Welfare Plan

Summary Plan Description and Plan Document
Part #1: Fact Sheet

Section 1: Introduction

Your complete Summary Plan Description and Plan Document is comprised of three parts as outlined below. This document is a wrap-around Plan Document and Summary Plan Description, meaning the full document is made up of several different parts. When this Plan Fact Sheet and the Disclosure and Detail Document is accompanied by the corresponding Certificates of Coverage, the three documents combined become the Summary Plan Description. When this Plan Fact Sheet and the Disclosure and Description Document is accompanied by the corresponding Insurance Contracts, the three documents combined become the Plan Document.

Part	Document Name	Description
Part #1	Plan Fact Sheet	Contains general plan information and specific benefit plan information on each of the component benefit plans that comprise the plan.
Part #2	Disclosure Document	Contains important disclosures and descriptions of plan details, rights, rules, and responsibilities under your welfare plan.
Part #3	Component Benefit Plan Documents	A. The insurance carrier Certificates of Coverage, when these documents are to act as a Summary Plan Description (SPD). B. The insurance carrier Contracts, when these documents are to act as a Plan Document.

Section 2: Plan Information

On September 2, 1974, the Employee Retirement Income Security Act of 1974 (often referred to as ERISA) was enacted, establishing Federal controls over most employee welfare benefit plans. The plans identified on the following pages are subject to regulation by ERISA.

All plans outlined have the following ERISA specifications in common:

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Employer/Plan Sponsor:	Talend Inc.
Contact Information:	400 South El Camino Real Suite 1400 San Mateo, CA 94402 (650) 539-3200
Affiliated Employers:	None
Employer Tax ID Number:	06-1807693
Effective Date:	January 1, 2013
Plan Year:	January 1 to December 31
Plan Administrator:	Talend Inc. The Plan Administrator has authority to control and manage the operation and administration of the Plan.
Agent for Service of Legal Process:	Talend Inc.

Plan Changes or Terminations:	The Plan Administrator may terminate, suspend, withdraw, amend or modify any element of this Plan in whole or in part at any time, subject to the applicable provisions of the group benefit policies or corporate policies as outlined in the contracts, corporate minutes and/or bylaws.
Wellness Program Notice:	Employer does NOT sponsor a formal wellness program.
HIPAA Covered Entity Status:	Full PHI for HIPAA Privacy Detailed PHI for HIPAA Security
HIPAA Privacy Officer:	Ivy Shen (650) 539-3200
Applicable Large Employer:	Talend Inc. is an Applicable Large Employer (for the purposes of the Pay or Play penalties of the Affordable Care Act).
ACA Variable Hour Employee Safe Harbor:	Talend Inc. is an Applicable Large Employer. Talend Inc. uses the following ACA Safe Harbor protocol for employees: Initial Measurement Period = 12 months from date of hire Initial Administration Period = 1 month Initial Stability Period = 12 months Ongoing Measurement Period = November through October Ongoing Administration Period = 2 months Ongoing Stability Period = January through December
Medicare Part D Notice:	If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Section 20 for more details. (This font is intentionally large for compliance purposes.)
Language Assistance:	SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-838-8482.
Component Benefit Plan Description:	The benefits identified in the following pages are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

The following pages outline the specific plan information for each of the component benefit plans that comprise this employee benefits Plan.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Anthem Blue Cross of California
Policy Number:	L03829
Type of Plan Benefit:	Medical HDHP-PPO
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	Anthem Blue Cross 21215 Burbank Blvd Woodland Hills, CA 91367
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Anthem Blue Cross 21215 Burbank Blvd Woodland Hills, CA 91367
Claims Appeal Address:	Anthem Blue Cross Attn: Grievances and Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310
Funding Arrangement:	Fully Insured
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions, including, in some cases, those made at employee direction through a salary reduction agreement.
Medicare Part D:	Creditable, see Section 21.
Grandfathered Plan:	No, see Section 23.
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Eligible dependents include your spouse and child(ren) under the age of 26.
Domestic Partner Coverage:	You may also enroll a Domestic Partner and a Domestic Partner's children as dependents in our medical, dental, and vision plans. Registered Domestic Partners may enroll in the plan with no additional documentation. Non-registered Domestic Partners must satisfy the eligibility requirements outlined in the Declaration of Domestic Partnership form and return the Declaration Form to Human Resources with the enrollment forms.
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Anthem Blue Cross of California
Policy Number:	L03829
Type of Plan Benefit:	Medical PPO
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	Anthem Blue Cross 21215 Burbank Blvd Woodland Hills, CA 91367
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Anthem Blue Cross 21215 Burbank Blvd Woodland Hills, CA 91367
Claims Appeal Address:	Anthem Blue Cross Attn: Grievances and Appeals P.O Box 4310 Woodland Hills, CA 91365-4310
Funding Arrangement:	Fully Insured
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions, including, in some cases, those made at employee direction through a salary reduction agreement.
Medicare Part D:	Creditable, see Section 21.
Grandfathered Plan:	No, see Section 23.
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Eligible dependents include your spouse and child(ren) under the age of 26.
Domestic Partner Coverage:	You may also enroll a Domestic Partner and a Domestic Partner's children as dependents in our medical, dental, and vision plans. Registered Domestic Partners may enroll in the plan with no additional documentation. Non-registered Domestic Partners must satisfy the eligibility requirements outlined in the Declaration of Domestic Partnership form and return the Declaration Form to Human Resources with the enrollment forms.
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Kaiser Health Plan
Policy Number:	604441 (NoCA) / 230642 (SoCA)
Type of Plan Benefit:	Medical HDHP-HMO
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	Kaiser Permanente 1950 Franklin Street, 18th Floor Oakland, CA 94612
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Kaiser Permanente 1950 Franklin Street, 18th Floor Oakland, CA 94612
Claims Appeal Address:	Kaiser Permanente Claims Appeal Department Special Services Unit P.O. Box 23280 Oakland, CA 94623
Funding Arrangement:	Pre-Paid
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions, including, in some cases, those made at employee direction through a salary reduction agreement.
Medicare Part D:	Creditable, see Section 21.
Grandfathered Plan:	No, see Section 23.
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Eligible dependents include your spouse and child(ren) under the age of 26.
Domestic Partner Coverage:	You may also enroll a Domestic Partner and a Domestic Partner's children as dependents in our medical, dental, and vision plans. Registered Domestic Partners may enroll in the plan with no additional documentation. Non-registered Domestic Partners must satisfy the eligibility requirements outlined in the Declaration of Domestic Partnership form and return the Declaration Form to Human Resources with the enrollment forms.
Special Notes:	This plan is available to employees that reside in Northern California (and within the service area of the carrier) only.

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Kaiser Health Plan
Policy Number:	604441 (NoCA) / 230642 (SoCA)
Type of Plan Benefit:	Medical HMO
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	Kaiser Permanente 1950 Franklin Street, 18th Floor Oakland, CA 94612
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Kaiser Permanente 1950 Franklin Street, 18th Floor Oakland, CA 94612
Claims Appeal Address:	Kaiser Permanente Claims Appeal Department Special Services Unit P.O. Box 23280 Oakland, CA 94623
Funding Arrangement:	Pre-Paid
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions, including, in some cases, those made at employee direction through a salary reduction agreement.
Medicare Part D:	Creditable, see Section 21.
Grandfathered Plan:	No, see Section 23.
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Eligible dependents include your spouse and child(ren) under the age of 26.
Domestic Partner Coverage:	You may also enroll a Domestic Partner and a Domestic Partner's children as dependents in our medical, dental, and vision plans. Registered Domestic Partners may enroll in the plan with no additional documentation. Non-registered Domestic Partners must satisfy the eligibility requirements outlined in the Declaration of Domestic Partnership form and return the Declaration Form to Human Resources with the enrollment forms.
Special Notes:	This plan is available to employees that reside in Northern California (and within the service area of the carrier) only.

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Delta Dental
Policy Number:	19185
Type of Plan Benefit:	Dental
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	Delta Dental of California 560 Mission St #1300 San Francisco, CA 94105
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Talend, Inc. 400 South El Camino Real Suite 1400 San Mateo, CA 94402
Claims Appeal Address:	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330
Funding Arrangement:	Self Insured
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions, including, in some cases, those made at employee direction through a salary reduction agreement.
Medicare Part D:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Eligible dependents include your spouse and child(ren) under the age of 26.
Domestic Partner Coverage:	You may also enroll a Domestic Partner and a Domestic Partner's children as dependents in our medical, dental, and vision plans. Registered Domestic Partners may enroll in the plan with no additional documentation. Non-registered Domestic Partners must satisfy the eligibility requirements outlined in the Declaration of Domestic Partnership form and return the Declaration Form to Human Resources with the enrollment forms.
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Vision Service Plan
Policy Number:	30095332
Type of Plan Benefit:	Vision
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Talend, Inc. 400 South El Camino Real Suite 1400 San Mateo, CA 94402
Claims Appeal Address:	VSP Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670
Funding Arrangement:	Self Insured
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions, including, in some cases, those made at employee direction through a salary reduction agreement.
Medicare Part D:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Eligible dependents include your spouse and child(ren) under the age of 26.
Domestic Partner Coverage:	You may also enroll a Domestic Partner and a Domestic Partner's children as dependents in our medical, dental, and vision plans. Registered Domestic Partners may enroll in the plan with no additional documentation. Non-registered Domestic Partners must satisfy the eligibility requirements outlined in the Declaration of Domestic Partnership form and return the Declaration Form to Human Resources with the enrollment forms.
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	UNUM
Policy Number:	652067
Type of Plan Benefit:	Life and AD&D
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Claims Appeal Address:	UNUM Life Benefits Center and Appeals Unit P.O. Box 9548 Portland ME, 04104-5058
Funding Arrangement:	Fully Insured
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions.
Medicare Part D:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Dependents are not eligible for this benefit.
Domestic Partner Coverage:	Domestic Partners are not eligible for this benefit.
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	UNUM
Policy Number:	652067
Type of Plan Benefit:	STD
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Claims Appeal Address:	UNUM Life Benefits Center P.O. Box 100158 Columbia, SC 29202-3158
Funding Arrangement:	Fully Insured
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions.
Medicare Part D:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Dependents are not eligible for this benefit.
Domestic Partner Coverage:	Domestic Partners are not eligible for this benefit.
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	UNUM
Policy Number:	652069
Type of Plan Benefit:	STD
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Claims Appeal Address:	UNUM Life Benefits Center P.O. Box 100158 Columbia, SC 29202-3158
Funding Arrangement:	Fully Insured
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions.
Medicare Part D:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Dependents are not eligible for this benefit.
Domestic Partner Coverage:	Domestic Partners are not eligible for this benefit.
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	UNUM
Policy Number:	652067
Type of Plan Benefit:	LTD
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Claims Appeal Address:	UNUM Life Benefits Center P.O. Box 100158 Columbia, SC 29202-3158
Funding Arrangement:	Fully Insured
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions.
Medicare Part D:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Dependents are not eligible for this benefit.
Domestic Partner Coverage:	Domestic Partners are not eligible for this benefit.
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	UNUM
Policy Number:	652068
Type of Plan Benefit:	Vol Life and AD&D
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	UNUM Life 2211 Congress Street Portland, ME 04122
Claims Appeal Address:	UNUM Life Benefits Center P.O. Box 100158 Columbia, SC 29202-3158
Funding Arrangement:	Fully Insured
Plan Premiums/ Contributions:	This benefit is paid by Employee contributions through a salary reduction agreement.
Medicare Part D:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on date of hire.
Dependent Eligibility:	Eligible dependents include your spouse and child(ren under the age of 26.
Domestic Partner Coverage:	Registered Domestic Partners may enroll in the plan with no additional documentation. Non-registered Domestic Partners must satisfy the eligibility requirements outlined in the Declaration of Domestic Partnership form and return the Declaration Form to Human Resources with the enrollment forms.
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Benefit Plan Information

Plan Name:	The Talend, Inc. Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Optum Health
Policy Number:	N/A
Type of Plan Benefit:	EAP
Type of Plan Administration:	Contract administration with benefits provided in accordance with the group policy.
Contract Administrator: *Responsible for plan administration and processing of claims.*	OptumHealth 11469 Olive Boulevard #314 St Louis, MO 63141
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	OptumHealth 11469 Olive Boulevard #314 St Louis, MO 63141
Claims Appeal Address:	OptumHealth 11469 Olive Boulevard #314 St Louis, MO 63141
Funding Arrangement:	
Plan Premiums/ Contributions:	This benefit is paid by Employer contributions.
Medicare Part D:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	All full-time employees working 30 or more hours per week are eligible on the date of hire.
Dependent Eligibility:	Eligible dependents include your spouse/domestic partner and your dependent child(ren) under the age of 26.
Domestic Partner Coverage:	Eligible (see above).
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Welfare Plan

Plan Document and Summary Plan Description Disclosure Document

Multiple Part Document Notice

Your complete Plan Document and Summary Plan Description (SPD) is comprised of the parts outlined below. This document is a wrap-around Plan Document and Summary Plan Description, meaning the full document is made up of several different parts. When this Fact Sheet and the Disclosure Document is accompanied by the corresponding Certificates of Coverage, the three documents combined become the complete Summary Plan Description. When this Fact Sheet and the Disclosure Document is accompanied by the corresponding Insurance Contracts, the three documents combined become the Plan Document. This description of the multiple-part construction of the combined Plan Document and SPD is intentionally repeated at the beginning of both the Fact Sheet and the Disclosure Document.

