Tandem HR Health & Welfare Benefits Plan

Summary Plan Description

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Introduction

Tandem HR, LLC (the "Company") maintains the Tandem HR Health & Welfare Benefits Plan (the "Plan") for the exclusive benefit of its clients' eligible employees and the eligible employees' eligible family members. This document summarizes important information about the Plan. The Plan provides health and welfare benefits through component benefit plans. Eligible employees and their family members may be eligible to participate in one or more of the component benefit plans, which are listed below:

- Health Care Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan

Each of the component benefit plans is summarized in a certificate of insurance booklet issued by an insurance company, a summary prepared specifically for that component benefit plan, or another written governing document. A copy of each booklet, summary, or other governing document is available through the Plan Administrator. The Plan Administrator's contact information is below in "Sponsoring Employer and Plan Administrator."

Purpose of this Summary Plan Description

You are being provided with this document to give you an overview of the Plan and to address certain information that may not be addressed in the governing documents for the component benefit plans. This document, together with the summary plan descriptions for the component benefit plans, is the summary plan description ("SPD") required by ERISA § 102 for benefits subject to ERISA. This SPD (referred to as the "Plan SPD" in this document) is not intended to give you any substantive rights to benefits that are not already provided by the component benefit plans. If you have not received a copy of the summary plan description for any of the component benefit plans in which you participate, contact the Plan Administrator. You must read the applicable summary plan descriptions for the component benefit plans and this document together to understand your benefits. In addition, you should keep a copy of this Plan SPD for your records.

Definitions

Capitalized terms and acronyms used throughout this Plan SPD have the following meanings:

"Client Employer" means an employer with employees who participate in the Plan.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Company" means Tandem HR, LLC, or any successor thereto.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Plan" means the Tandem HR Health & Welfare Benefits Plan, as in effect as of January 1, 2022.

"Plan Administrator" means Tandem HR, LLC, or any successor thereto.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

General Information About the Plan

Plan Name

Tandem HR Health & Welfare Benefits Plan.

Type of Plan

The Plan is a welfare benefit plan that provides health, dental, and vision benefits.

Plan Year

Each plan year is a twelve-month period beginning January 1 and ending the following December 31.

Plan Number

The Plan number is 503.

Effective Date

The effective date of the Plan summarized in this Plan SPD is January 1, 2022.

Funding Medium and Type of Plan Administration

The component benefits under the Plan are fully insured. As discussed below under the heading "How the Plan Is Administered," the Company is responsible for administering the Plan, but it shares that responsibility with the respective insurance companies. Information about the insurance companies that share responsibility for administering the component benefit plans that are group health plans is provided in the SPDs for those plans, which are available at no charge to Plan participants and beneficiaries through the Plan Administrator. The insurance companies, not the Company, are responsible for managing and paying claims with respect to the insured component benefit programs.

Insurance premiums for eligible employees and their eligible family members are paid in part by the Company out of its general assets and in part by employees. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the component benefit plans, as applicable. Insurance premiums and employee contributions may be made on a pre-tax basis through the Tandem Professional Services, Inc. Section 125 Cafeteria Plan. There is no trust for the Plan or any component benefit program.

Sponsoring Employer and Plan Administrator:

Tandem HR, LLC

2400 Wolf Road, Suite 100

Westchester, IL 60154

Plan Administrator's Employer Identification Number (EIN)

36-3968652

Agent for Service of Process

Service may be made on the Plan Administrator at the address listed above.

Insurance Companies

Benefits under some of the component benefit plans are provided through insurance contracts with the insurance companies. Information regarding the insurance companies is included in the Summary Plan Description or insurance policy for each component benefit plan.

Important Disclaimer

Benefits hereunder are provided pursuant to an insurance contract or governing written plan document adopted by the Company. If the terms of this Plan SPD conflict with the terms of such insurance contract or governing plan document, or the terms of the Plan, then the terms of the insurance contract, governing plan document, or Plan will control, rather than this Plan SPD document, unless otherwise required by law.

Eligibility and Participation Requirements

Eligibility and Participation

An eligible employee with respect to the Plan is any common-law employee of a Client Employer who is eligible to participate in and receive benefits under one or more of the component benefit plans. The eligibility and participation requirements applicable to eligible employees may vary with respect to each component benefit plan. You must satisfy the eligibility requirements of a specific component benefit plan in order to receive benefits under that plan. Certain individuals related to you, such as your spouse or your dependents, may be eligible for coverage under certain component benefit plans. To determine whether you or your family members are eligible to participate in a component benefit plan, please read the eligibility information contained in the SPDs for the applicable component benefit plan. Participants and beneficiaries can obtain, without charge, copies of the SPDs for the component benefit plans by contacting the Plan Administrator.

