Office Interiors
Health Reimbursement Arrangement
Plan and Summary Plan Description

Garner Health Technology, Inc., Claims Administrator

Memphis Furniture Group DBA Office Interiors ("Employer") has established the Office Interiors Health Reimbursement Arrangement Plan ("Plan" or "HRA") effective 1/1/2023 (the "Effective Date"). This document (the "Summary") is both the Plan and the Summary Plan Description for the HRA.

Your Employer has hired Garner Health Technology, Inc. ("Garner") to administer a program (the "Garner Program") that identifies the high-quality doctors in your network that suit your particular needs ("Top Doctors") and covers your out-of-pocket copay, deductible, and coinsurance expenses if you choose those doctors. Top Doctors have better clinical outcomes because they practice evidence-based medicine and avoid care that is medically inappropriate. If you use a Top Doctor through the Garner Program, you will be more likely to get the highest-quality medical care.

Because Top Doctors keep you healthier, your Employer has agreed to pay for your copay, deductible, and coinsurance through the HRA when you get care from Top Doctors, up to the following limits:

- If you have individual coverage, your employer will cover $5,000.
- If you have family coverage, your employer will cover $10,000.

Where possible, Garner Health helps your employer make these payments directly to the doctors, relieving you of complicated paperwork. The result is higher-quality care, thousands of dollars of savings each year, and less time spent dealing with medical bills.

This Summary describes the basic terms and conditions of the HRA and the Garner Program, including how it interacts with your Employer's major medical plans.

Your participation in the Garner Program is completely voluntary. You are not required to participate in the Program in order to enroll in your Employer's major medical plan. But if you choose not to participate, your employer will not be able to pay for any of your medical expenses through the HRA.

1. Introduction to the Garner Program and the HRA

Here is how the Garner Program works. First, you must use Garner's website, smart-phone app, or concierge service (the "Garner Services") to receive a list of Top Doctors near you that can meet your specific medical needs. Garner will only ever recommend Top Doctors, and it will keep track of which Top Doctors it has recommended to you. Once you have received a list of Top Doctors from Garner, you can then book an appointment with any of those Top Doctors

knowing that the out-of-pocket copay, deductible, and coinsurance expenses that you incur from the visit will be paid by your Employer, up to the limits listed above. These payments reward you for selecting Top Doctors.

The Garner Program uses a Health Reimbursement Arrangement ("HRA") to pay for your medical qualified expenses. The HRA is a bookkeeping account that your Employer sets up for you when you register online for the Garner Program. The HRA is also a pre-tax benefit, so you should not be required to pay taxes on payments or reimbursements from the HRA for cost-sharing expenses.

Your eligible out-of-pocket cost-sharing obligations will be paid by the HRA directly to Top Doctors when that is possible. Alternatively, you may use the Garner smartphone app or website to submit evidence that you have already paid for services from a Top Doctor that was recommended to you by Garner Health. You will then receive tax-free reimbursement from the HRA in the form of a check sent to you by mail. The deadline for submitting claims incurred during the HRA Plan Year is ninety (90) days after the end of the Plan Year.

Expenses eligible for payment or reimbursement under this HRA are limited to out-of-pocket copay, deductible, and coinsurance expenses that you incur from visits with Top Doctors ("Garner-Eligible Expenses"). The HRA will not pay or reimburse you for out-of-pocket copay, deductible, and coinsurance expenses related to non-emergency treatment from doctors who are not Top Doctors—*i.e.*, doctors who were not recommended to you by Garner Health.

2. Garner-Eligible Expenses

This section further describes the kinds of medical expenses that qualify as Garner-Eligible Expenses. If you have questions about a particular expense, please contact the Garner Health concierge service, which can be reached via online chat using the Garner Health website or smartphone app, or by phone at (866)-761-9586.

If a Top Doctor refers you to another doctor for other medical services, and you are in a position to make your own decision about who that other doctor will be, then you must use the Garner Services to make sure that the new doctor is also a Top Doctor. If you do not, then medical expenses you incur from the new doctor may not be eligible for reimbursement under the HRA. For example, if your primary care physician recommends you see a specific spine surgeon, then you are responsible for first making sure that that spine surgeon is also recommended by Garner Health. If the spine surgeon is not recommended by Garner Health, and you choose to see him/her anyway, then care you receive from him/her will not be reimbursable under the HRA. In order to avoid such situations, you should contact the Garner Health concierge service, which is available to help you quickly locate a spine surgeon that suits your needs and is reimbursable under the HRA.