Part	Document Name	Description
Part #1	Fact Sheet	Contains general plan information and specific benefit plan information on each of the component benefit plans that comprise the plan.
Part #2	Disclosure Document	Contains important disclosures and descriptions of plan details, rights, rules, and responsibilities under your welfare plan.
Part #3	Component Benefit Plan Documents	Participant Documents. Insurance Carrier Certificates of Coverage, Evidence of Coverage, or other Plan Detail Documents Employer Documents. Insurance carrier contracts, agreements, or other contract documents

Table of Contents

Section 3: Purpose

The Employer/Plan Sponsor and its named subsidiaries and affiliates sponsor various Benefit Plans as outlined in Sections 1 and 2 of the Fact Sheet for the exclusive benefit of the Participants. This Plan has been written and is intended to conform to the written plan document and other requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Any assets of the Benefit Plans shall be held for the exclusive purposes of providing benefits to the Benefit Plan participants and their beneficiaries and for defraying reasonable costs of administration.

Section 4: Accompanying Documents

A. Summary Plan Description (SPD). The term "Certificates of Coverage" refers to the plan documentation provided by the Contract Administrator or insurance carrier, which describes the plan benefits in detail. Certificates of Coverage are sometimes alternately referred to as Certificates, Evidence of Coverage, Plan Booklets, Group Insurance Plan Benefits, Plan Detail Documents, (or other similar names) by the Plan Administrator that issues them. If you do not have a copy of your Certificate of Coverage you may obtain one from the Plan Administrator. The applicable Certificate of Coverage describes the plan coverage provisions, the use of network providers, the composition of the network, and the circumstances, if any, under which coverage will be provided for out-of-network services. A directory of participating network providers may be accessed online at no cost to you. The Certificate of Coverage will also inform you about any conditions, limits, exclusions, or restrictions on coverage.

B. Plan Document. The term "Insurance Contract" refers to the plan documentation provided by the Contract Administrator, which outlines the important elements of the agreements/contracts between the Employer/Plan Sponsor and the Contract Administrator. Insurance Contracts are sometimes alternately referred to as Insurance Policies, Contracts/Policies, Service Agreements or Plan Detail Documents (or other similar names) by the Contract Administrator or insurance carrier that issues them.

C. Wrap-around Document. This document is a wrap-around Plan Document and a wrap-around Summary Plan Description. When accompanied by the appropriate Certificates of Coverage, this document, along with those Certificates, becomes the Summary Plan Description. When accompanied by the appropriate Insurance Contracts, this document, along with those Contracts, becomes the Plan Document. The detailed plan information required by ERISA is shown in your Certificates of Coverage or Insurance Contracts for each benefit. If you do not have a copy of your Certificate of Coverage you may obtain one from the Plan Administrator.

Section 6: Termination/Modification/Amendment of the Plan

A. Permanency. While the Employer/Plan Sponsor fully expects this Plan to continue indefinitely, permanency of the Plan is subject to the Employer/Plan Sponsor's right to amend or terminate the plan as provided below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant to vested or non-terminable benefits.

B. Right to Modify or Amend. The Employer/Plan Sponsor reserves the right to amend or modify the Plan or any element or provision of the Plan at any time. For example, Employer reserves the right to amend or terminate benefits, covered expenses, benefit copays, policy provisions and reserves the right to amend the Plan, to require or increase employee contributions, and to implement any cost control measures that it may deem advisable. No consent of any Participant is required to amend or modify the Plan. Any amendment or modification shall be effective as of the date determined by the Employer/Plan Sponsor. All amendments shall be made in writing and shall be approved by the Employer/Plan Sponsor according to its normal procedures for transacting business. Such amendments may apply retroactively or prospectively as provided in the amendment. Any amendment made shall be deemed to be approved and adopted by any Affiliated Employer who has adopted the Plan.

C. Right to Terminate. The Employer/Plan Sponsor has the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. No consent of any Participant is required to amend, modify or terminate the Plan. Any discontinuance or termination shall be effective as of the date determined by the Employer/Plan Sponsor. The decision to terminate the Plan shall be made in writing and shall be approved by the Employer, according to its normal procedures for transacting business. Affiliated Employers who have adopted the Plan may withdraw from participation in the Plan but may not terminate the Plan.

D. Contract Administration. The Employer/Plan Sponsor may enter into contracts with a Contract Administrator to provide coverage. The Employer/Plan Sponsor has the right to amend, terminate, or modify any relationship with a Contract Administrator at any time. A Contract Administrator may terminate coverage if the Employer/Plan Sponsor fails to pay the required premium in a timely manner as prescribed by the contract. A Contract Administrator may also terminate the Insurance Contract on any premium due date if the number of persons insured is less than the minimum number required.

E. Effect on Participants. A Participant's coverage is amended or modified upon the amendment or modification of the Plan. An individual Participant's coverage terminates at the earliest of the following conditions:

1. When you leave your employment
2. When you are no longer eligible
3. When you cease to contribute (if the Plan is contributory)
4. When the Plan terminates.

If a Participant ceases active work, individual Certificates of Coverage will determine what arrangements, if any, may be made to continue coverage beyond the date active work is ceased.

Section 7: Description of Types of Funding Arrangements

F. Fully Insured Plan. In a fully insured plan, benefits are provided under a group insurance contract entered into between the Employer/Plan Sponsor and the insurance company identified as the Contract Funding Agent. Claims for benefits are sent to the insurance company or Contract Administrator. The insurance company, not the Employer/Plan Sponsor, is responsible for paying claims and for the financial risk of paying claims under the plan. (However, the insurance company and Employer share the responsibilities for administering the plan.) Insurance premiums for plan participants as well as employee contributions (pre-tax and after-tax, as applicable) are paid by the Employer/Plan Sponsor out of the general assets of the Employer/Plan Sponsor.

G. Self-Insured Plan. In a self-insured plan or a partially self-insured plan, the Employer/Plan Sponsor hires the Contract Administrator to process claims under the plan. The Contract Administrator does not serve as an insurer, but merely as a claims processor and administrator. Claims for benefits are sent to the

Contract Administrator. The Contract Administrator processes the claims, then requests and receives funds from the Employer/Plan Sponsor to pay the claims and make payment on the claims to health care providers. The Employer/Plan Sponsor is ultimately responsible for providing plan benefits, not the Contract Administrator. (However, the Contract Administrator and Employer/Plan Sponsor share responsibilities for administering the plan.) Plan benefits are paid by the Employer/Plan Sponsor out of the general assets of the Employer/Plan Sponsor. There is no special fund or trust or insurance from which benefits are paid. Employee contributions (pre-tax and after-tax, as applicable) are also paid by the Employer/Plan Sponsor out of the general assets of the Employer/Plan Sponsor.

H. Pre-paid Plan. In a pre-paid plan, benefits are provided under a contract entered into between the Employer/Plan Sponsor and the Contract Administrator. Typically, pre-paid plans are Health Maintenance Organizations (HMO). Premiums are due in advance of services being received. Providers are typically paid on a capitated basis for basic services and on a fee-for-service basis for other services. The Contract Administrator negotiates payment arrangements with providers. Insurance premiums for plan participants as well as employee contributions (pre-tax and after-tax, as applicable) are paid by the Employer/Plan Sponsor out of the general assets of the Employer/Plan Sponsor.

Section 8: Participation, Eligibility, Enrollment, and Termination Specifications

A. Participation. The term "Participant" with respect to this Plan means any employee or beneficiary who meets the eligibility requirements of one of the Benefit Plans offered and participates in the Plan in accordance with the terms and conditions established for that specific Benefit Plan and has not for any reason become ineligible to participate. An employee, dependent, or beneficiary shall be a Participant in this plan if he or she actively elects coverage under one or more of the Benefit Plans or if that employee becomes covered by one or more of the Benefit Plans by virtue of automatic administrative processing. Specific participation requirements for each Benefit Plan are outlined in the Certificates of Coverage or Insurance Contracts for each Benefit Plan.

B. Eligibility Requirements. Information regarding specific employee and dependent eligibility requirements and any conditions and limitations to eligibility are contained in the Certificate of Coverage or the Insurance Contracts describing each separate Benefit Plan. Eligible dependents include dependents who qualify under the Insurance Contracts currently in force under the Employee Benefit Plan of the Employer/Plan Sponsor. A plan participant or beneficiary may obtain a copy of the plan's Qualified Medical Child Support Order (QMCSO) procedures from the Plan Administrator. Plan participants must complete an enrollment application (provided by the Plan Administrator) in a timely fashion in order to receive certain benefits under this plan.

   The following types of individuals are specifically not eligible for benefits under this plan:

   - If you are regularly scheduled to work less than the hours per week as indicated above for the specific benefit plan
   - If you are classified as a seasonal employee (according to the ACA definition) and your Employer/Plan Administrator excludes seasonal employees
   - If you are classified as a leased employee as defined in section 414(n) of the Code
   - If you are classified as an independent contractor
   - If you are classified as a consultant or advisor on a retainer or fee basis, and compensation paid to you is reported on a Form 1099 rather than a Form W-2
   - If you are a member of a collective bargaining unit who is eligible under a separate union negotiated plan.

C. Enrollment. When you begin working at your Employer, you will receive the information necessary to enroll in the Plan. If you satisfy the eligibility criteria for the benefit offerings and you timely complete the appropriate enrollment paperwork, your coverage begins as of the effective date outlined in the Certificate of Coverage for each component benefit plan. Your eligible dependents' coverage under the Plan will begin on the same date if you make the necessary elections within the time period required. As a rule, the benefits elections you make at the beginning of your employment will remain in force for the full Plan Year. If you do not enroll for benefit offerings when you are first eligible, you will have to wait until the next annual Open Enrollment period unless you meet the criteria to qualify for a Mid-Year Enrollment Opportunity, experience a Qualified Life Event, or qualify for a Special Open Enrollment.

1. Open Enrollment. Open Enrollment happens once annually and, during that time, you may typically make changes to your benefit plans, add dependents to your plans, or delete dependents from your plans. Any changes you make become effective at the beginning of the Plan Year.

