SUMMARY PLAN DESCRIPTION (SPD)
for the
HEALTHCARE REIMBURSEMENT ACCOUNT PLAN (HRA)

The Employer named below also serves as Plan Administrator:
Stellar Solutions
250 Cambridge Ave Ste 204
Palo Alto, CA 94306
The Employer accepts service of legal process.

Federal Tax ID: 94-3218045

ERISA Plan Number: 520

Plan Name: The Stellar Solutions Healthcare Reimbursement Account Plan (HRA)

Group Name, if applicable: N/A

Plan Effective Date: 01/01/2022

Plan Year: 01/01 to 12/31

Run Out - Number of Days: 90 days

HRA Plan Design:
HRA Benefits: Benefits allowed for reimbursement: Medical, Dental, and Vision Expenses
HRA Deductible: No

HRA Payout Tiers
Single Maximum Payout: $4,500.00
Family Maximum Payout: $4,500.00
Aggregate
Percent Pay out: 100%

Rollover Allowed with applicable limit: N/A

Waiting Period: 0 (not to exceed 90 days)

EBHRA: No
This HRA is an Excepted Benefit HRA (EBHRA) see details below.

ICHRA: No
This HRA is an Individual Coverage HRA (ICHRA) see details below.

QSEHRA: No
This HRA is a Qualified Small Employer HRA (QSEHRA) see detail below.

'You' and 'Your' refers to an Employee who has been enrolled by the Employer as a Participant in this HRA for the current Plan Year, or has a Carryover balance from the prior Plan Year when a Carryover is allowed as indicated above.

Purpose. Your Employer has adopted this HRA under Internal Revenue Code Section 105 Accident and Health Plans, to pay for medical care as defined in Code Section IRS Code Section 213(d) which is rendered or received during the Plan Year for You, Your spouse, and Your dependents. The employer funds this Plan out its general assets.

This SPD expressly incorporates by reference the Enrollment Materials provided by Your Employer at the time of enrollment.

All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Participant, Participant 's enrolled spouse, or enrolled dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan.

The Participant Reference Guide. The Participant Reference Guide which is incorporated by express reference into this SPD, includes all the information You need to access Your HRA and submit requests for reimbursement. By signing into Your online account, You will have access to information about Your enrollment, available funds, total contributions, and total reimbursements.

Enrollment. An Employee's right to enroll in and maintain coverage under the Employer's group health plan and this HRA are described in detail in the Enrollment Materials provided by the Employer, including:

1) Under what circumstances a spouse, dependents and other persons may be enrolled including any proof of a relationship needed to meet the eligibility requirements (note that group health plans are required to cover dependent children placed with a participant for adoption under the same terms and conditions as apply in the case of dependent children who are Your natural children);
2) The existence of any waiting periods and how they are applied;
3) When enrollment is allowed and a description of the enrollment procedures;
4) When coverage will be effective and when it will end including the events that can occur that will terminate coverage; and,
5) Details regarding when special enrollment rights allowing individuals who previously declined health coverage for themselves and their dependents have an opportunity to enroll (regardless of any open enrollment period). The Special Enrollment Notice, a copy of which was previously furnished to each participant, also contains important information about the potential special enrollment rights including a 30-day time limit for requesting the enrollment. You can contact Your Benefits Coordinator to receive an additional copy of that notice.
6) Details regarding when special enrollment rights for an employee who is eligible, but not enrolled for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) when either:
   (a) The employee or dependent were covered under a Medicaid plan or under a State Child Health Plan (SCHIP) and that coverage is terminated as a result of loss of eligibility; or,
   (b) The employee or dependent becomes eligible for premium assistance from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

Participant Termination. You will automatically cease to be a participant on the date of, or the last day of the month in which the following events occur:

1) Your death,
2) This HRA terminates,
3) You are no longer an Employee,
4) The Employer determines You made fraudulent or improper use of a plan,

5) For HRA plans that require enrollment in the Employers Group Health Plan, the date You lose coverage under that Employers Group Health Plan,
6) The day You opt-out of coverage under this HRA Plan. (Not applicable to a (QSEHRA). You can opt-out of HRA coverage at each annual open enrollment or if retiree benefits are provided under this HRA Plan, You can opt-out the day You terminate employment, or
7) For coverage under the Individual Coverage HRA (ICHRA), the Participant no longer maintains ICHRA-compatible individual health insurance.