If you are involved in a care episode that is directed primarily by a Top Doctor recommended to you by Garner Health, and you are not in a position to decide which other doctors render you supporting or ancillary services during the care episode, then the care you receive from such other in-network doctors will be covered even though those doctors were not recommended to you by Garner Health. For example, if you are receiving spine surgery from a Top Doctor, then the charges associated with care you receive from an anesthesiologist, radiologist, physician's

assistant, or second surgeon who assists on the surgery will be eligible for reimbursement under the HRA even though they were not recommended to you by Garner Health.

If, prior to the Effective Date, you were already receiving services for a specific medical condition from a health care provider who was not recommended by Garner Health, then the related medical expenses may still be eligible for reimbursement under the HRA. This is allowed until a safe transfer of care to a Top Doctor can be arranged. Examples of medical conditions that may qualify for this transitional treatment include: pregnancy for the duration of pregnancy and through six weeks post-delivery; newborn care for a child between birth and age thirty-six (36) months; newly-diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy, or reconstruction; transplant candidates or transplant recipients in need ot ongoing care; recent major surgeries in the acute phase and follow-up period; serious acute conditions in active treatment, such as heart attacks or strokes; other serious chronic conditions that require active treatment; treatment for terminal illness; and behavioral health and substance abuse care. Examples of conditions that may not qualify for this transitional treatment include: routine exams, vaccinations, and health assessments; chronic conditions that are stable; and minor illnesses.

In order for expenses related to such continuous care to be eligible for reimbursement, (a) the care must be covered currently by your major medical plan at in-network levels, and (b) you must notify the Garner Health concierge that you would like such care to be covered. If, and when, there is a break in the continuity of such care, you may be required to find a Top Doctor to provide you with further care, or else the related expenses will not be eligible for reimbursement under the HRA.

If, prior to the Effective Date, you had a pre-existing relationship with a particular Primary Care Provider ("PCP"), you may request that your PCP be classified as a Top Doctor going forward for the sake of this HRA. Doctors qualifying as PCPs include family medicine doctors, general pediatricians, and obstetrician-gynecologists. In order to have your pre-existing PCP treated as a Top Doctor, please contact the Garner Health concierge, and tell him/her of the name of your PCP and that you would like the pre-existing relationship to be carried over. You will receive confirmation from Garner Health if your request is approved, and that related medical expenses incurred from your PCP will be treated the same as expenses incurred from a Top Doctor.

If a Top Doctor recommends additional medical services (for example, blood tests, labs, or imaging studies), medical devices, or drugs, any copay, deductible, and coinsurance expenses you owe for those services , medical devices, or drugs will be eligible for reimbursement under the HRA.

If you experience a medical emergency, please dial 911. The Garner Program will cover your copay, deductible, and coinsurance expenses incurred for emergency care, regardless of whether you receive that care from a Top Doctor.

3. Who is Eligible to Participate?

The Garner Program and HRA are part of, and integrated with, your Employer's major medical group health plan (the "Group Health Plan"). If you (and your dependents, if applicable) enroll

in the Group Health Plan, you (and your dependents, if applicable) are automatically eligible to participate in the Garner Program and HRA. To participate in the Garner Program and benefit from payment or reimbursement of your Garner-Eligible Expenses from the HRA, you must register online and agree to Garner Health's Terms of Service and Privacy Policy. Any of your adult dependents who are enrolled in the Group Health Plan must register online with Garner separately in order to benefit from the Garner Program and HRA.

4. Health Savings Accounts (HSAs) and Health Flexible Spending Accounts (FSAs)

If you are enrolled in a Group Health Plan that is intended to be offered alongside an HSA, the HRA will only pay or reimburse Garner-Eligible Expenses that you incur after you reach the minimum statutory deductible during the year for an HSA-eligible high deductible health plan. In 2022, this minimum HDHP deductible amount is $1,400 for self-only coverage, and $2,800 for individuals with family coverage. In 2023, this minimum HDHP deductible amount is $1,500 for self-only coverage, and $3,000 for individuals with family coverage.