2. Mid-Year Enrollment Opportunities. If you initially waived coverage or waive coverage for any eligible dependents either upon your initial eligibility or at any annual Open Enrollment, under certain circumstances, you may be eligible to enroll in coverage on a mid-year basis. To be eligible, you must experience a Qualified Status Change or another defined event that qualifies you to make such a mid-year election. This is often referred to as a Special Open Enrollment. Examples of events that qualify include birth of a child, marriage, divorce, coverage being lost under another employer-sponsored plan, coverage being changed or lost under a spouse's plan, or coverage being lost due to exhausting COBRA coverage from a prior employer. In all cases, you must notify your Employer within 30 days of the event in order to make a mid-year change. Certain of the special events allow for a 60 day notification period, however, others only allow for a 30 day notice period. Therefore, it is advisable to notify your employer within 30 days of the event, to ensure timely enrollment. If you do not make the notification within the prescribed window, you must wait to enroll until the next annual Open Enrollment period. If you enroll yourself or a dependent in the benefit offerings midyear due to a change in status, coverage may begin on the date of the event, or it may begin on the first of the month following your event or it may begin on the first of the month following your notification to your Employer. Please consult your Certificate of Coverages for each plan to confirm the specific coverage effective date under your plans.

D. Benefit Termination. This SPD and Plan Document is issued in conjunction with corresponding Certificates of Coverage or Insurance Contracts for each of the plans identified on the previous pages. Information regarding loss of benefits and when benefits terminate can be found in the Certificates of Coverage or the Insurance Contracts describing each separate Benefit Plan. Please refer to the corresponding benefit plan Certificate of Coverage for specific details. However, following is an overview of the general types of provisions governing when coverage will terminate:

1. The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the insurance contract or agreement, or by discontinuance of contributions by the Employer/Plan Administrator

2. The end of the period for which you paid your required contribution, if applicable

3. The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA)

4. The end of the period for which you are no longer eligible, for example if your hours drop below the required eligibility threshold.

Section 9: Changing Coverage Elections Mid-Year

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. In addition, elections you make at Open Enrollment generally remain in effect for the entire Plan Year. If you experience one of the events described below and want to make a change to your coverage due to such event, you must notify your Employer within 30 days of the event, or 60 days for certain events as described under HIPAA Special Enrollments in this document. If you do not notify your Employer within the allowed timeframe, you will not be able to make any changes to your coverage until the next Open Enrollment period.

A. Changes in Status. You may be able to change your medical election during the Plan Year if you experience a change in status. Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.) The following is a list of changes in status that may allow you to make a change to your elections:

1. Legal marital status. Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment

2. Domestic Partner status. A change in your status due to establishing a domestic partnership, or dissolution of a domestic partnership

3. Number of eligible dependents. Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption
4. Employment status. Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include beginning or ending employment, a strike or lockout, starting or returning from an unpaid leave of absence, changing from part-time to full-time employment or vice versa, or a change in work location
5. Dependent status. Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances
6. Residence. A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your health plan's network service area
7. FMLA leave. Beginning or returning from an FMLA leave.

B. Other Events that Allow You to Change Elections. There are several other events that are not Status Changes that may allow you to make changes in your elections.

1. QMCSOs. If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator automatically may change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire. If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.
2. Coverage Change Events. In some instances, you can make elections if the type of coverage changes. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.
3. Restriction or Loss of Coverage. If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that provides similar coverage. Coverage is considered "significantly restricted" if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.
4. Addition to or Improvement in Coverage. If Employer adds a coverage option or significantly improves a coverage option during the year, you may revoke your existing election and elect the newly added or newly improved option.
5. Changes in Coverage under another Employer Plan. If you or your eligible dependents are employed and the other employer plan allows for a change in your family member's coverage (either during that employer's Open Enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during his or her employer's Open Enrollment period, you may request to end your coverage under the Plan.
6. Loss of Other Group Health Plan Coverage. If you or your spouse or dependent child(ren) lose coverage under another group health plan sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll for coverage under this Plan.

Section 10: HIPAA

As required by law, this plan complies with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA provisions apply to group health plans only, not all benefit plans offered under this plan.

A. Special Enrollment Rights. HIPAA also requires a group health plan to provide special mid-year enrollment opportunities to certain employees and/or their dependents in three circumstances: 1) loss of other employer sponsored coverage, 2) loss of Medicaid or CHIP coverage, or 3) acquisition of a new

dependent. If you seek to enroll under these special enrollment rules, you will not be considered a late enrollee and thus would not be subject to the late enrollment penalties as prescribed by HIPAA or have to waive until the next Open Enrollment period.

1. Other Group Coverage. If you are covered under another employer sponsored group health plan and involuntarily lose that coverage (due to expiration of COBRA or loss of eligibility under the other group plan), you or your dependents may enter the plan under the special mid-year enrollment rights. You must request enrollment in writing within 30 days after the loss of the other coverage or the other employer's cessation of contributions for such other coverage. Coverage will begin on the first day of the month after the plan receives the enrollment form.
2. Medicaid/CHIP. If you or any eligible dependents are covered under Medicaid or CHIP coverage and you lose eligibility under one of those programs or you become eligible for the state's premium assistance program, you and your eligible dependents may enter the plan under the special mid-year enrollment rights. You must request enrollment in writing within 60 days after the Medicaid/CHIP event. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.
3. Acquire New Dependent. If you as an employee acquire a new dependent -- by marriage, birth, adoption, or placement for adoption -- you have a right to enroll yourself and the new dependent in the group health plan. You must request enrollment in writing within 60 days of the marriage, birth, adoption, or placement for adoption. Coverage applied for as a result of one of these HIPAA special enrollment events will become effective as outlined in your plan certificate. Please refer to your Certificate of Coverage for specifics.

B. Continuity of Coverage. HIPAA requires that your group health plan reduce or eliminate the exclusionary period of coverage for pre-existing conditions under your group health plans (not long term disability plans), if you have creditable coverage from another plan. Typically, you should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer in the following events: when you lose coverage under the plan; when you become entitled to elect COBRA continuation coverage; or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion of 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Section 11: Lookback Method for Eligibility

This section is only applicable for employers who are Applicable Large Employers (ALEs) under the Affordable Care Act. To determine if your employer is an Applicable Large Employer, please refer to the Section 2: Plan Information which can be found in Part #1: Plan Fact Sheet of this Summary Plan Description. The Part #1: Plan Fact Sheet accompanies this Summary Plan Description Disclosure Document.

A. Overview. This section explains how health plan eligibility is determined for employees when the lookback method is adopted.

B. Basic Rule. You will be subject to a measurement period (as outlined in Part #1: Fact Sheet of this Summary Plan Description). During the measurement period, you will NOT be eligible for health insurance. During that period, your eligibility for health benefits will be determined by tracking your hours of service during an "initial measurement period." Hours of service that count towards your eligibility for health benefits include: (1) hours for which you are paid for work, and (2) hours for which you are paid for vacation, holiday, illness, disability, layoff, jury duty, military duty, or leave of absence.

C. Averaging 30 Hours or More. If your average hours worked exceeds the threshold during the initial measurement period, then you will be eligible for health benefits for a period of time equal to the stability period (also noted in Part #1: Fact Sheet of this Summary Plan Description). At that point, your eligibility for coverage will have been "earned" for the duration of the stability period, and your coverage will be maintained through the stability period, even if your actual average hours worked falls below the threshold. However, you must elect coverage, pay your share of premiums, and continue to be an employee during this period in order to maintain coverage through your stability period. One last note, there is an administration period (as noted below) in between the end of the measurement period and the beginning of the stability period to allow for processing of your election.

D. Averaging Less Than 30 Hours. If your average hours worked does not meet the threshold during the initial measurement period, then you will not be eligible for health benefits for a period of time equal to the stability period (identified below). You will not be eligible for health coverage through the entire stability period even if your average hours during the stability period increases above the threshold. However, if you have a change in employment status such that you are no longer a variable hour employee and you are newly in a classification that is eligible for health benefits, you would not be subject to the entire stability period lock out period.

E. Variable Hour Employees. If you are a variable hour employee with a flexible work schedule such that it cannot be determined in advance whether or not you will work an average of 30 hours per week (the federal minimum threshold to qualify for health plan coverage), whether you are eligible for coverage for the stability period is determined based on your actual hours during the measurement period.

F. After the Initial Measurement Period. Regardless of the outcome of your initial measurement period (eligibility for health coverage earned or not), your hours will be counted toward eligibility for future coverage based on the company's ongoing measurement period. In some cases, your initial measurement period and the standard measurement period will overlap. During any such overlap, your hours will be counted separately toward each of the measurement periods and your eligibility will accrue *separately* to each of the initial and ongoing measurement periods. Your initial measurement period is based on when you are hired. The ongoing measurement period is based on a specific calendar year cycle.

G. Administration Period. The period after the end of your measurement period (and before the beginning of the stability period associated with your measurement period) during which the plan sponsor is allowed to perform administrative tasks, such as calculating the hours for the measurement period, determining eligibility for coverage, providing enrollment materials to eligible employees, and conducting Open Enrollment and processing enrollment documents.

H. Rehires and Leaves of Absence. If you terminate employment and are rehired or go on a leave of absence such that you have a break in service of 13 continuous weeks or more (26 weeks for an educational organization), you will be subject to a new waiting period. However, if you terminate employment and are rehired or go on a leave of absence such that your break in service is less than 13 weeks, you will not be subject to a new waiting period.

I. Change in Employment Status. If you are an ongoing employee (not in your initial measurement period) and you experience a change in employment status before the end of the stability period, the change will not affect your classification as a full-time employee (or not a full-time employee) for the remaining portion of the stability period. However, if you transfer to a position that would have been considered part-time had you originally been hired into that position, and are continuously working under 30 hours per week, your classification as a full-time employee may change. If you are a new variable hour employee and your employment status materially changes before the end of your initial measurement period in such a way that, if you had begun employment in the new position, you reasonably would have been expected to average at least 30 hours of service per week, and you actually average at least 30 hours of service per week during the initial measurement period, your change in status will move you from a variable hour employee to full-time employee status and your benefits eligibility will follow the rules for regular full-time employees.

Section 12: Monthly Measurement Method for Eligibility

This section is only applicable for employers who are Applicable Large Employers (ALEs) under the Affordable Care Act. To determine if your employer is an Applicable Large Employer, please refer to the Section 2: Plan Information which can be found in Part #1: Plan Fact Sheet of this Summary Plan Description. The Part #1: Plan Fact Sheet accompanies this Summary Plan Description Disclosure Document.

A. Overview. This section explains how health plan eligibility is determined when the monthly method is adopted.

B. Basic Rule. The actual hours your work each month determines whether you are eligible for coverage during that month.

C. Averaging 30 Hours or More. If your average hours worked each week exceeds the 30 hour threshold during any given month, your employer is required to either provide you coverage for that month or pay a penalty (Shared Responsibility Payment).

D. Averaging Less Than 30 Hours. If your average hours worked each week does not meet the 30 hour threshold during any given month, your employer is not required to provide you coverage for that month.

E. Retroactive Nature of Method. If your hours exceed the 30 hour threshold for a month, your employer may elect to provide coverage retroactively in that month (or pay the penalty). It is important to understand that under this method, whether or not coverage can or must be provided cannot be determined until the end of the month, therefore any actual offer of coverage would typically be retroactive. There is no administration period for enrollment or termination of coverage, so coverage enrollments and terminations often must be executed retroactively.

Section 13: Taxation

A. Taxation of Benefits. In general, health benefits provided to you and your eligible dependents are tax free (subject to certain limitations for life insurance benefits).

B. Domestic Partner Taxation. Whether or not your plan offers coverage for Registered Domestic Partners or Non-Registered Domestic Partners may be found under the eligibility criteria of each Certificate of Coverage. However, it should be noted that tax treatment of employee benefits is not the same for domestic partners. Unless your domestic partner and/or his or her children, if any, are considered your federal tax dependents under the Internal Revenue Code for health benefits, the Internal Revenue Service currently requires that your employer impute income to you equal to the value of the coverage provided for your domestic partner and his or her dependent children. You are advised to consult with your tax advisor to determine if your domestic partner and his or her dependent children are your federal tax dependents and to review the tax consequences of electing coverage for a domestic partner. Also, please speak to your tax advisor regarding whether your domestic partner, and his or her children, if any, may qualify for special state tax treatment.

