (for reasons other than gross misconduct) or have a reduction in your hours of employment (including a military leave of absence);
- you die;
- you and your spouse divorce or legally separate;
- you become entitled to Medicare;

Your covered dependent children may have the right to COBRA continuation coverage under the plan if your dependent children lose coverage as a result of any one of the following five events:

- you terminate employment or have a reduction in your hours of employment;
- you die;
- you and your spouse divorce or legally separate;
- you become entitled to Medicare;
- your dependent child ceases to be an eligible dependent under the Plan;

A child born to or adopted by (including a child placed for adoption with) a covered employee during the covered employee's COBRA period is also considered a "qualified beneficiary" if properly enrolled.

Notice and Election Rules

The Plan Administrator must send notice to qualified beneficiaries of the right to the continuing participation following the covered employee's termination of employment, reduction in hours or death. If the covered spouse and/or covered dependent children lose coverage as a result of a divorce, legal separation, or dependent child ceasing to be a dependent, you or the affected Qualified Beneficiary must send notice to the COBRA Administration identified in the Plan Information Appendix within 60 days of the later of

- The event and
- The date coverage is lost as a result of such event.

The Qualified Beneficiary will then be sent a notice of this right to continuing participation following receipt of Qualified Beneficiary's notice.

Once you and/or any other Qualified Beneficiary have been provided notice of the right to elect COBRA continuation coverage, an election for continuation coverage under the Plan must be made within 60 days of the later of the date of the notice or the date coverage is lost as a result of the Qualifying Event. If a qualified beneficiary fails to provide this notice to the COBRA Administrator identified in the Plan Information Appendix during this 60-day notice period, the qualified beneficiary will lose the right to COBRA continuation coverage and coverage under the Plan will cease as of the last date you were eligible for coverage. Each Qualified Beneficiary has a separate and independent right to elect COBRA continuation coverage. A qualified beneficiary employee or spouse can elect coverage for any other

qualified beneficiary. On the other hand, you may not decline COBRA continuation coverage for the Qualified Beneficiary spouse. A parent or guardian can elect coverage for a Qualified Beneficiary child who is a minor.

Duration of Coverage

Qualified beneficiaries may continue coverage for 18 months if coverage is lost as a result of your termination of employment (for reasons other than gross misconduct) or coverage ends because of your reduction in hours of employment. Qualified beneficiaries other than the covered employee may continue coverage under the Plan for 36 months if coverage is lost as a result of the covered employee's death, a divorce or legal separation or a dependent child ceasing to be a dependent, or you become entitled to Medicare.

If you or a qualified beneficiary family member, determined by the Social Security Administration to have been disabled at any time prior to the end of the first 60 days of continuation coverage resulting from a termination or reduction in hours of employment, COBRA may be extended from 18 months up to 29 months. You or a qualified beneficiary must notify the Plan administrator prior to the end of the end of the original COBRA period (up to 18 months) or the 60-day notice period, whichever comes first. The 60 day notice period ends 60 days after the latter of:

- The date of the determination;
- The date of the qualifying event (i.e. termination of employment);
- The date that coverage is lost as a result of the qualifying event;

If the Social Security Administration determines that you or a qualified beneficiary is no longer disabled while on COBRA continuation coverage, you or a qualified beneficiary must notify the Plan Administrator within 30 days of the date the Social Security Administration's determination that you are no longer disabled.

If you become entitled to Medicare (and don't lose coverage under the Plan) and then terminate employment or have a reduction in hours of employment within 18 months of your Medicare entitlement, your qualified beneficiary spouse and/or covered children are eligible to receive 36 months of continuation coverage beginning on the Medicare entitlement date.

If COBRA coverage was elected following a termination of employment or reduction in hours of employment, additional qualifying events (such as divorce, Medicare entitlement, or death) may occur during the first 18 months (or during the disability extension discussed above) that may result in an extension of the 18-month (or 29 month) continuation period to 36 months for the Qualified Beneficiary Spouse and/or child. In no event will COBRA continuation coverage last longer than 36 months from the date of the termination of employment or reduction in hours of employment. You or your qualified beneficiary must notify the COBRA Administrator within 60 days of the event if a second qualifying event occurs during your continuation coverage period. NOTE: A second event will not entitle your Qualified Beneficiary Spouse to additional coverage unless the event would have caused a loss of coverage if it was the initial qualifying event.