If you have a health Flexible Spending Account (FSA), then special rules apply to your use of the Garner HRA. You may not be reimbursed for the same medical expense by both your FSA and the Garner HRA. Payments to Top Doctors will be paid automatically from the HRA where possible. If you have already paid for services from a Top Doctor that was recommended to you by Garner Health coverage, then you are encouraged to use your Garner HRA coverage, if available, rather than your FSA coverage.

5. Is my Personal Health Information Protected?

Yes. Any personal health data made available to Garner or its contractors under the Garner Program will be subject to strict privacy and security requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HRA is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the HRA's Notice of Privacy Practices (which summarizes the HRA's Privacy Rule obligations, your Privacy Rule rights, and how the HRA may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.

6. When HRA Coverage Ends – COBRA

If you terminate employment, or if you or a family member loses coverage because of an event such as a divorce or reduction in hours (a "qualifying event"), you or the family member or former spouse ("qualified beneficiary") may elect and pay for continuation of coverage in your Employer's Group Health Plan under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Because the Garner Program and HRA are part of the Group Health Plan, COBRA applies to these benefits as well. If you or any other qualified beneficiary elects COBRA continuation coverage under your Employer's Group Health Plan, you will continue to be eligible for reimbursement of cost-sharing expenses when you use the Garner Program.

7. Overpayments from the HRA

If it is later determined that you received an overpayment from the HRA, or if you receive an erroneous payment from the HRA, you will be required to refund the overpayment.

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 permitted by applicable law. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Employer may include the amount on your W-2 as gross income. In addition, if the Employer determines that you have submitted a fraudulent claim under the Garner Program, the Employer may terminate your eligibility for the Garner Program and take any disciplinary employment actions permitted by applicable law, including termination of employment.

8. Claims and Appeals Procedures

If you disagree, in whole or in part, with whether you are entitled to reimbursement from your HRA under the Garner Program, you may bring a claim for benefits and, if that claim is denied, in whole or in part, you may file an appeal.

Step 1: *Claim Denial received from Garner.* If your claim is denied, in whole or in part, you will receive a notice of Adverse Benefit Determination from Garner as soon as reasonably possible but no later than 30 days after receipt of the claim. This period may be extended by Garner for up to 15 days if Garner believes that such an extension is necessary due to matters beyond its control and notifies you before expiration of the initial 30-day period. Such notification shall describe the circumstances requiring the extension and the date by the which the Garner expect to render a decision. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the request for additional information to obtain that information. The time period during which Garner 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 Garner please review it carefully. The Notice of Adverse Benefit Determination will contain:

- The specific reason or reasons for the adverse determination
- Reference to the specific plan provisions on which the determination is based;
- Description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

Step 3: *If you disagree with the decision, you may file an appeal.* If you do not agree with the decision of Garner, you may file a written appeal. You must file your appeal no later than 180

days after receipt of the notice described in Step 1. 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. The following conditions apply to your appeal:

- Review must be conducted by an "appropriate named fiduciary" who is not the same person that made the initial adverse benefit determination, nor that person's subordinate.

- If the plan considers or relies on any new or additional evidence or rationale in issuing an adverse determination, it must provide that information to you free of charge (and not only on request). The information must be provided as soon as possible and before a final decision so that you can respond to it.

- You have the right to review your claim file and present evidence and testimony as part of the internal claims and appeals process.

- The Plan must avoid conflicts of interest in claims and appeals. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator) must not be made based upon the likelihood that the individual will support the denial of benefits.

Step 4: *Appeal denial is received from Garner.* If the claim is again denied, you will be notified in writing no later than 60 days after receipt of the appeal by Garner. A notice of adverse determination on appeal will include the following:

- The specific reason or reasons for the adverse determination
- Reference to specific plan provisions
- Statement that they can receive copies of all documents, records, relevant to claim
- Statement of any voluntary appeal procedures and right to bring an action
- Statement of what rule, protocol, etc. criterion was relied on
- A statement regarding voluntary alternative dispute resolution options through the local DOL or state insurance regulatory office.

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 Garner.