C. Same-Sex Marriage Tax Implications. The US Department of the Treasury and the Internal Revenue Service (IRS) have ruled that same-sex couples, legally married in jurisdictions that recognize their marriages, will be treated as married for federal tax purposes. This ruling applies regardless of whether you live in a jurisdiction that recognizes same-sex marriage or not. If your dependent is a same sex spouse pursuant to the above, his/her benefits are excludable from income.

D. Life Insurance. The value of employer provided life insurance benefits in excess of $50,000 will be imputed income to you as required by the IRS. The actual value of the life insurance depends on your age and the amount of insurance in excess of $50,000. The imputed income may be added to your income each pay cycle or it may be added in a lump sum at the end of the calendar year.

Section 14: Important Disclosures

These notices are available online or via paper, free of charge, upon request to the Plan Administrator.

A. Newborns and Mothers Health Protection Act of 1996. Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law allows the mother's or the newborn's attending provider, after consulting with the mother, to discharge the mother or her newborn earlier than 48 or 96 hours, as applicable. In any case, no plan or issuer may require an authorization for prescribing a length of stay that does not exceed 48 hours (or 96 hours in the case of a cesarean section).

B. Women's Health and Cancer Rights Act. The Federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If you are eligible for mastectomy benefits under

your health coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

- All stages of reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction on the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under your plan, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Coverage is subject to applicable deductibles, copayments and coinsurance payments.

C. Mental Health Parity Act. When required by law, it is the intent of this Plan that health care benefit plans comply with the Federal Mental Health Parity Act (MHPA). In general, the law requires parity of mental health benefits, meaning that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. In addition, the law provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity). The law does not apply to benefits for substance abuse or chemical dependency. Small employers are exempt from this law; any group health plan of any employer who employed an average of between 2 and 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the Plan Year is exempt.

D. Mental Health Parity and Addiction Equity Act. When required by law, this law requires that if a group health plan provides medical/surgical benefits and mental health benefits, the financial requirements (deductibles and co-payments) and any treatment limitations that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. Likewise, if the plan includes substance use disorder benefits, the financial requirements and treatment limitations for substance use disorders must also be equivalent to coverage for other conditions. Small employers are exempt from this law; any group health plan of any employer who employed an average of between 2 and 50 employees during the preceding calendar year is exempt.

E. Qualified Medical Child Support Orders (QMCSO) Provision. A dependent child may become eligible for coverage by way of a QMCSO. If approved, coverage will become effective as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process. The order must clearly identify all the following:

- The name and last known mailing address of the participant
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient)
- A reasonable description of the type of coverage to be provided to the child or the manner in which such coverage is to be determined
- A statement that the child has the right to receive health benefits for which you are eligible under the ERISA Plan for which you are eligible
- The period to which the order applies.

A Plan participant must submit a Medical Child Support Order to the Plan Administrator to determine whether it is qualified, and thus a QMCSO. A copy of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders may be requested from Plan Administrator, at no charge.

F. Patient Protection and Affordable Care Act. Following is an outline of plan provisions implemented in accordance with PPACA. These provisions become effective for group health plans upon renewal after September 23, 2010. Where noted, some provisions may not apply to grandfathered plans. Please refer to Section 3 to determine the grandfathering status of your health plan.

1. Pre-Existing Conditions. This provision applies to all group health plans, regardless of grandfathering status. Health plans may not deny or exclude benefits for pre-existing health conditions.

2. Preventive Care Services. Plans and issuers are required to provide certain preventive services without imposing any cost-sharing (no deductible, no coinsurance, no copay, etc.)

3. Essential Health Benefits. Plans and issuers are prohibited from imposing any annual limits on essential health benefits (as defined under the ACA).

4. Choice of Primary Care Provider. This provision does not apply to grandfathered plans. For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries (such as an HMO plan or Point of Service plan), you have the right to designate any primary care provider who participates in that plan's network and who is available to accept you or your family members. Until you affirmatively make this designation, the health plan designates a primary care provider for you. For children, you may designate a pediatrician as the primary care provider. For individuals seeking gynecological or obstetric care, you do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers or participating health care professionals who specialize in obstetrics or gynecology, contact the health plan (contact information is provided in Section 2 of the Fact Sheet).

5. External Claims Review. This provision does not apply to grandfathered plans. Plans and issuers are required to establish both internal and external review procedures in accordance with state or federal guidelines, as appropriate. Please refer to your health plan certificate of coverage for complete claim appeal and review procedures.

6. Rescission of Coverage. This provision applies to all group health plans, regardless of grandfathering status. Coverage may only be rescinded or cancelled if there is fraud or intentional misrepresentation of fact, as prohibited by plan terms of coverage. Plan must provide 30 days advance notice before coverage can be rescinded. Rescission of coverage will be treated as a claim denial and may be appealed in accordance with the claim appeal procedures of the plan.

7. Medical Loss Ratio Rebates. This provision applies to all group health plans, regardless of grandfathering status. The plan must meet minimum loss ratio standards established by the PPACA. Plans that do not meet the minimum requirement must rebate excess premium to the employer. Your employer is required to apply that rebate equitably for the benefit of all currently enrolled employees. Funds may be used to offset future premium increases or to enhance future plan benefits. Cash rebates will not be issued.

G. No Surprises Act. When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance, or deductible. The following sections present information about the No Surprises Act that is important for you to know.

1. What is Balance Billing? For reference, "balance billing" is also sometimes called "surprise billing." When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

   "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

   "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

2. Balance Billing Protections. You're *never* required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network. You're protected from balance billing for the following services:

   - Emergency services. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You *can't* be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

   - Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

   If you get other services at these in-network facilities, out-of-network providers *can't* balance bill you, unless you give written consent and give up your protections.

3. When Balance Billing is Prohibited. When balance billing isn't allowed, you also have the following protections:

   - You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
   - Generally, your health plan must:
     - ✓ Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
     - ✓ Cover emergency services by out-of-network providers.
     - ✓ Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
     - ✓ Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

4. Additional Information. If you need additional information, believe you've been wrongly billed, or have a complaint, you may contact the CMS office which oversees compliance with the No Surprises Act for more information about your rights under federal law.

   Phone: 1-800-985-3059

   Website: https://www.cms.gov/nosurprises/consumersSubmission of Fraudulent Claims. If you (or any covered dependents) submit fraudulent claims to the plan, your coverage may be terminated.

H. Wellness Programs. These disclosure notifications provide important information about wellness incentives. They apply if a participatory or health-contingent wellness program is offered. Please refer to the Summary Plan Description Fact Sheet to confirm if an applicable wellness program is offered and, thus, whether these wellness disclosures apply to you.

1. Notice Regarding Wellness Incentives. The voluntary wellness program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment (HRA) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which includes testing for common indicators of health and disease.

2. Voluntary. You are not required to complete the HRA or to participate in the biometric testing or other medical examinations. However, employees who choose to participate in the wellness program will receive an incentive for completing the HRA and/or participating in the biometric screening. Only employees who do so will receive the incentive.

3. Incentives. Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes (such as an improvement in blood pressure or cholesterol levels). If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the H.R. team.

4. Information for You. The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

5. Notice of Reasonable Accommodation. Rewards for participating in the wellness program are available to all employees. If you feel you may be unable to meet the standard for a reward under the wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Employer/Plan Sponsor (and, if you wish, with your doctor) to arrange an alternate wellness activity that will qualify for the same reward that is appropriate based on your personal health status.

6. Protections from Disclosure of Medical Information. Employer/Plan Sponsor is required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

I. Genetic Information Nondiscrimination Act of 2008. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, you should not provide any genetic information when responding to requests for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

J. Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP). As required by law, this plan complies with the applicable provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA provisions apply to group health plans only, not all benefit plans offered under this plan.

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, however, you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify,

you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. You should contact your state for further information on eligibility.

ALABAMA – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://www.myalhipp.com Phone: 1-855-692-5447	Website: http://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, Ext 5218
ALASKA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/Medicaid/default.aspx	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
ARKANSAS – Medicaid	**NEW YORK** – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
CALIFORNIA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 1-916-445-8322 Email: hipp@dhcs.ca.gov	Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**NORTH DAKOTA** – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
FLORIDA – Medicaid	**OKLAHOMA** – Medicaid and CHIP
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
GEORGIA – Medicaid	**OREGON** – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162, ext. 2131	Website: http://www.healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
INDIANA – Medicaid	**PENNSYLVANIA** – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid Phone: 1-800-457-4584	Website: http://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462

IOWA – Medicaid and CHIP (Hawki)	**RHODE ISLAND** – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.eohhs.ri.gov Phone: 1-855-697-4347 (Direct RIte Share Line)
KANSAS – Medicaid	**SOUTH CAROLINA** – Medicaid
Website: https://www.kancare.ks.gov Phone: 1-800-792-4884	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
KENTUCKY – Medicaid	**SOUTH DAKOTA** – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspxPhone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dss.sd.gov Phone: 1-888-828-0059
LOUISIANA – Medicaid	**TEXAS** – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov.lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)2447	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
MAINE – Medicaid	**UTAH** – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
MASSACHUSETTS – Medicaid and CHIP	**VERMONT**– Medicaid
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: http://www.greenmountaincare.org/ Telephone: 1-800-250-8427
MINNESOTA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Phone: 1-800-432-5924
MISSOURI – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005	Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022
MONTANA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
NEBRASKA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: http://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
NEVADA – Medicaid	**WYOMING** – Medicaid
Website: https://dhcfp.nv.gov/ Phone: 1-800-992-0900	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Telephone: 1-800-251-1269

To see if any more states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

K. Paperwork Reduction Act Statement. According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Section 15: Conversion Privileges

Life insurance and disability benefits, if applicable, are not subject to the COBRA continuation provisions. Certain life and disability insurance policies include a conversion privilege such that you may be able to continue a portion of your coverage after termination of employment or after you are no longer eligible for the group policy; however, this provision is not universally included in all contracts. In addition, conversion provisions are often limited in the coverage that may be continued and/or the circumstances under which coverage conversion may be elected. Generally, if any conversion privilege is available, it must be elected in writing within 30 days of the termination of coverage. For specific requirements and coverage continuation restrictions regarding conversion privileges, please refer to your Certificate of Coverage.

Section 16: Continuation Coverage (COBRA)

When required by law, our benefit program complies with the Federal COBRA legislation (Public Law 99-272, Title X) which requires continuation rights for health expense coverage explained in this notice. If the Employer/Plan Sponsor is subject to the law and you have health expense coverage under their benefit plan, and if that coverage would end for a reason listed below, you may be able to continue the coverage under the Employer/Plan Sponsor's benefit plan for a specified period of time. In general, Employers/Plan Sponsors are subject to COBRA if they employed 20 or more persons for more than 50% of the business days during the prior calendar year. Employed persons are defined as any persons who appeared on the payroll for full or part time work.

It is important that you, your covered spouse, and any covered child(ren) over the age of 18 read this COBRA section carefully as it outlines both your rights and your responsibilities under the COBRA law.

A. What is COBRA Coverage. COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called Qualifying Events) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your

rights beyond COBRA's requirements. The coverage that is provided to you under COBRA is the same coverage that the Plan provides to similarly situated employees or participants under the Plan who are not receiving COBRA coverage. As a COBRA qualified beneficiary, you will have the same rights under the Plan as other participants, including Open Enrollment and special enrollment rights.

B. Coverages Subject to COBRA. COBRA applies to group health coverage. This includes medical, dental, vision, EAP, and health FSA plans. COBRA does not apply to any other benefits offered under the Plan (such as Life, AD&D, or disability benefits).

C. Who Can Be Covered? Once a Qualifying Event occurs, COBRA coverage can be continued for you, your spouse, or any dependents that were covered under the plan at the time of the Qualifying Event. It can also become available to your ex-spouse in the event of a divorce and to dependent children who lose coverage for certain specified situations. The federal COBRA law does not recognize domestic partners or children of domestic partnerships as your spouse or dependents; thus, they are not considered COBRA qualified beneficiaries. However, some plans permit such individuals to continue group health coverage in a COBRA-like fashion, but without all the rights bequeathed to formal qualified beneficiaries. If you take a leave of absence that qualifies under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your covered dependents, if any) will have the right to elect COBRA if:

   - You were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
   - You lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

   In the event of an FMLA leave as outlined above, COBRA coverage will begin on the earliest of the following to occur:

   - When you definitively inform Employer that you are not returning at the end of the leave; or
   - The end of the leave, assuming you do not return to work.