Note: In all situations in which you or another qualified beneficiary is required to provide notice of a qualifying event (either an initial qualifying event or a subsequent qualifying event), you must identify the qualifying event, the date of the qualifying event, and the qualified beneficiaries impacted by the qualifying event.

Type of Coverage

If you choose continuation coverage, you are entitled to the level of coverage under the HRA in effect for

you immediately preceding the qualifying event. At the beginning of each Plan Year that COBRA is in effect under this HRA, you will be entitled to an increase in your Reimbursement Account Balance equal to the sum of the HRA Dollars allocated to similarly situated active participants (subject to any restrictions applicable to similarly situated active participants) so long as you continue to pay the applicable premium.

Cost

For the period of continuation coverage, the cost of such coverage will not exceed 102% of the "applicable premium", as determined by the Plan Administrator, or 150% of the "applicable premium" during any disability extension to which you may be entitled, as determined by the Social Security Administration. The Plan Administrator will notify you of the applicable premium. The notice you receive will describe the premium payment requirements under the Plan (e.g., who you pay the premium to, etc.).

Early Termination of Coverage

Your continuation coverage will end prior to the expiration of the 18-, 29-, or 36-month period for any of the following reasons:

- The company no longer provides group health coverage to any of its employees;
- The qualified beneficiary does not make the required payments (within the grace period);
- You or a qualified beneficiary on COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation with respect to any pre-existing condition of the individual (this does not apply during the 1st 18 months of continuation coverage due to a military leave of absence);
- You or a qualified beneficiary on COBRA becomes entitled to Medicare after the date COBRA is elected;
- Coverage has been extended for up to 29 months due to qualified beneficiary's disability and there has been a final determination that the qualified beneficiary is no longer disabled on the 29 month period is exhausted. Coverage will end the first day of the month that begins more than 30 days after the determination that you are no longer disabled.

Special rule for leaves of absence due to services in the Uniformed Services:

If a covered employee takes a leave of absence to perform services in the Uniformed Services (as addressed in the Uniformed Services Employment and Reemployment Act or "USERRA") that is expected to last 31 days or more, the covered employee may be able to continue health coverage for the employee and any covered dependents until the earlier of 24 months from the date the leave began or the date that the employee fails to return to work as required under USERRA). The cost to continue this coverage during the 24 month period is 102% of the applicable premium. The USERRA continuation period will run concurrent with the COBRA period described herein. The rights described in this Notice apply only to the COBRA continuation period. Notwithstanding anything to the contrary in this Notice, continuation of coverage during a military leave of absence covered under USERRA will be administered in accordance with requirements of USERRA.

Q-19. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. All modifications/terminations effectuated by the Employer will be applied to all Participants and Covered Dependents except as otherwise stated.

Q-20. Does the Plan coordinate benefits with other Component Medical Plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). As such, this HRA does not coordinate benefits with any other group or individual health coverage except as provided herein.

If you are also a participant in a Health Flexible Spending Arrangement (commonly referred to as a Health FSA) sponsored by your Employer that covers the same expenses as this HRA, the expenses covered both by the HRA and the Health FSA will be paid as described in the Plan Information Appendix.

Q-21. Who do I contact if I have questions about the HRA?

If you have any questions about the HRA, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the Plan Information Appendix.

PART II:
ERISA RIGHTS

This HRA may be a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA). If it is an employee welfare benefit plan subject to ERISA, ERISA provides that you, as a Plan Participant, will be entitled to:

1. Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Coverage

- Continue health coverage for you, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Obtain reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Component Medical Plan, if you have creditable coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your Component Medical Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases (if you requested continuation coverage), before losing coverage (if you requested continuation coverage), or up to 24 months after losing coverage (if you requested continuation coverage). Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. Prudent Actions by Plan Fiduciaries

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

4. Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and

reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

5. Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

PLAN INFORMATION APPENDIX
TO THE
DR. HAUSCHKA SKIN CARE, INC.
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

This Appendix provides information specific to the **Dr. Hauschka Skin Care, Inc.** Health Reimbursement Arrangement (HRA). The Effective Date of this Plan Information Appendix is March 1, 2018.