Step 6: *External Review.* If you are not satisfied with the result of the internal review, you may request that your appeal be referred to an Independent Review Organization (an "IRO"). Upon request, Garner will provide you with additional information regarding an IRO so that you can make an informed decision regarding whether or not to pursue the voluntary appeal. Such information will include information about the rules of the voluntary appeal, your right to representation, the process for selecting the individuals conducting the independent review and any circumstances (such as financial or personal interests) that may affect the independence of those individuals. Submission of a voluntary appeal will have no effect on other benefits to which you may be entitled under the plan. The plan will abide by the decision of the IRO. To request a review, you must submit your request to the IRO within 60 calendar days of your receipt of internal claim denial.

The IRO will generally respond within 30 days.

After exhaustion of the claims and appeals procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available.

9. Funding of the Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

10. Establishment of HRA Account

The Plan Administrator will establish and maintain an HRA account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) Crediting of Accounts. You HRA account will be credited at the beginning of each Plan Year with an amount equal to the applicable maximum dollar limit for the Plan Year.

(b) Debiting of Accounts. You HRA account will be debited during each Plan Year for any reimbursement of Garner-Eligible Expenses incurred during the Plan Year.

(c) Available Amount. The amount available for reimbursement of Garner-Eligible Expenses is the amount credited to your HRA account under subsection (a), reduced by prior reimbursements debited under subsection (b).

(d) Unused Amounts. Amounts that are credited to your account but unused during the Plan Year will not roll over for use in the following Plan Year.

11. Administration of the Garner Program and HRA

Your Employer is the Administrator of the Group Health Plan. Garner has been retained as the nondiscretionary claims administrator for the Garner Program and the HRA. You may contact Garner at:

Garner Health Technology, Inc., Claims Administrator
64 Bleecker Street # 103
New York, NY 10,012
(866) 761-9586
concierge@getgarner.com

12. Termination of Participation

When Participation Ends. Your participation in the HRA will end on the date of your termination of coverage under the Group Health Plan, or if earlier, upon the date of termination of the HRA by your Employer.

13. Amounts Remaining After Termination

Any amounts remaining in your HRA account following your termination or other loss of eligibility for the HRA will be forfeited. Please refer to the "Notice of COBRA Continuation Rights" section of this Summary Plan Description.

14. QMSCOs; Special Enrollment Rights

A court or administrative agency may issue an order requiring you to provide health coverage for your child. In most cases your child will already be an eligible family member, but such an order may require that all or part of your account in the HRA be used to reimburse eligible medical expenses for your child. If such an order is submitted to your employer, your employer will determine whether the order meets the requirements to be considered a Qualified Medical Child Support Order or "QMCSO." If the order is a QMCSO, your child will be added to coverage if he or she is not already an eligible family member, and the employer will follow other requirements of the order in administering the HRA. Your employer will give you written notice if an order relating to coverage of your child is received and of the employer's decision as to whether the order is a QMCSO.

Your eligible family members, who are also enrolled in the Group Health Plan, are automatically eligible for coverage under the HRA. You do not have to request special enrollment upon the addition of new family members, and the HRA will reimburse Garner-Eligible Expenses as long as they are eligible family members at the time a medical expense incurred.

15. Adding Dependents; Special Enrollment Rights

If your Employer provides for different contributions levels to employees based on whether they require single or family coverage, or based on the number eligible family members, you must notify your employer within 30 days of a change in family status and your employer will make an appropriate increase or decrease of your contribution retroactive to the effective date of the change. The following events are changes in family status:

(i) Legal marital status. Events that change your legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.

(ii) Number of dependents. Events that change your number of dependents or eligible family members, including the following: birth; death; adoption; and placement for adoption.

(iii) Dependent satisfies or ceases to satisfy eligibility requirements. Events that cause an employee's dependent or eligible family member to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

If your eligibility is conditioned upon lack other coverage through your spouse's employer or through the employer of a family member of which you are a dependent, you must notify your employer within 30 days of the date when you become (or cease to be) eligible for such other coverage, and your employer will review your eligibility for the HRA. Failure to provide notice of a change in eligibility due to other coverage may be grounds for discipline, up to and including termination of employment.

16. Participation During a Leave of Absence

Coverage will continue under the HRA during a leave of absence in accordance with your employer's leave policies and the terms and conditions of the HRA. If there is a conflict between the information provided in this section and your employer's leave policies, your employer's leave policies will control.