D. What is a Qualifying Event? A Qualifying Event is an event that causes you or your dependents to lose health benefits. The law defines Qualifying Events as a termination of employment (voluntary termination or involuntary termination, except in the case of termination for gross misconduct), reduction in work hours, death of employee, divorce or legal separation, or a child no longer satisfying eligibility requirements of a plan (for example, when a child no longer qualifies as a dependent because of age).

E. Subsequent Qualifying Event. If a Qualified Beneficiary elects COBRA coverage and then subsequently experiences what would have been a Qualifying Event if still active under the Plan, that subsequent Qualifying Event may allow for a further extension of COBRA coverage. You must notify Employer/Plan Administrator within 30 days of the subsequent Qualifying Event or forfeit any potential rights to further extend COBRA coverage.

F. When Continued Coverage Applies. Following is an outline of when continuation coverage applies based on the type of Qualifying Event.

   1. Employee or Dependent of Employee. If you are an *employee or the dependent of an employee* you may elect up to 18 months of continued health expense coverage for yourself if you lose coverage due to voluntary or involuntary termination of employment (except for gross misconduct) or reduction in work hours to less than the minimum needed to remain covered by the plan; or if an employee (or spouse or dependent child of an employee) is enrolled on the group health plan the day before the first day of a leave defined under the Family Medical Leave Act (FMLA), or becomes enrolled during the FMLA leave, and the employee does not return to employment at the end of the FMLA leave.

   2. Employee's Spouse or Dependent Child. If you are an *employee's spouse or dependent child*, you may also elect up to 36 months of continued health expense coverage for yourself if you lose coverage due to the employee's death, or divorce or legal separation, or no longer qualifying as a dependent child under the contract *(dependent children only)*.

   3. Covered Retiree. If you are a *covered retiree* and your Employer/Plan Sponsor commences a bankruptcy proceeding, you and your dependents are entitled to a lifetime of continuation coverage.

Upon the retiree's death, dependents are entitled to up to 36 months of coverage from the date of death.

4. Domestic Partner or Child or Domestic Partner. If your plan covers *domestic partners* or *children of domestic partners*, those individuals are generally not eligible for COBRA continuation coverage unless they qualify as IRS dependents under IRC 152(a)(9). Your Employer/Plan Sponsor may have negotiated COBRA rights for your covered domestic partners; please check with your Employer/Plan Sponsor for full details.

G. What Coverage is Continued. COBRA continuation rights apply only to health coverage as defined by the law (typically medical, dental, vision, employee assistance programs, health reimbursement accounts, and health care spending accounts). Any other type of coverage provided by the employee benefit plan is not included in these continuation rights. Your continued health coverage will be the same as the health coverage provided by the plan for similarly situated employees or dependents who have not had a Qualifying Event. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. Thus, any future plan or rate changes affecting the group plan will affect your continued coverage as well. Continuation is available only for coverages that you or your dependents were enrolled in at the time of the Qualifying Event. However, you may enroll new dependents acquired while you are covered under COBRA in the same manner as similarly situated employees. A child born to or placed for adoption with an employee covered under COBRA is considered a Qualified Beneficiary, provided the child is enrolled under COBRA, and may have additional COBRA extension rights. The covered employee or family member must notify the plan administrator within 30 days of the birth or adoption, in order to enroll the child on COBRA.

H. How Long Can Coverage Continue. There are three different potential durations of COBRA coverage, depending on the type of Qualifying Event.

1. 18 Month Duration. Coverage continuation based on a Qualifying Event of termination of your employment or a reduction in your work hours is available for up to 18 months.

2. 36 Month Duration. Coverage continued by virtue of a Qualifying Event of death of the employee, divorce or legal separation of the employee, or loss of dependent child eligibility is available for up to 36 months.

3. Extensions Beyond 18 Months. There are several additional circumstances when you can potentially continue COBRA beyond 18 months.

   - If you become entitled to Medicare and, within 18 months, experience a termination of employment or reduction in work hours resulting in a loss of coverage, your covered dependents may elect to continue coverage for the period ending 36 months after the date you became entitled to Medicare.
   - If any Qualified Beneficiary (employee, spouse, or child) is determined to have been disabled according to the Social Security Administration before the date of the original Qualifying Event (termination of employment or reduction of work hours) or within the first 60 days of COBRA coverage, all Qualified Beneficiaries may extend COBRA coverage for an additional 11 months, up to 29 months total, from the date of the Qualifying Event. Non-disabled family members on COBRA coverage may also be eligible for this extension. To receive such an extension, your disability must have started at some time before the 61st day after the Qualifying Event date and must last until the end of the period of COBRA coverage that would have been available without the disability extension (generally 18 months). You must notify the plan administrator of your disability determination before the end of the initial 18-month COBRA period and within 60 days of the Social Security determination date. If Social Security makes a determination of disability prior to the date of the Qualifying Event, then you must notify the plan administrator within 60 days of the date of the Qualifying Event.
   - The Cal-COBRA extension provides up to 36 months of medical coverage from the date Federal COBRA coverage began. You may be eligible for this extension provided you are entitled to less than 36 months of continuation coverage under Federal COBRA. The premium charged under this Cal-COBRA extension may be up to 110% of the total cost. You must contact your insurance carrier directly to inquire about the availability of this option. Note this extension applies to medical coverage only and self-funded plans are not subject to this extension.

I. When Does Coverage End. Within the limits described above, continuation coverage will terminate on the earliest of the following dates. COBRA coverage can be terminated before the maximum coverage period expires. In no event can coverage continue beyond 36 months from the original Qualifying Event date:

1. When no health coverage is provided by the Employer/Plan Sponsor for any employees; or
2. When premium payment for your continued coverage is not made in the prescribed time limit; or
3. When, after electing COBRA, you become a covered employee and/or dependent under another group health plan; or
4. When, after electing COBRA, you first become entitled to Medicare; or
5. When you or your dependents have extended coverage up to 29 months due to a disability and there has been a final determination by the Social Security Administration that you are or your dependent is no longer disabled. (You are required to notify the Employer/Plan Sponsor within 60 days of the Social Security determination.)

In no event will COBRA continuation coverage last beyond 36 months from the original Qualifying Event date that enabled election of continuation coverage.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You must notify the Employer/Plan Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions have been exhausted or satisfied). The Employer, the insurance carriers, and service providers may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice. In addition, you must notify the Employer, in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See 29-Month Qualifying Event.

In the event a partial premium payment is made that results in a significant shortfall in the total premium due, coverage will be terminated retroactively with no opportunity for reinstatement, unless sufficient premium is postmarked no later than the end of the payment due grace period. A premium shortfall is insignificant if it is not more than the lesser of $50 or 10% of the full premium due.

J. Making a COBRA Election. A COBRA election notice will be provided to qualified beneficiaries/individuals eligible for continuation at the time of the Qualifying Event. Under federal law, you must elect COBRA coverage within 60 days from the later of: (a) the date your coverage would terminate due to the Qualifying Event; or (b) the date on which the Qualified Beneficiary is provided the notice and election materials. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA. Assuming timely election is made, your coverage effective date will be retroactive to the date of the Qualifying Event or the date of the termination of coverage. If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

K. Separate Elections. Each qualified beneficiary/individual eligible for continuation has an independent election right for COBRA (or COBRA-like) coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries / individuals eligible for continuation may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary/individual eligible to continue coverage who is eligible for COBRA continuation coverage/COBRA-like benefits is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child or individual eligible to continue coverage may elect different coverage than the employee elects. A covered employee or spouse can also make the COBRA

election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage. In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

L. Interaction with Other Group Health Plan or Medicare. Qualified Beneficiaries may be enrolled in both COBRA and another group health plan or Medicare at the same time, provided the other group health plan or Medicare coverage was elected prior to, or on the same date as the COBRA election. Having coverage provided by more than one entity will affect which entity is the primary or secondary payer of medical claims. Medicare Secondary Payer (MSP) rules will apply if you are enrolled in, eligible to enroll, or if you waived enrolling in any part of Medicare. In other words, COBRA coverage will generally be the secondary payer of claims. Please check with your health plan to determine which plan is the primary and secondary payer during your COBRA period.

M. Continuation beyond COBRA. In some instances, you may be eligible to continue health coverage beyond COBRA by conversion to an individual plan. A conversion privilege can be exercised, subject to all the rules that would apply to conversion privileges. However, coverages and costs will not be the same as your COBRA coverage.

N. What Does It Cost. You are required to pay the entire cost of your continued health coverage. Your cost would be the amount of the insurance premium (or the actuarial equivalent premium for a self-funded plan) including any part formerly paid by the Employer/Plan Sponsor, plus an administrative expense fee of 2% of the premium. (In the case of extended COBRA eligibility due to disability as specified above, the administrative fee increases to 50% of the premium after the 18th month through the 29th month.) The amount of your COBRA premiums my change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

O. When Are Premiums Due. If you decide to elect continued coverage, you have 45 days from your election date to pay all retroactive and current premiums. Your coverage will be retroactively reinstated once the premium(s) and all required re-enrollment forms are received. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, premiums are due on the first of each month in which the payments apply and must be paid within a grace period of 30 days for regularly scheduled premium payments. All premiums must be paid or postmarked on or before the end of the 30-day grace period. If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

P. Formal COBRA Notice. In the event of a termination of employment, reduction of work hours, or death, you need not take any immediate action to request COBRA information or a COBRA election notice. You should automatically receive COBRA election materials at your home address via the U.S. Postal Service. The COBRA election materials will outline coverage costs and options available to you and your covered dependents. If you wish to elect coverage, you *must* follow the guidelines and timelines detailed in the COBRA election materials.

Q. Responsibility to Keep Plan Informed of Address Changes. All COBRA correspondence and notices will be sent to your last known home address. In order to protect your and your family's rights, you should keep Employer informed of any changes in your and your family members' addresses. If your address has changed, you must notify your employer so that notification may be sent to you. It will not be Employer's responsibility if you do not receive a COBRA notice or other COBRA correspondence because of an address problem or because of a problem with receiving your mail. If you do not receive notification as described herein, it is your responsibility to notify Employer so that duplicate notifications may be forwarded to you and/or your dependents.

R. Responsibilities in the Event of Divorce or No-Longer Eligible-Dependent Child. In the event of a divorce, legal separation or dependent child who no longer qualifies as an eligible dependent, it is your responsibility to formally notify the Employer/Plan Sponsor. Our plan guidelines dictate that this notification *must* be received in writing on a COBRA Notification of Qualifying Event form as specified by

the Plan Administrator. This form must be provided to Employer or postmarked to the Employer/Plan Sponsor within 60 days of the date of the Qualifying Event or loss of coverage, whichever is later. If this notification is not provided within the 60 day window, the impacted dependents will forfeit their right to COBRA continuation coverage.

S. Medicare and Other Coverage. Qualified beneficiaries/persons permitted to continue coverage who are entitled to elect COBRA benefits may do so even if they have other existing group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. If you elect coverage under COBRA, you must notify Employer/Plan Sponsor if any qualified beneficiary/person has become entitled to Medicare (Part A, Part B or both) or become covered under another group health policy, and, if so, the effective date of such coverage. Coverage under such plans is considered a disqualifying Event under COBRA.

T. Other Options Available. You may have other options available to you when you lose group health coverage. Following is an overview of some of the options that you may consider instead of enrolling in COBRA coverage. You have a Special Open Enrollment option to elect coverage under any of these options at the time your coverage terminates and when you are initially eligible to continue your coverage under COBRA. Some of these options may cost less than COBRA continuation coverage, so you will want to carefully review all your options.

1. Other Group Sponsored Coverage. You may enroll in other group health coverage (such as a spouse' plan). If you request enrollment within the special Open Enrollment window, you may elect coverage under a spouse's plan even if it is not the regular annual Open Enrollment time for that plan.