Need for Enrollment: Time Limits

While some of the Plan's component benefits are provided automatically to employees, other component benefit plans require completion of application forms, annual elections, or other administrative forms, as described in the SPDs or insurance policies for the component benefit plans. For benefits requiring enrollment, new employees must generally enroll within certain time periods after being hired or after first becoming eligible, as described in the SPDs or insurance policies for the component benefit plans. Thereafter, enrollment for each component benefit plan is generally limited to the annual open enrollment period that occurs before the beginning of each plan year, unless circumstances give rise to special enrollment rights as described immediately below, or unless other enrollment opportunities are available for a particular component benefit plan, as described in the applicable SPD or insurance policy for the component benefit plan.

Special Enrollment Rights

In certain circumstances and with respect to some component benefit plans, enrollment may occur at times outside the annual open enrollment period (this is referred to as “special enrollment”), as explained in the SPDs or insurance policies for the component benefit plan. A component benefit plan’s Special Enrollment Notice also contains important information about your potential special enrollment rights.

Electronic Forms

To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means as permitted by law.

When Participation Begins

Coverage under the Plan begins once you, as an eligible employee, meet eligibility requirements of a component benefit plan, and complete the necessary enrollment paperwork, or when you become eligible for a benefit that does not require enrollment, if earlier. Requirements may vary depending on the component benefit plan. For information about when coverage begins, please read the eligibility and participation information contained in the SPDs for the component benefit plans.

When Participation Ends

Coverage under a component benefit plan ends according to the terms and conditions reflected in the SPDs for the component benefit plans. Note that termination of coverage under a particular component benefit plan does not necessarily mean all Plan coverage terminates. Coverage under certain component benefit plans may be able to continue at your cost for a limited time, which is discussed below in “Continuation Coverage: COBRA, USERRA, and Other Opportunities.” In addition, you (or your covered family member) may still have coverage under another component benefit plan.

In general, your coverage under this Plan (including all component benefit plans) terminates on the day on which you terminate employment with a Client Employer. Coverage under the Plan or a particular component benefit plan may terminate earlier if you fail to pay your share of the premiums, if your hours drop below any required eligibility threshold, if you submit false claims, and for certain other reasons described in the SPDs or insurance policies for the component benefit plans.

Coverage for your covered family members stops when your coverage stops. Coverage for a family member will also stop if that family member becomes ineligible (for example, due to divorce or a dependent's attaining the age limit specified for the component benefit) or for other reasons specified in the SPDs or insurance policies for the component benefit plans (such as nonpayment of applicable premiums). It is your responsibility to provide correct information and to make accurate and truthful statements regarding your family status, your age and the age of your family members, your relationships, etc., and to update previously provided information and statements. Failure to do so may be considered an intentional misrepresentation of material fact and may result in termination of coverage. In some circumstances such termination of coverage may be retroactive.

Coverage also ceases for employees, spouses, and dependents upon termination of the Plan. The Plan Sponsor's ability to amend or terminate the Plan is discussed below in "Amendment to or Termination of the Plan." In addition, your coverage will end if your Client Employer ceases its participation in the Plan and/or a component benefit plan or chooses to no longer use the Plan Sponsor's services.

Continuation Coverage: COBRA, USERRA, and Other Opportunities

For certain component benefit plans, in the event your Plan coverage for that component benefit terminates, you or your family member(s) may be eligible to continue the coverage for a limited period of time. There are several types of continuation coverages that may apply to particular component benefit plans, as summarized below and specified in more detail in the SPDs or insurance policy for the component benefit plans.

If coverage for you or your eligible family members under the Health Care Benefit Plan, the Dental Benefit Plan, the Vision Benefit Plan, or any other eligible health care coverage ceases because of certain "qualifying events" specified in COBRA (for example, termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. The SPDs or insurance policies for the applicable component benefit plans provide additional information about the qualifying events and the duration of temporary coverage available pursuant to COBRA.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is included in the SPDs or insurance policies for the component benefit plans.

Note also that state law may provide continuation and/or conversion coverage.

Summary of Plan Benefits

Available Benefits and Contributions

Through the component benefit plans, the Plan makes available to you and your eligible family members health, dental, and vision benefits. A summary of each component benefit plan, describing the benefits provided under the plan, is set forth in the SPDs or insurance policies for the component benefit plans. Participants and beneficiaries can obtain, without charge, copies of the SPDs for the component benefit plans by contacting the Plan Administrator.

In general, the cost of the benefits provided through the component benefit plans will be funded in part by Company contributions and in part by employee contributions (which may be made on a pre-tax basis, subject to the terms of the Tandem Professional Services, Inc. Section 125 Cafeteria Plan and applicable component benefit plan). The Company will determine and periodically communicate your share of the cost of the benefits provided through each component benefit plan, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and forward your contributions to the insurer of each component benefit plan.