Upon termination a Participant can submit claims for coverage incurred prior to the termination date as long as they are submitted on or before the Run Out End Date.

Check with Your Employer for Your actual coverage end date.

For Qualified Small Employer HRAs and other applicable HRAs that pro-rate the annual benefit provided under the Plan, You are subject to proration of the annual HRA benefit if You are not covered under the Plan for the entire 12-month Plan Year. Additionally, You must provide sufficient proof of Minimum Essential Coverage (MEC) to receive benefits under the Plan.

Administration. Your Employer acting as the Plan Administrator has sole discretionary powers and is responsible for the administration of this Plan. Should You need to see any records or have any questions regarding these Plans, contact Your Employer. Your Employer has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. The Plan Administrator has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time.

The Plan Administrator appoints TASC as a Service Provider to maintain certain plan records and to be responsible for the plan's day-to-day administration. TASC is not a Plan Administrator and has no discretionary authority regarding the plan.

Family Medical Leave Act. The Family & Medical Leave Act of 1993 (29 U.S.C. 2611) as amended, is referred to as FMLA. FMLA Leave will not be available to Employees for Plan Years in which the Employer has fewer than 50 Employees as counted in that Act. For Plan Years in which the Employer has 50 or more Employees, the Employer is required to make FMLA Leave available to Eligible Employees under circumstances that are prescribed by applicable federal law, including a period in which an Employee is off due to the FMLA shall be treated in accordance with the rules for a layoff or a leave of absence and provided to the extent required by the FMLA (e.g., the employer will continue to pay its share of the contribution to the extent the Participant opts to continue coverage). If the Employer is subject to the FMLA, a Participant may revoke or continue an election through the plan upon commencement of the FMLA Leave, whether such leave is paid or unpaid. This provision applies in addition to any other right to revoke and reelect benefits under the plan. Upon return from FMLA Leave, a Participant may be reinstated to all pre-leave elections.

Qualified Medical Child Support Order (QMCSO). This HRA will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of a Participant in a group health plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits. Participants may obtain, without charge, a copy of the plan's procedures from the Plan Administrator.

Claim Denials. If Your claim is denied in whole or in part, You will be notified in writing within 30 days after the date Your claim is received. This time period may be extended for an additional 15 days for matters beyond our control. TASC will provide written notice of any extension, including the reasons for the extension and the date by which a decision is expected. When a claim is incomplete, the extension notice will also specifically describe the required information

needed. You will have 45 days from receipt of the notice in which to provide the specified information. The time for a decision on Your claim will be suspended until the specified information is provided.

Appeals. If Your claim is denied in whole or part, then You (or Your authorized representative) may request review. Your appeal must be made in writing within 180 days after Your receipt of the notice that the claim was denied. If You do not appeal on time, You will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that You feel Your claim should not have been denied. It should include any additional facts and/or documents that You feel support Your claim. You will have the opportunity to ask additional questions and make written comments, and You may review (upon request and at no charge) documents and other information relevant to Your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision On Review. Your appeal will be reviewed and determination made within a reasonable time, defined as not later than 60 days after receipt of Your appeal. If the decision on review affirms the initial denial of Your claim, You will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of Your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied on and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to You upon request; and a statement of Your right to bring suit under ERISA §502(a) (where applicable)

ERISA Rights. An Account Plan that reimburses the Accountholder for medical services is subject to the Employee Retirement Income Security Act of 1974 (ERISA). An Account Plan that reimburses only medical premium is not subject to ERISA. Some of Your basic rights under ERISA are described below. Your rights under ERISA and other federal and state law as related to other Qualified Benefit Plans You elected are fully detailed in the Summary Plan Descriptions that are maintained by Your Employer for those plans.

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 and 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 Pension and Welfare Benefit Administration [sic Employee Benefits Security Administration]. Obtain, upon written request to the plan administrator, copies of 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 administrator may make 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.

Continue Group Health Plan Coverage. (Not applicable to employers with less than 20 employees or the QSEHRA). Continue health care coverage for Yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your group health plan, if You have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from Your group health 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 request it before losing coverage, or if You request it up to 24 months after losing 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.

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 employee benefit plan. The people who operate Your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of You and other 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 (pension, welfare) benefit or exercising Your rights under ERISA.

Enforce Your Rights. If Your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report 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 administrator. If You have a claim for benefits which 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 domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions. If You have any questions about Your 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 in obtaining documents from the plan administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.