2. Medicaid. If you qualify for Medicaid coverage, you may enroll by contacting your local Medicaid office.

3. Conversion Coverage. In some circumstances/states conversion coverage is available. Refer to the details in Section 13 of this document.

4. Health Insurance Marketplace. You may purchase health insurance through an online health insurance Exchange (sometimes referred to a Marketplace) in lieu of electing COBRA or after COBRA coverage ends. Coverage through the Marketplace may cost less than COBRA (depending on your age and whether you qualify for a federal premium subsidy). Subsidies may be available if your household income is between 138% and 400% of the federal poverty level. In certain circumstances your copay and coinsurance amounts may also be lower if you qualify for a premium subsidy. You have a "special enrollment" period 60 days from the date you lose your employer's group health coverage to enroll in the Marketplace. After 60 days your special enrollment period will end, and you may not be able to enroll until a Marketplace "Open Enrollment" which typically starts in the fall for coverage starting as early as January 1st. However, if you elect COBRA and your coverage ends involuntarily, such as exhausting the maximum coverage period or if the employer no longer offers group health plan coverage, you may be able to enroll in the Marketplace through the special enrollment period.

5. Individual Coverage. Individual private health insurance may also be purchased directly through an insurance carrier. The coverage and premiums will be the same as the options available through the Marketplace. However, if you qualify for a federal premium subsidy, you may only access that subsidy if you purchase your insurance on an Exchange (Marketplace).

U. Submission of Fraudulent Claims. As is the case with active employees, if you (or any covered dependents) submit fraudulent claims to the plan while you are covered under COBRA, your coverage may be terminated.

V. COVID Relief. In response to COVID-19, the CARES Act and the IRS/DOL have provided a temporary extension of the deadline for COBRA premium payments. The extended deadline for COBRA premium payments is the earlier of the following:

- 60 days after the end of the national emergency (the "Outbreak Period")
- One year after the initial deadline for any given individual (but not beyond the end of the Outbreak Period)

Each plan participant may activate an extended deadline which will begin from the point of the normal deadline (up to a maximum of one year). However, when the national emergency formally ends, all personalized deadlines will shorten to 60 days after the end of the national emergency.

Section 17: Leaves of Absence

A. Military Leave. Congress enacted the Uniformed Services Employment and Reemployment Act (USERRA) legislation to protect the rights and benefits of employees who leave their civilian jobs to perform service in the military. In general, USERRA establishes employment and reemployment rights and benefits protections for returning military personnel and prohibits discrimination by employers against veterans, members of the military services and applicants for military service. USERRA applies to all employers, regardless of size, including foreign employers doing business in the United States, and covers full-time, part-time, seasonal, and temporary employees. As required by law, our benefit program complies with the Federal USERRA legislation, which requires continuation rights for health expense coverage.

If you take a military leave, whether for active duty or for training, you are entitled to extend your health coverage for up to 24 months as long as you give your Employer advance notice of the leave, unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable. If your coverage would otherwise end because of your military tour of duty, you and/or your covered dependents may be able to continue that coverage under the Employer/Plan Sponsor's benefit plan for up to 24 months while you continue to be in military service.

USERRA coverage is similar to COBRA continuation coverage in that the employee must make an election for coverage and may be required to pay up to 102% of the full premium for the coverage elected during the leave. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to the benefit plan coverage when you are reemployed, generally without any waiting period or exclusions (for example, pre-existing condition exclusions), except for service-connected illnesses or injuries. For military service of less than 31 days, health care coverage is provided as if the service member had remained continuously employed.

Your total leave, when added to any prior periods of military leave from Employer cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit – including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends. If the entire length of the leave is 30 days or less, you will not be required to pay any contributions. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

If you take a military leave, but your coverage under the Plan is terminated – for instance, because you do not elect the extended coverage – when you return to work at Employer you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverage. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services. If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave, you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See COBRA section.) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and

USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

B. Family Medical Leave Act (FMLA). The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. When required by law, our benefit program will comply with the Family and Medical Leave Act (FMLA). This law provides continuation rights for health expense coverage assuming the Employer/Plan Sponsor meets certain criteria during the preceding calendar year and provided that you have met the eligibility criteria for the law. If the Employer/Plan Sponsor is subject to the law and you are covered under health benefit plans, you may be able to continue the coverage under our benefit plan for a certain period of time.

   If you take an FMLA leave, you may continue your group health coverage for you and any covered dependents as long as you pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the employer sponsored portion of the cost of group health coverage will continue to be paid by Employer. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you continue to contribute your portion of the premium during the leave. In either case, you are responsible for paying your monthly contribution for your benefits plans during any leave. In some cases, this will require payment during your leave on an after-tax basis. You also have the option to suspend your health coverage during the leave. If you do not make arrangements to pay for your contribution, your benefit coverage may be terminated.

   If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections. Any coverage that is terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period. If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions. If you do not return to work at the end of your FMLA leave you may be entitled to COBRA continuation coverage.

   To the extent required under the FMLA, and the regulations thereunder, an employee on leave of absence under the FMLA may choose to continue coverage under the Plan by making the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with the FMLA. In addition, to the extent required under and in accordance with the FMLA and the regulations thereunder, any Employer/Plan Sponsor contributions made under the terms of the Plan shall continue to be made on behalf of an employee on an FMLA leave.

C. Other Personal Leaves of Absence. In certain circumstances, if you have a personal leave of absence that is approved by Employer, certain benefits may be continued, but only to the extent that Employer has a standing corporate policy that outlines such continuation, that policy is in writing, and that policy is approved in advance by the insurance carrier. Otherwise, benefits will not be continued in the event of a non-USERRA, non-FMLA leave of absence.

Section 18: Claims and Appeals Procedures

The determination of whether a claim falls under the procedures for health claims or under the procedures for disability and other non-health claims is based on the nature of the specific claim or benefit, not the characterization of the plan under which the claim is made or the benefit offered.

A. Filing a Claim. The claims filing procedures are set forth in the Certificates of Coverage for each benefit plan. While furnished separately, these booklets accompany this SPD and are provided automatically, without charge. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Plan Administrator. When you submit a claim, the insurance company will be responsible for reviewing the claim and determining how to pay the claim on behalf of the Plan. As described in the Evidence of Coverage documents, there may be other reasons that a claim for benefits is not paid (or 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.

B. Disability and Non-Health Claims. If any portion of your disability-based claim is denied, you will receive a written notice of denial containing an explanation of the reasons for such denial. You may request a review of any denied claim. For a detailed description of the required procedures for filing claims and of the appeals procedures for any denied claims, please refer to the Certificates of Coverage for each of the separate Benefit Plans. If you cannot locate your plan Certificate, you may request a duplicate from the Plan Administrator identified on Part 1: Fact Sheet of this Summary Plan Description.

C. Health Claims. Under PPACA, DOL and ERISA regulations, claimants are entitled to full and fair review of any claims made under the Plan. As required by law, the Plan recognizes four categories of health benefit claims as described below. Each of the different types of claims have different timing requirements.

1. Urgent Care Claims. Claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. Individuals in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process.

2. Pre-Service Claims. "Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving Preauthorization or referral requirements).

3. Post-Service Claims. Claims involving the payment or reimbursement of costs for health care that has already been provided.

4. Concurrent Care Claims. "Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" – a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on the following:

- An individual being ineligible to participate in the Plan
- Utilization review
- A service being characterized as experimental or investigational or not medically necessary or appropriate
- A concurrent care decision

For a full description of the required procedures for filing claims and of the appeals procedures for any denied claims, please refer to the Certificates of Coverage for each of the separate Benefit Plans. Your Certificates of Coverage also provide a full description of the procedures for appealing an adverse benefit decision, for requesting internal review of an adverse benefit decision, as well as the procedures required to request an external review of any adverse benefit decision.

D. Acts of Third Parties. When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery. Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury. By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree to the following rights of the Plan:

- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds. You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it. Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds. The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict, or other amount that you, your guardian or other representatives receive
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian, or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan. If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

E. Recovery of Overpayment. Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

F. Non-assignment of Benefits. Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and Employer to the extent of such payment.

G. Misstatement of Fact. In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

H. Pre-existing Conditions Limitations – Health Plan Coverage. Effective January 1, 2014, Health Care Reform prohibits Plans from applying a pre-existing condition limit on eligible employees and dependents. Pre-existing Conditions Limitations for individuals under age 19 have been prohibited since the first Plan Year beginning on or after September 23, 2010.

I. Pre-existing Conditions Limitations – Non-Health/Disability Plan Coverage. The prohibition on pre-existing conditions for health plan coverage does not apply to disability insurance coverage. Disability plans typically have a pre-existing condition exclusion that will exclude from coverage any disability that is caused or contributed to by a pre-existing condition. This includes both coverage provided at your initial effective date and any increases in coverage thereafter. Refer to your Certificate of Coverage for full details.

Section 19: Use and Disclosure of Protected Health Information (HIPAA Privacy Rule)

The HIPAA Privacy Rule applies to all employer sponsored health plans. However, some plans that have limited access to Protected Health Information may elect more streamlined compliance methods which allow for less complicated compliance procedures. This is referred to as Covered Entity status, which is either Incidental PHI or Detailed PHI for the Privacy Rule. Some of the processes outlined below are not required of Incidental PHI entities, however, the same obligation to maintain the confidentiality of Protected Health Information applies to the Covered Entity. The Covered Entity status is identified in Section 2: Plan Information which can be found in Part #1: Fact Sheet of this Summary Plan Description. The Fact Sheet accompanies this Summary Plan Description Disclosure Document.

The following section describes how medical information about you and your dependents may be used and disclosed and how you can obtain access to this information. Employer is required by law to maintain the privacy of "Protected Health Information." Protected Health Information (PHI) includes any identifiable health information obtained from the Plan by you or others that relates to your physical or mental health, the health care you have received, or payment for your health care. This information includes almost all individually identifiable health information held by this Plan, whether received in writing, in an electronic medium, or as a verbal communication.

A. Duties with Respect to Protected Health Information. The following information addresses the uses and disclosures the Plan may make of your protected health information. It's important to note that these rules apply to the Plan, not as an employer - that's the way the HIPAA rules work. If you participate in an insured plan or an HMO option, you will also receive a privacy notice directly from the Insurer or HMO. The Plan must comply with the general HIPAA provisions of this notice, although Plan Sponsor reserves the right to change the terms from time to time and to make any revised notice effective for all PHI that the Plan maintains. You can always request a copy of the most current privacy notice from the Privacy Official.

B. General Disclosure Rule. The Plan and any Contract Administrator, health insurance issuer or business associate servicing the Plan will disclose Protected Health Information to the Employer/Plan Sponsor only to permit the Employer/Plan Sponsor to carry out plan administrative functions for the Plan consistent with the requirements of the HIPAA Privacy Rule ((45 CFR §164.501). Any disclosure to and use by the Employer/Plan Sponsor of Protected Health Information will be subject to and consistent with this Section 19.

C. Participant Disclosure. This Plan complies with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have questions about the privacy of your health information

under the Plan, please contact the Plan Administrator or the Privacy Officer named in the Employer/Plan Sponsor's Privacy Policy.

D. In General. The HIPAA Privacy Rule generally allows the use and disclosure of your health information without your permission (known as authorization) for purposes of health care treatment, payment activities, and health care operations (as outlined below in more detail). It is likely some of the examples noted below are inapplicable because they don't generally apply to employer sponsored welfare benefit plans. Regardless, please find an overview of the uses and disclosures permitted without authorization:

1. Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

2. Payment includes activities by the Plan, other plans, or providers to obtain premiums, make coverage determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

3. Health Care Operations include activities by this Plan for plan administration purposes (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purpose. The HIPAA Privacy Rule also prohibits the use of "genetic information" for "underwriting purposes," with the exception of the underwriting of long-term care policies.

E. Employer/Plan Sponsor's Obligations. Employer/Plan Sponsor is in compliance with the following practices regarding using/not using or disclosing/not disclosing your PHI.