I. GENERAL PLAN INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:	Dr. Hauschka Skin Care, Inc. 20 Industrial Drive East, South Deerfield, MA 01373 (413)397-1214
2. Name, address, and telephone number of the Plan Administrator: (The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan.)	Dr. Hauschka Skin Care, Inc. 20 Industrial Drive East, South Deerfield, MA 01373 (413)397-1214
3. Employer's federal tax identification number:	04-3182607
4. Plan Number:	501
5. Effective Date of the Plan (This is the date that the Plan was first established.)	March 1, 2010
6. Effective Date of this SPD (Note: This is the most recent date of the SPD other than the Plan Information Summary and the Appendices.)	March 1, 2018
7. Plan Year:	March 1 through February 28
8. Adopting Employers participating in the Plan:	None
9. Third Party Administrator:	Group Dynamic, Inc. 411 US Route One Falmouth, ME 04105 (207)781-8800
10. Identity of Component Medical Plan(s) under which this HRA is a component:	Blue Cross Blue Shield of MA HMO Blue New England 1500
11. How is the HRA Funded? (Trust or General Assets)	General Assets
12. Who is the COBRA Administrator for the HRA?	Group Dynamic, Inc.

II. EFFECTIVE DATE OF COVERAGE

A. The effective date of coverage for Participants is as follows:

Coverage in the HRA plan is effective when coverage commences in the Employer's component medical plan.

B. The effective date of coverage for Covered Dependents is as follows:

Coverage in the HRA plan for covered Dependents is effective when coverage commences in the Employer's component medical plan.

C. Participants may change their previous HRA Plan coverage level with respect to group health coverage offered under the Plan on account of and consistent with the following events otherwise required under HIPAA's special enrollment rules (as amended by the Children's Health Insurance Program Reauthorization Act of 2009):

- The Participant or an otherwise eligible Dependent loses coverage under a state Medicaid Plan or a state Children's Health Insurance Plan due to loss of eligibility or
- The Participant or an otherwise eligible Dependent becomes eligible for state funded group health plan premium assistance under a state Medicaid or Children's Health Insurance program.

The Participant must request enrollment within 60 days of the date coverage is lost or the date the Participant or Dependent is determined to be eligible for premium assistance (whichever is applicable).

III. ELIGIBLE MEDICAL EXPENSES

The following medical expenses are eligible for reimbursement under this Plan (provided all other terms and conditions of the HRA have been satisfied):

Group Health Plan expenses attributable to the Deductible;
Under the terms of the Group Health Plan, such expenses are calculated on a Plan Year basis.

NOTE: Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or newborn earlier than 48 (or 96) hours. In any case, the plan may not require a provider to obtain pre-authorization for a hospital stay in connection with childbirth not in excess of the applicable time period.

IV. HRA DOLLARS

A. The annual amount of HRA Dollars that may be allocated to a Reimbursement Account is:

$750 Single/$1500 Family
The HRA benefit is embedded at the Single reimbursement level for each member.

B. HRA dollars will be allocated to the Participant's Reimbursement Account in the following manner:

Annually

V. REIMBURSEMENT ACCOUNT (applies only to plans that allow carryover)

The amount in your Reimbursement Account may not exceed the following amount: See item IV(A).

VI. CARRYOVERS

This plan does not allow carryover of any unused benefit.

VII. CHANGING COVERAGE

The amount of HRA dollars allocated to your Reimbursement Account will be adjusted if you experience a change in status that allows you to adjust the level of coverage under the group health plan (e.g., Single coverage to family coverage; family coverage to single coverage).

VIII. RUN OUT PERIOD

The Run Out Period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.

(i) The Run Out Period for active employees ends **60 days** after the last day of the Plan Year.
(ii) The Run Out Period for terminated employees ends **60 days** after the date of termination.

IX. UNCLAIMED PAYMENTS

Any unclaimed reimbursement amounts (e.g., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) prior to the employer's plan reconciliation date (which follows the end of a plan year's Run Out period).

X. INTERACTION/COORDINATION WITH MEDICAL FSA

To the extent that Eligible Medical Expenses are covered both by this HRA and by an Employer sponsored Medical FSA in which the employee participates, the Eligible Medical Expenses will be paid as follows:

HRA pays first. Flexible Spending Account (FSA) funds do not need to be exhausted prior to the HRA reimbursing for eligible medical expenses.