ADOPTION AGREEMENT
FOR
HEALTH REIMBURSEMENT ARRANGEMENT

The undersigned Employer adopts this Health Reimbursement Arrangement and elects the following provisions:

EMPLOYER INFORMATION

1. EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER:

   Name: Global Healthy Living Foundation, Inc.

   Address: 515 North Midland Avenue
   Upper Nyack, NY 10960

   Telephone: 845-348-0400

2. EMPLOYER'S TAXPAYER IDENTIFICATION NUMBER: 20-4039120

3. TYPE OF ENTITY:
   a. [ ] Corporation (including Tax-exempt or Non-profit Corporation)
   b. [ ] Professional Service Corporation
   c. [ ] S Corporation
   d. [ ] Limited Liability Company that is taxed as:
      1. [ ] a Partnership or Sole Proprietorship
      2. [ ] a Corporation
      3. [ ] an S Corporation
   e. [ ] Sole Proprietorship
   f. [ ] Partnership (including Limited Liability)
   g. [ ] Governmental Entity
   h. [X] Non-profit Corporation
   i. [ ] Other: _________________ (must be a legal entity recognized under federal income tax laws)

   NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Heath Reimbursement Arrangement.

PLAN INFORMATION

4. PLAN NAME: Global Healthy Living Foundation, Inc. Health Reimbursement Arrangement

5. EFFECTIVE DATE:
   a. [ ] This is a new Health Reimbursement Arrangement effective as of ________________ (hereinafter called the "Effective Date"). The Plan Year begins ______________ and ends ______________.

   b. [X] This is an amendment and restatement of a previously established Health Reimbursement Arrangement of the Employer which was originally effective December 1, 2019 (hereinafter called the "Effective Date"). The effective date of this amendment and restatement is January 1, 2022. The Plan Year begins January 1 and ends December 31, except the first Plan Year which began December 1.

6. NUMBER assigned by the Employer:
   a. [ ] 501
   b. [ ] 502
   c. [ ] 503
   d. [X] 526

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7. PLAN ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:
   a. [X] Employer
   b. [ ] Use name, address and telephone number below:

   Name: ______________________________

   Address: ______________________________
   Street

   ______________ ______________ ______________
   City State Zip

   Telephone: ______________________________

8. CLAIMS ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:
   a. [ ] Employer
   b. [X] Use name, address and telephone number below:

   Name: PrimePay, LLC

   Address: Attn: Benefit Services Department

   1487 Dunwoody Drive

   West Chester, PA 19380

   Telephone: 1-877-972-6272

ELIGIBILITY REQUIREMENTS

9. ELIGIBLE EMPLOYEES:
   a. [ ] N/A. No exclusions.
   b. [X] The following are excluded:
      1. [ ] Union Employees
      2. [ ] Non-resident aliens
      3. [X] Employees who are not participants in the Aetna group medical plan
      4. [ ] Salaried Employees
      5. [ ] Hourly Employees
      6. [ ] Leased Employees
      7. [X] Part-Time Employees scheduled to work less than 40 hours per week.
      8. [ ] Employees who are participants in an Employer sponsored Health Savings Account
      9. [ ] Other: ______________________________

10. THE FOLLOWING AFFILIATED EMPLOYERS will adopt this Health Reimbursement Arrangement as Participating Employers:
    a. [X] N/A
    b. [ ] Name of Affiliated Employer (s): ______________________________

11. CONDITIONS OF ELIGIBILITY:
    Any Eligible Employee will be eligible to participate in the Health Reimbursement Arrangement upon satisfaction of the following:
    a. [X] Date of Hire (No service required)
    b. [ ] Same conditions as Employer's group medical plan
    c. [ ] _______ months after date of hire
    d. [ ] _______ days after date of hire
    e. [ ] Other: ______________________________