1. Not use or further disclose the information other than as permitted or required by this Section, the Plan, or such other plan documents or as Required by Law, which shall have the same meaning as the term "required by law" under the HIPAA Privacy Rule.

2. Restrict sharing of information between the Plan and Employer/Plan Sponsor to the following circumstances:
   - To provide coverage under the plan or for modifying, amending, or terminating the Plan. Summary Health Information is information that summarizes participants' claims information from which names and other identifying information have been removed.
   - The Plan may disclose to Employer information on whether an individual is participating in the Plan or has enrolled or dis-enrolled in an insurance option offered by the Plan.

3. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree, by signing a Business Associate Agreement, that the agent agrees to implement reasonable and appropriate privacy and security measures to protect any Protected Health Information received or created to a level that is equivalent to the protections required by HIPAA of the Covered Entity.

4. Not use or disclose the information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer/Plan Sponsor. In addition, you should know that Employer cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Employer from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, any sick leave or PTO program, or workers compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses and disclosures provided for in this Section or the Plan of which it becomes aware. Report to the Privacy Officer any security incident of which it becomes aware.
6. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (including electronic Protected Health Information) created, received, maintained, or transmitted.
7. Make available Protected Health Information (including electronic Protected Health Information) to Plan Participants upon their request of Protected Health Information or electronic Protected Health Information disclosures in accordance with the Privacy Rule.
8. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with the Privacy Rule.
9. Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule and document such disclosures of Protected Health Information.
10. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information or electronic Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA.
11. If feasible, return or destroy all Protected Health Information received from the Plan that Employer/Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
12. Ensure that adequate separation between the Plan and Employer/Plan Sponsor, is established pursuant to the Privacy Rule. Certain employees, equivalently titled employees or classes of employees, or other workforce members under the control of the Employer/Plan Sponsor may be given access to Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan. The specific classes of employees or workforce members who may have access to Protected Health Information are identified in the Employer/Plan Sponsor's separate Privacy Policy. The Plan Administrator or the Privacy Official named in the Employer/Plan Sponsor's Privacy Policy can provide information on the specific employees or classes of employees who have access to Protected Health Information. The list provided in the Privacy Policy shall include every class of employees or other workforce members under the control of the Employer/Plan Sponsor who may receive Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The classes of employees or other workforce members identified in the Employer/Plan Sponsor's Privacy Policy will have access to Protected Health Information only to perform the plan administration functions that the Employer/Plan Sponsor provides for the Plan.
13. The classes of employees or other workforce members identified in the Employer/Plan Sponsor's Privacy Policy will be subject to disciplinary action and sanctions, including termination of employment or affiliation with Employer/Plan Sponsor, for any use or disclosure of Protected Health Information in breach or violation of or noncompliance with the provisions of this Section. Employer/Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant or beneficiary, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.
14. The classes of employees or other workforce members identified in the Employer/Plan Sponsor's Privacy Policy will be subject to disciplinary action and sanctions, including termination of employment or affiliation with Employer/Plan Sponsor, for any use or disclosure of Protected Health Information in breach or violation of or noncompliance with the provisions of this Section. Employer/Plan Sponsor will promptly report such breach, violation, or noncompliance to the Provide participants in the Plan with such notice of privacy practices as required pursuant to the Privacy Rule.

F. How Your PHI May Be Used/Disclosed by Employer. Your Employer may use or disclosure your health information to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. "Summary health information" is information that summarizes participants' claims information, from which names and other identifying information have been removed.

G. Other Allowable Uses or Disclosures of Your Health Information. Following is additional information about how and when your PHI may be shared and/or disclosed outside of the Plan and/outside of Employer. In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made - for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan is allowed to use or disclose your health information without your written authorization for the following activities:

1. Workers' Compensation. Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws.
2. Necessary to Prevent Serious threat to Health or Safety. Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
3. Public Health Activities. Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
4. Victims of Abuse, Neglect or Domestic Violence. Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk).
5. Judicial and Administrative Proceedings. Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).
6. Law Enforcement Purposes. Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises.
7. Decedents. Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
8. Organ, Eye or Tissue Donation. Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantations after death.
9. Research Purposes. Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project.
10. Health Oversight Activities. Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.

11. Specialized Government Functions. Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
12. HHS Investigations. Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule.
13. Specialized Government Functions. Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
14. Disclosures Required by Law. Disclosures of your health information as required by law provided such use or disclosure complies with and is limited to the relevant requirements of such law.

Except as described in this HIPAA section, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

F. Your Individual Rights. You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitation, as discussed below. This section describes how you may exercise each individual right.

1. Right to request restrictions and the Plan's right to refuse. You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses and disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief. If you want to exercise this right, your request to the Plan must be in writing. The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to restriction.
2. Right to receive confidential communication of your health information. With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial. If you want to exercise your right, your request to the Plan must be in writing. Within 90 days of receipt of your request, the Plan will provide you with one of the following:
    - The access or copies you requested
    - A written denial that explains why your request was denied and any rights you may have to have denial reviewed or file a complaint
    - A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

    The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request. You may request an electronic copy of your protected health information. If Plan Sponsor can readily

produce it, then it must be supplied to you. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies, if any, must be reasonable, based on the Plan's cost and identify separately the labor for copying PHI (if any).

3. Right to amend your health information that is accurate or incomplete. With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created that information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings). If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of the following actions:
   - Make the amendment as requested
   - Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
   - Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.
4. Right to receive an accounting of disclosures of your health information. You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below. You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in the following circumstances:
   - For treatment, payment, or health care operations
   - To you about your own health information
   - Incidental to other permitted or required disclosures
   - Where authorization was provided
   - To family member or friends involved in your care (where disclosure is permitted without authorization)
   - For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
   - As part of a "limited data set", (health information that excludes certain identifying information).

   In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.
5. Right to obtain a paper copy of this notice from the Plan upon request. You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.
6. Right to be notified if you are affected by a breach. You have the right to be notified should you be affected by a breach of unsecured protected health information. The 2013 Amendments modify this definition by providing that an impermissible use or disclosure of PHI is presumed to be a breach, unless it can be demonstrated that there is a low probability that PHI has been compromised based upon a four-part risk assessment that will be conducted by our HIPAA Privacy and/or Security Official(s).

H. Changes to the information in this HIPAA Section. The plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies, as described here at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this SPD, you will be provided with a revised privacy notice. The revised notice will either be hand delivered or mailed via first class to your residence at the address on file.

I. Complaints. If you believe your privacy or security rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may contact our Privacy and/or Security Official(s). You won't be retaliated against for filing a complaint. To file a complaint, please contact the HIPAA Official.

J. Survival. The provisions of this Section shall survive the expiration or termination of the Plan or this Section for any reason.

K. Compliance with State and Federal Law. Employer/Plan Sponsor shall comply, and shall ensure that the Plan complies, with HIPAA and other applicable state and federal confidentiality, privacy, and security laws.

L. Interpretation. Any ambiguity in the Plan or this Section or in determining controlling provisions shall be resolved in favor of an interpretation that permits the parties to comply with HIPAA and other federal and state laws and that provides the greatest privacy protections for Protected Health Information. In the event of an inconsistency between the provisions of this Section and mandatory provisions of HIPAA, the HIPAA provisions shall control.

Section 20: Security of Protected Health Information (HIPAA Security Rule)

This Section applies to all Plan Sponsors. For the purpose of the HIPAA Security Rule, all Plan Sponsors are required to provide Detailed PHI Security measures as identified in Section 2: Plan Information which can be found in Part #1: Plan Fact Sheet of this Summary Plan Description. The Part #1: Plan Fact Sheet accompanies this Summary Plan Description Disclosure Document.

A. Participant Disclosure. This Plan complies with the Security Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have questions about the privacy or security of your health information under the Plan, please contact the Plan Administrator or the Privacy/Security Officer named in the Employer/Plan Sponsor's Privacy Policy and reiterated in Part 1 (the Fact Sheet), Section 2 of this Summary Plan Description.

B. Employer/Plan Sponsor's Obligations. Employer/Plan Sponsor certifies compliance with the following:

1. Reasonable Safeguards. Develop, implement, and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Protected Health Information that it creates, receives, maintains, or transmits in an electronic format (with the exception of enrollment or disenrollment information and any Summary Health Information) on the Plan's behalf, and it will ensure that any of its agents or subcontractors to whom it may provide such electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect such information.

2. Report Incidents. Report to the Plan any use or disclosure of the information that is inconsistent with the uses and disclosures provided for in this Section or the Plan of which it becomes aware. Report to the Security Official any security incident of which it becomes aware.

3. Notification of Breach. Follow the required notification procedures required by the Security Rule in the event of a breach of unsecured Protected Health Information which compromises the security of such information.

4. Protect PHI. Ensure the availability, integrity, and confidentiality of electronic PHI. Protect against reasonably anticipated threats or hazards to the security of electronic PHI. Protect against reasonably anticipated impermissible uses or disclosures of electronic PHI. Ensure compliance by members of the entity's workforce.

C. Survival. The provisions of this Section shall survive the expiration or termination of the Plan or this Section for any reason.

D. Interpretation. Any ambiguity in the Plan or this Section or in determining controlling provisions shall be resolved in favor of an interpretation that permits the parties to comply with HIPAA and other federal and state laws and that provides the greatest privacy protections for Protected Health Information. In the event of an inconsistency between the provisions of this Section and mandatory provisions of HIPAA, the HIPAA provisions shall control.

Section 21: Prescription Coverage and Medicare Part D

(The font in this section is intentionally larger to comply with legal guidelines.)

Please read this section carefully. This notice has information about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

A. Rx Coverage Availability. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

B. Rules and Penalties. The rules and potential penalties vary for creditable and non-creditable coverage. Please refer to the Plan Information in Section 3 (Benefit Information) of this Summary Plan Description to see whether your plan is Creditable or Non-Creditable under Medicare.

Individuals covered by both Medicare and a group health plan should carefully evaluate their prescription drug needs to determine when and whether to purchase additional coverage under a Medicare Prescription Drug Plan.

That decision will depend heavily upon whether or not your group health plan offers prescription drug benefits that are "creditable" under Medicare. To be considered "creditable", the prescription drug benefit of your health plan must be expected to pay, on average for all plan participants, at least as much as the standard Medicare prescription drug coverage would pay.

A. For Plans with Creditable Prescription Drug Coverage. Because your existing coverage is on average at least as good as the standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage, so long as you apply for Medicare prescription drug coverage within 63 days of terminating your creditable group sponsored plan. Each year, you will have the opportunity to enroll in a Medicare prescription drug plan between October 15th and December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a Medicare drug plan. If you drop your

employer sponsored coverage and enroll in a Medicare prescription drug plan, you may not be able to get the employer sponsored coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Information about your employer's group health plans and prescription drug benefits is available in your health plan certificate. In addition to prescription drugs, your current health plan coverage pays for other health expenses, and you may lose your current health and prescription drug benefits if you choose to drop your employer sponsored coverage in favor or enrolling in Medicare and a Medicare prescription drug plan.

B. For Plans with **Non-**Creditable Prescription Drug Coverage. Because your existing coverage is, on average for all plan participants, **not** expected to pay out as much as the standard Medicare prescription drug coverage would pay, you need to make some important decisions regarding your prescription drug coverage. Most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from the employer plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

   Starting January 1, 2006, prescription drug coverage became available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

   If you did not purchase Medicare prescription drug coverage or equivalent coverage before May 15, 2006, you may have to pay a higher premium if you join later. You will pay that higher premium as long as you have Medicare prescription drug coverage.

C. For all Medicare Eligible Individuals

   1. Periodic Notice. Medicare eligible individuals are entitled to notice regarding their rights under Medicare before each annual enrollment period. You will also receive notification if the prescription benefit under your group health plan ends or changes so that is no longer creditable or becomes creditable. You may request a certificate of Medicare prescription drug plan creditability from the plan sponsor at any time.

   2. Premium Surcharge for Late Enrollment. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your Medicare base beneficiary premium will go up at least 1% per month for every month that you did not have that coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. In addition, you may have to wait until the following October to join.