- **Paid Leave of Absence.** Your HRA coverage and your contributions for the coverage will automatically continue during a leave of absence as long as you continue to receive pay.
- **Unpaid Leave of Absence.** Your right to continue HRA coverage during unpaid leave depends on the type of leave. If you do not elect to continue your HRA coverage at the beginning of leave, you will not be able to submit medical expenses you incur during the leave for reimbursement. Rules regarding specific types of unpaid leave are as follows.

    - **FMLA Leave.** If your employer has fifty (50) or more employees and you take FMLA Leave, your HRA coverage will continue if you choose to maintain your coverage under the Group Health Plan during this period pursuant to one or more methods your Employer will offer under that Plan. If you do not maintain your coverage under the Group Health Plan, your HRA coverage will be terminated, and expenses you incur while on leave will not be reimbursed. Upon return from FMLA Leave, your HRA account will be reinstated.
    - **Military Leave.** If you go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may elect to continue your HRA coverage for up to 24 months during the military leave to the extent required by USERRA. USERRA continuation coverage information is provided in the "Other Legal Notices" section of this *Summary*. You may reinstate your coverage on return from leave to the extent required by USERRA. Contact the Plan Administrator for more information.

17. Notice of Cobra Continuation Rights

HRAs sponsored by employers with 20 or more full-time employees are subject to COBRA. If your Employer is subject to COBRA, this section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the HRA. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the HRA. It can also become available to other members of your family who are covered under the HRA when they would otherwise lose their coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a

30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of HRA coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the HRA is lost because of the qualifying event. Under the HRA, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the HRA because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the HRA because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the HRA because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the HRA as a "dependent child."

When is COBRA Coverage Available?

The HRA will offer COBRA continuation coverage to qualified beneficiaries only after your Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the

employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer will be aware of the qualifying event and you will not have to notify your Employer.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify your Employer within 60 days after the qualifying event occurs. You must provide this notice to the address set forth in this document. You must notify your Employer within 60 days of a qualifying event, such as divorce that would result in a loss of coverage for a dependent. Qualified beneficiaries that wish to continue coverage must notify your Employer in writing. your Employer must notify qualified beneficiaries of the option to continue coverage within 10 days of receiving notice of a qualifying event.

Qualified beneficiaries have 45 days from the date of choosing continuation to pay the first continuation charges, except that surviving dependents of a deceased employee have 90 days to pay the first continuation charges. After this initial grace period, qualified beneficiaries must pay charges monthly in advance to your Employer to maintain coverage in force.

Charges for Continuation

Charges for continuation will be equal to a premium determined by your Employer plus a two (2) percent administration fee (if the qualifying event for continuation is the employee's total disability, the administration fee is not required). Premiums are determined under section 4980B of the Internal Revenue Code. All charges are paid directly to your Employer. Your Employer will provide qualified beneficiaries, upon request, written verification of the cost of continuation coverage at the time of eligibility or at any time during the continuation period.

How is COBRA Coverage Provided?

Once your Employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. If your Employer terminates the HRA, COBRA continuation coverage for your HRA will not extend beyond the termination date.

Non Replication of Account Balance

Regardless of whether a qualifying event causes the family unit to separate, a qualified beneficiary can only elect to continue the coverage that existed before the qualifying event. Upon a qualifying event of divorce or loss of eligibility of a dependent, the spouse or former dependent losing coverage will continue to have access to the account balance that existed before the qualifying event until that account balance is depleted. Employer contributions that are made to the HRA following the election of continuation coverage by a former spouse or dependent will be separated into a subaccount. This means that Employer contributions made for the former spouse or dependent will not be available for use by the employee. Similarly, contributions

made to the HRA for the employee after the divorce or a dependent child's loss of eligibility will not be available to the former spouse or dependent.

If You Have Questions

Questions concerning your HRA or your COBRA continuation coverage rights should be addressed to the contact or contacts identified in this document. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your Employer Informed of Address Changes

In order to protect your family's rights, you should keep your Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Employer.

Coordination with Employer plans. Your Employer may offer COBRA under the HRA in coordination with other group health plans sponsored by employer, if any, as a component of such plans.

18. Other Legal Notices

Uniformed Services Employment and Reemployment Rights Act (USERRA) Continuation Coverage. If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible family members under USERRA. This continuation right runs concurrently with your continuation right under COBRA and allows you to extend an 18-month continuation period to 24 months. You and your eligible family members qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. Your eligible family members do not have independent election rights for USERRA continuation coverage so you must elect to continue coverage for USERRA coverage to be provided beyond any COBRA coverage period. You will be required to pay for USERRA continuation coverage.

