Coastal States Bank
APPENDIX
SUMMARY OF BENEFITS AND COVERAGE ("SBC")
HEALTH REIMBURSEMENT ARRANGEMENT PLAN (THE "PLAN")

For the period from 01/01/2021 through 12/31/2021 (the "Plan Year")

This SBC will help you choose a health plan coverage. The SBC shows you how you and the Plan would share the cost for covered health care services.

What benefits are you provided under the Plan?

With HSA - You will be reimbursed up to $2,000 for single and $4,000 for family coverage of covered in-network medical expenses, incurred by you and/or your covered dependents in the Plan Year, if those expenses are not reimbursed under your employer's insured group medical plan.

The Plan will reimburse you for covered in-network medical expenses after you incurred covered medical expenses of $ 3,750 per insured. This is called the deductible.

Without HSA - You will be reimbursed up to $2,300 for single and $4,600 for family coverage of covered in-network medical expenses, incurred by you and/or your covered dependents in the Plan Year, if those expenses are not reimbursed under your employer's insured group medical plan.

The Plan will reimburse you for covered in-network medical expenses after you incurred covered medical expenses of $ 3,450 per insured. This is called the deductible.

Child(ren) HIA Credit – If the family is held responsible for more than the amounts listed above AND all covered adults did both HIA credits, the HRA will reimburse up to an additional $1,250 per child of in-network deductible expenses ($2,500 family max).

You will be credited with a portion of the annual amount, specified above (Select a, b, or c): a. ■ at the beginning of the Plan Year, b. □ at the end of the Plan Year or c. □ pro rata during the Plan Year (Select i, ii, iii, iv or v): i □ every pay period, ii □ every month, iii □ every other month, iv □ every calendar quarter or v □ other_____.

Remember, you will only be reimbursed for covered medical expenses up to the amount credited for the Plan Year.

What expenses are considered covered medical care expenses? For reimbursement, "covered medical care expenses" means (Specify a, b or c): a. □ Expenses incurred by you and/or your covered dependents for "medical care" as defined in Code Section 213(d). Generally, this means an item for which you could have claimed a medical care expense deduction on an itemized federal income tax return (without regard to any threshold limitation or time of payment) for which you have not otherwise been reimbursed or could be reimbursed from insurance or from some other source. For a list of those expenses not covered, please refer to the Summary Plan Description; b. ■ Those expenses that would be reimbursed by your employer's insured group medical plan, but for (Select all that apply): i ■ the deductible, ii □ co-payment, and/or iii □ co-insurance amounts; or c. □ Other (Specify) _____.

When are covered medical expenses incurred? For you to be reimbursed for covered medical expenses, you must have incurred them during the Plan Year. An expense is incurred when the service that gives rise to the expense is provided, not when the expense was paid. Note that if you have paid for the expense but if the services have not yet been rendered, then the expense has not been incurred for this purpose. You may not be reimbursed for any expenses arising before you participate or after the close of the Plan Year, or after you terminate, unless you continue coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Can you continue coverage after termination? Under COBRA, your employer is required to provide you and/or your covered dependents with the opportunity to be reimbursed for covered medical expenses under the Plan for a limited period of time after termination of your participation in the Plan, unless your participation was terminated due to gross misconduct. You may be eligible for this continued coverage after certain defined qualifying events have occurred that otherwise would cause you and/or your covered dependents to lose coverage under this Plan.

Please note that such continued coverage will not be offered if you or your covered dependents were not eligible for benefits under the Plan prior to your qualifying event. Please review the Summary Plan Description for the Plan for more details.

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

What happens if your claim for benefits is denied? If you have a complaint or are dissatisfied with a denial of coverage for claims under the Plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Benefit Coordinators, Inc. PO Box 197 Irmo, S.C. 29063 or 803-772-0110.

When does your participation under the Plan end? If you terminate employment (including retirement), and do not continue coverage as explained above, your participation under Plan will end on (Select a, b or c): a.□ the last day of the month in which the termination or loss of eligibility occurs, b.□ coverage ends on the date termination or loss of eligibility occurs, or c.■ other (Specify): Same date as your underlying medical plan.

Does this coverage provide minimum essential coverage? The Affordable Care Act (the "Act") requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan along with the employer's insured group health plan (Select a or b): a. ■ does or b. □ does not provide minimum essential coverage.

Does this coverage meet the minimum value standard? The Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage along with the coverage of the employer's insured health plan (Select a or b): a. ■ does or b. □ does not meet the minimum value standard for the benefits it provides.

Where can you receive information regarding coverage under the employer's insured group health plan? This Plan is integrated with your employer's insured group medical plan. For details regarding coverages under that plan, please refer to its SBC.

If you have any questions? Questions: Call 1-803-765-9604