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12. EFFECTIVE DATE OF PARTICIPATION:
An Eligible Employee who has satisfied the eligibility requirements will become a Participant on
a. [ ] the day on which such requirements are satisfied.
b. [X] the first day of the month coinciding with or next following the date on which such requirements are satisfied.
c. [ ] the first day of the calendar quarter coinciding with or next following the date on which such requirements are satisfied.
d. [ ] the first day of the pay period coinciding with or next following the date on which such requirements are met.
e. [ ] the first day of the Coverage Period coinciding with or next following the date on which such requirements are satisfied.
f. [ ] same date as Employer's group medical plan.
g. [ ] Other: ____________________

BENEFITS

13. MAXIMUM BENEFIT PER COVERAGE PERIOD (EMPLOYER CONTRIBUTION):
a. [X] $4,800 after the Employee pays the first $1,400 for Employee Only coverage;
$4,800 per-insured up to a maximum of $9,600 after the Family pays the first $1,400 per-insured ($2,800 maximum).

14. COVERAGE PERIOD is:
a. [ ] monthly
b. [ ] quarterly
c. [X] yearly
d. [ ] Other: ____________________

15. THIS ARRANGEMENT SHALL REIMBURSE:
a. [X] coinsurance under the Aetna group medical plan
b. [X] In-Network deductibles under the Aetna group medical plan
c. [ ] all medical expenses within the meaning of Code Section 213
d. [ ] all medical expenses within the meaning of Code Section 213 that do not constitute "essential benefits"
e. [ ] medical insurance premiums
f. [ ] dental and/or vision expenses
g. [ ] dental, vision and preventative care only or expenses in excess of the deductible (HSA also provided) with the following further limitations: ____________________
h. [ ] the following types of medical expenses ONLY: ____________________
____
i. [ ] Other: ____________________

16. IF THE EMPLOYER MAINTAINS A HEALTH FLEXIBLE SPENDING ACCOUNT, WHICH PLAN SHALL PAY EXPENSES FIRST?
a. [ ] N/A. The Employer does not maintain a Health Flexible Spending Account under a Cafeteria Plan.
b. [X] This Plan (Heath Reimbursement Arrangement).
c. [ ] The Health Flexible Spending Account under the Employer's Cafeteria Plan.

17. IS THE PLAN SUBJECT TO COBRA?
If b. is selected, COBRA will not apply
a. [X] Yes.
b. [ ] No.

18. CARRY FORWARD: Amounts not used during a Coverage Period shall:
a. [ ] Be carried forward to the next Coverage Period, in an amount up to $_____________
However, the maximum accumulation limit for a Coverage Period is $____________
b. [X] Be forfeited.

19. RETIREES AND TERMINATED EMPLOYEES:
a. [ ] Shall continue to be eligible for reimbursement of any remaining balances.
b. [X] May opt not to participate and forfeit any unused amounts.

20. A CLAIM may be submitted up to 90 days after
    a. [X] the end of the Coverage Period
    b. [ ] the end of each calendar year
    c. [X] the Employee's date of termination

21. DEBIT/CREDIT CARDS will be provided by the Employer for Medical Expenses:
    a. [ ] Yes
    b. [X] No

22. HEALTH SAVINGS ACCOUNT will be provided by the Employer:
    a. [ ] Yes
    b. [X] No

23. IS THE PLAN SUBJECT TO HIPAA?
    a. [X] Yes.
    b. [ ] No.

24. COVERAGE OF DEPENDENTS: The Plan will cover the following:
    a. [ ] Participant
    b. [ ] Spouse
    c. [ ] Dependents:
        1. [ ] natural and adopted children
        2. [ ] stepchildren
        3. [ ] foster children
        4. [ ] Other: ____
    d. [X] All of the above

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This Adoption Agreement may be used only in conjunction with The Health Reimbursement Arrangement Basic Plan Document. This Adoption Agreement and the Health Reimbursement Arrangement document shall together be known as the Global Healthy Living Foundation, Inc. Health Reimbursement Arrangement.

The Employer, by executing below, hereby adopts this Arrangement:

EMPLOYER: GLOBAL HEALTHY LIVING FOUNDATION, INC.

By: ______________________________ ______________________________
DATE SIGNED

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