HIPAA Privacy Rule Notice of Privacy Practices. The HRA is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the HRA's Notice of Privacy Practices (which summarizes the HRA's Privacy Rule obligations, your Privacy Rule rights, and how the HRA may use or disclose health information protected by the Privacy Rule) from the Plan Administrator. Your Employer is the Plan Administrator of the HRA. HRA HIPAA privacy and security obligations are stated in a separate document(s), which are incorporated by reference.

Statement of ERISA Rights of HRA Participants. As a Participant in the HRA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all HRA Participants shall be entitled to:

Receive Information About Your HRA and Benefits.

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the HRA and a copy of the latest annual report (Form 5500 series) filed by the HRA 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 HRA and copies of the latest annual report (Form 5500 series) and the latest updated summary plan description. This *Summary*, combined with the HRA Adoption Agreement, serve as the HRA Plan Document for this benefit. The Plan 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 HRA Coverage. Continue health care coverage if there is a loss of coverage under the HRA as a result of a qualifying event. You or your eligible family members may have to pay for such coverage. Review this *Summary* for your HRA COBRA continuation rights.

Prudent Actions by HRA Fiduciaries. In addition to creating rights for HRA Participants ERISA imposes duties upon the people who are responsible for the operation of this HRA. The people who operate your HRA, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other HRA 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 benefit provided under this HRA or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a 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 HRA documents or the latest annual report from the HRA 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 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 HRA's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in

Federal court. 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 this HRA, 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 (formerly the Pension and Welfare Benefits 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.

19. Other Terms and Conditions

Company's Right to Terminate or Amend the HRA. Your Employer reserves the right and complete discretion to amend or terminate the HRA at any time and without notice.

No Guarantee of Employment. Participation in this HRA is not a guarantee of employment. All Employees are considered to be employed at the will of the Employer.

Amendment and Termination. This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason.

Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of TN, to the extent not superseded by the Code, ERISA or any other federal law.

Code and ERISA Compliance. It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for you or your dependents under this HRA will be excludable from your gross income for federal, state or local income tax purposes.

Non-Assignability of Rights. Your right to receive any reimbursement under this Plan shall not be alienable by your assignment or any other method and shall not be subject to claims by the your

creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Headings. The headings of the various Articles and Sections are inserted for convenience of reference and shall not be construed as defining or limiting the meaning or construction of any provision.

Severability. Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

Plan Administrator's Discretion. The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the HRA. Benefits under the HRA will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

Customer Service

Questions?	Garner is available to answer your questions about your benefits and claims payments. Monday through Friday: 8:00 AM - 8:00 PM EST *Hours are subject to change without prior notice.*
Customer Service Telephone Number	1 (866) 761-9586
Garner Website	www.getgarner.com
Garner's Mailing Address	64 Bleecker St. #103, New York NY, 10012

20. Administrative Information

The Plan Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits. The Plan Administrator's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties to agents.

Name of Plan: Office Interiors Health Reimbursement Arrangement

Plan Administrator's Employer Identification Number (EIN): 62-1642404

Plan Number: 501

Plan Year: January 1 - December 31

Agent for Service of Process: Service may be made on the Plan Administrator at the address listed below.

Type of Plan: The Plan is intended to qualify as a health reimbursement arrangement.

Type of Administration: The Plan Administrator pays applicable benefits from the general assets of the Employer. The Plan is administered by employees of the Plan Sponsor and under an administrative services contract with a third-party administrator.

Funding: The Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which Benefits are paid.

Plan Administrator: Memphis Furniture Group DBA Office Interiors

281 Moore Lane, Collierville, TN 38017

Plan Sponsor: Memphis Furniture Group DBA Office Interiors

281 Moore Lane, Collierville, TN 38017

Named Fiduciary: Memphis Furniture Group DBA Office Interiors

281 Moore Lane, Collierville, TN 38017

Third Party Administrator (claims administrator): Garner Health, 64 Bleecker St #103, New York NY, 10012

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the Office Interiors Health Reimbursement Arrangement Plan, this Plan is executed on _____ day of _____, 20__.

Memphis Furniture Group DBA Office Interiors

Signed

Name

Date