Qualified Medical Child Support Orders

With respect to the component benefit plans, the Plan extends health benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO) under ERISA § 609(a). The Plan has procedures for determining whether an order qualifies as a QMSCO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Administrative Requirements and Timelines

As described in the SPDs or insurance policies for the component benefit plans, there may be other reasons that a claim for benefits under a particular component benefit plan is not paid or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. For details regarding administrative requirements that may impact benefit availability, please consult the SPDs or insurance policies for the component benefit plans.

How the Plan Is Administered

Plan Administration

The Company is the Plan Administrator. As the Plan Administrator, the Company is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs for this Plan and the component benefit plans).

The principal duty of the Plan Administrator is to ensure that the Plan functions according to its terms and for the exclusive benefit of the individuals entitled to participate in the Plan. The administrative duties of the Plan Administrator are set forth in the Plan and include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for benefits and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. As provided by the Plan, the Plan Administrator may delegate any of these administrative duties among one or more persons or entities.

To the fullest extent permitted by law, the Plan Administrator and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including component benefit plans), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including component benefit plans), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

The Company will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Companies

The benefits provided under the Plan through the component benefit plans are fully insured. These benefits are provided under group insurance contracts entered into between the Company and the applicable insurance companies. Claims for benefits under the component benefit plans are submitted to the insurance companies. The insurance companies, not the Company, are responsible for determining and paying claims.

The insurance companies: (a) determine eligibility for a benefit and the amount of any benefits payable under the Plan through the component benefit plan, and (b) provide the claims procedures to be followed and the claims forms to be used by eligible individuals with respect to component benefits under the Plan. (See the "Claims Procedures" section below for more information about claims.)

The insurance companies, to the fullest extent permitted by law and the Plan, have the discretionary authority to interpret the Plan in order to make benefit determinations. The insurance companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular component benefit plan offered through the Plan, or the amount of any benefit payable under the self-insured component benefit plans), please contact the Plan Administrator.

If you have any question regarding your eligibility for, or the amount of, any benefit payable under any component benefit plan, please contact the appropriate insurance company.

Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates, including upon termination of the Plan. See the section titled “Eligibility and Participation Requirements” for more information on when participation in the Plan may end.

Other circumstances can result in the termination, reduction, or denial of benefits. The applicable insurance contracts (including the certificate of insurance booklets), plans, and other governing documents for the component benefit plans provide additional information about the termination, denial, or loss of benefits, and about the Plan's recovery and reimbursement rights.

Other Plan Provisions

Amendment to or Termination of the Plan

The Company, as the sponsor of the Plan, has the general right to amend or terminate the Plan or any component benefit plan under the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company. Note, for this purpose, that an insurance contract is not necessarily the same as the Plan. (An insurance contract is how benefits under a particular component plan offered through the Plan are provided.) Consequently, termination of an insurance contract does not necessarily terminate the Plan.

No Contract of Employment

The Plan, including the component benefit plans, is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Company or any Client Employer to the effect that you will be employed for any specific period of time.

Claims Procedures

Claims and Claims Review Procedures

For purposes of determining the amount of, and entitlement to, benefits of the component benefit plans, the respective insurer is the named fiduciary under the component benefit plan with the full power to interpret and apply the terms of the component benefit plan as they relate to the benefits provided under the applicable insurance contract. To obtain benefits from the insurer of a component benefit plan, you must follow that insurer's claims procedures.

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable laws. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial within the timeframe required by applicable law.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable laws. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain component benefit plan you may also have the right to obtain external review (that is, review outside of the Plan).

The SPD or insurance policy for each component benefit plan provides additional information about the claims procedures and claims review procedures applicable to the component benefit plan, and the component benefit plan SPD or insurance policy is provided without charge to each participant of the component benefit plan as required by law. A copy of an SPD or insurance policy of a component benefit plan is also available at no charge to Plan participants and beneficiaries by request to the Plan Administrator.

Limitations Period for Filing Suit

No lawsuit can be brought under the Plan prior to your exhausting the Plan’s and component benefit plan’s claims and claims review procedures. No lawsuit to recover benefits can be commenced or maintained after the date that is 12 months after the date on which the claimant is notified of a final decision regarding a claim under the applicable claims and claims review procedures.

Statement of ERISA Rights

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Company, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue health care coverage under certain component benefit plans for yourself, your spouse, or your 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 Plan SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, 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 Company, as Plan Administrator, to provide the materials and pay you up to $110 per 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 which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or 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 contact 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.