   3. Annual Enrollment Period for Medicare Prescription Drug Plans. Generally, you can only join a Medicare prescription drug plan between October 15 and December 7 of any year. This may mean the number of months you have to wait for coverage will be longer, which could make your premium higher.

   4. Group Health Plan Considerations. Your current employer-sponsored coverage pays for other health expenses in addition to prescription drugs. You will still be eligible to receive all your current health and prescription drug benefits if you

choose to enroll in a Medicare prescription drug plan. When you make your decision, you should also compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

5. Additional Information Regarding Available Medicare Prescription Drug Plans. Detailed information is available in the "Medicare and You" handbook. Medicare eligible individuals will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:
    - Visit www.medicare.gov
    - Call your State Health Insurance Assistance Program (see your copy of Medicare & You handbook for their telephone number)
    - Call 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048.
6. Extra Financial Help Available: For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

Section 22: Health Savings Accounts

This section only applies to the extent that a health savings account option is offered through the Plan and outlined in Section 3: Benefit Plan Information which can be found in Part #1: Plan Fact Sheet of this Summary Plan Description. The Part #1: Plan Fact Sheet accompanies this Summary Plan Description Disclosure Document.

A. Definition. A Health Savings Account (HSA) is a personal trust or custodial account established with a custodian or trustee to be used for reimbursement of eligible medical expenses incurred by the account Beneficiary and his or her tax dependents, as set forth in Code Section 223. The HSA is administered by the HSA Custodian or Trustee or its designee subject to the terms and conditions set forth in the Custodial or Trust Agreement between the Account Beneficiary and the Custodian or Trustee. The HSA is not an employee benefit plan sponsored or maintained by the Employer. The Employer's role with respect to the HSA is limited to making contributions through this Plan to the HSA established by you with the Custodian/Trustee (through Employer contributions and/or pre-tax salary reductions elected by you). The Employer has no authority or control over the funds deposited in your HSA. As such, the HSA identified in this summary Plan description and offered through this plan is not subject to ERISA.

B. Eligibility Requirements. HSA eligibility is determined under IRS rules and the applicable terms and conditions of any Custodial or Trust agreement. You are eligible for Plan contributions to your HSA during any month if you satisfy the following conditions on the first day of that month:

    1. You are covered under a qualifying High Deductible Health Plan (as defined in Code 223) maintained by Employer.
    2. You certify, in accordance with policies and procedures established by the Employer, that you satisfy all of the requirements to be an Eligible Individual as set forth in Code Section 223. You are required to notify the Employer if you fail to satisfy these conditions by the first day of the month following the date that you first fail to meet these requirements. In addition to being covered under a qualifying High Deductible Health Plan maintained by Employer, you must not be (i) covered under any other health plan or program that is not a qualifying High Deduction Health Plan unless that coverage is limited to "permitted coverage," "permitted insurance," and/or preventive care as defined in Code

Section 223 and related guidance, (ii) entitled to Medicare; or (iii) eligible to be claimed as a Dependent of any other taxpayer.

3. You are otherwise eligible for this Plan.

C. Account Beneficiary. An Account Beneficiary is an eligible participant who has properly enrolled in their own HSA in accordance with the terms of the applicable Custodial Agreement.

D. Withdrawals. Funds may be withdrawn tax-free to pay for qualified medical expenses, which include all Section 213(d) expenses. HSA funds may be used to pay premiums only for long-term care insurance, COBRA premium, or other health insurance premiums for people receiving unemployment benefits. Non-medical withdrawals are permitted but are subject to a 10% penalty and income tax.

E. Carryover of Funds and Portability. Amounts not used for medical expenses at the end of the year may be carried over to future years. HSAs are portable. Employees may take the funds in the account when they leave.

Section 23: Affordable Care Act – Grandfathering Status

Some of the component benefit plans of this welfare benefit plan may be "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Please refer to Section 3: Benefit Plan Information on Part #1: Plan Fact Sheet to confirm the grandfathered status of each component benefit plan. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the plan administrator identified in Section 3: Benefit Plan Information which can be found in Part #1: Plan Fact Sheet of this Summary Plan Description. The Part #1: Plan Fact Sheet accompanies this Summary Plan Description Disclosure Document. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Section 24: Definitions

A. Affiliated Employer**.** An entity that is considered with the Employer to be a single Employer according to Code Section 414(b), (c), or (m).

B. Board of Directors. The Board of Directors or other governing body of the Employer (the "Board"). Upon adopting this Plan, the Board of Directors appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

C. Code. The Internal Revenue Code of 1986, as amended, and where applicable, the regulations thereunder.

D. Dependent. A Dependent of the Participant within the meaning of Code Section 152 and the regulations issued under Code Section 106. A Spouse is an individual who is legally married to a Participant and who is treated as a spouse under the Code.

E. Employee. An individual who is a common-law employee of the Employer and is treated as an employee for income and employment tax purposes.

F. Employer. The Employer indicated in the Plan Information and any Affiliated Employer who is authorized by the Employer to adopt the Plan. Affiliated Employers who adopt the Plan are bound by the terms of the Plan unless they clearly withdraw from participation. Affiliated Employers who have adopted the Plan are set forth in the Plan Information of this document.

G. ERISA. The Employee Retirement Income Security Act of 1974, as amended.

H. Highly Compensated Individual. An individual defined under Code Section 105(h), as amended, as a "highly compensated individual" or a "highly compensated employee."

I. Participant. A person who becomes a Participant according to the terms of Article II of this Summary Plan Description and Plan document who is in one of the following categories:

1. An Employee or Dependent of Employee
2. A person who was previously an Employee or Dependent who elected continuation coverage under the terms of the Plan (for example under COBRA or USERRA)
3. A person who is no longer an employee but who is receiving benefits under the plan for which they are entitled under the terms of the plan (for example, life insurance, disability insurance, or coverage while on leave)
4. A person who is or was covered under the Plan by reason of special terms that are consistent with the eligibility criteria set out in the Certificates of Coverage in a manner that is consistent with the insurance carrier understanding of eligibility criteria under the plan.

J. Plan Administrator. The person(s) or Committee identified in the Plan Information section that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator is the Employer.

Section 25: General Plan Information and Plan Administration

A. Tax Qualification. The benefits provided by the Plan are intended to qualify as a health and welfare benefits and meet the requirements for qualification under Code Section 79, Section 105(b) and Section 106(a), and that benefits paid Employees hereunder be excludible from their gross incomes by virtue of Section 79, Section 105(b) and Section 106(a).

B. Exclusive Benefit. The Plan is established and maintained for the exclusive benefit Plan Participants.

C. Nondiscrimination. Employer will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

D. Not an Employment Contract. None of the plans or benefits discussed on the preceding pages should be considered contracts for employment between the employee and the Employer/Plan Sponsor. This Plan does not guarantee any employee or plan participant the right of continued employment nor do they limit the Employer/Plan Sponsor's right to discharge any employee.

E. Reduction of Coverage to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any requirement imposed by the Code, the Plan Administrator shall take appropriate action(s), under rules uniformly applicable to similarly situated Participants, to assure compliance with the requirement or limitation. Action may include, without limitation, modifying or terminating a Highly Compensated Employee's coverage under this HRA without the consent of the Employee.

F. Provision for Third-Party Plan Service Providers. The Plan Administrator, along with the approval of the Employer/Plan Sponsor, may employ services in connection with the operation of the Plan, and rely upon its tables, valuations, certificates, reports, and opinions. These services may be provided by a Third Party Administrator, identified in the SPD. Unless otherwise provided in the Service Agreement, obligations under this Plan shall remain the obligation of the Employer/Plan Sponsor.

G. Fiduciary Responsibility. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for those that involve the Plan Administrator's own gross negligence, willful neglect, willful misconduct, or willful breach of this Plan.

H. Allocation of Authority. The Board of Directors or applicable governing body of the Employer/Plan Sponsor (or an authorized officer of the Employer/Plan Sponsor) may appoint a Plan Administrator who keeps the records for the Plan, and controls and manages the operation and administration of the Plan. The Plan Administrator has the exclusive right to interpret and decide all matters of the Plan. The Plan

Administrator's determinations are conclusive and binding. Without limitation, the Plan Administrator has all the following powers and duties:

1. To require any person to provide information in order to properly administer the Plan
2. To make and enforce rules and regulations necessary to efficiently administer the Plan
3. To decide all questions concerning the Plan, the eligibility of the Plan, according to the Plan's provisions
4. To determine the amount of benefits payable, according to the Plan's provisions; to inform the Employer/Plan Sponsor and insurer as appropriate, of the amount of the benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part
5. To designate persons to carry out any duty or power which may or may not be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan
6. To keep all records, books of account, data and other documents necessary to properly administer the Plan
7. To do everything necessary to operate and administer the Plan according to its provisions.

I. Compensation of Plan Administrator. Unless determined by the Employer/Plan Sponsor and permitted by law, any Plan Administrator who is also an Employee of the Employer/Plan Sponsor, will not receive compensation for services rendered as the Plan Administrator, but the Employer/Plan Sponsor will pay all reasonable expenses incurred in the performance of their duties.

J. Bonding. Unless otherwise determined by the Employer/Plan Sponsor, or required by any federal or state law, the Plan Administrator is not required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

K. Payment of Administrative Expenses. The Employer/Plan Sponsor may decide to pay the Plan's administrative expenses or pass the expenses on to the Plan's Participants.

L. Funding Policy. The Employer/Plan Sponsor has the sole discretion to determine if benefits will be paid from a trust (taxable or non-taxable), established according to applicable law, or from the Employer/Plan Sponsor's general assets.

M. Indemnification. The Plan Administrator shall be indemnified by the Employer/Plan Sponsor against claims, and the expenses of defending against these claims, resulting from any action or conduct relating to the administration of the Plan, except claims arising from gross negligence, willful neglect, or willful misconduct.

N. Applicable Laws. The provisions of the Plan shall be construed, administered, and enforced according to applicable federal law and the laws of the State of California to the extent not preempted.

O. Post-Mortem Payments. Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving Spouse, otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights are determined, without liability for any interest.

P. Non-Alienation of Benefits. Except as expressly provided by the Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

Q. Mental or Physical Incompetency. Every person receiving or claiming benefits under the Plan is presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in acceptable form, that a person is mentally or physically incompetent or a minor, and that a guardian, conservator, or other person legally vested with the care of his estate has been appointed.

R. Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant, or other person who is due payment under the Plan, because he cannot ascertain that person's identity or whereabouts, and reasonable efforts have been made to identify or locate this person, all payments due will be forfeited after a reasonable time, and after the date payment first became due.

S. Requirement for Proper Forms. All communications in connection with the Plan, made by a Participant, shall become effective only when executed using the required forms, which may be furnished by, and are filed with, the Plan Administrator.

T. Source of Payments. The Employer/Plan Sponsor and any insurance company contracts held by the Employer/Plan Sponsor or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or Beneficiary shall have any right to, or interest in, any assets of the Employer/Plan Sponsor upon termination of employment or otherwise, except as specifically provided for under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or Beneficiary.

U. Tax Effects. Neither the Employer/Plan Sponsor, nor the Plan Administrator makes any warranty or other representation as to whether any benefits made to or on behalf of any Participant will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator, the Employer/Plan Sponsor, or the Third Party Administrator, with respect to any increased taxes or other losses or damages suffered by the Employee.

V. Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

W. Headings. The headings and titles contained herein are for convenience of reference only and shall not be construed as defining or limiting the matter contained thereunder.

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

Y. Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer/Plan Sponsor from Compensation paid by the Employer/Plan Sponsor.

Section 26: Discretionary Authority

A. Self-Funded Plan Components (Summary Plan Description Disclosure). The Plan Administrator has the sole and exclusive discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the sole discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

B. Self-Funded Plan Components (Plan Document Disclosure). The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator 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. 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 of those decisions as described by this section.

C. Fully-Insured Plan Components (Plan Document Disclosure). The insurance carrier documents outline the discretionary authority for any fully insured plan components. To the extent that discretionary authority is not explicitly stated in the fully insured insurance carrier contracts or is called into question, discretionary authority is presumed for the carrier for the specific plan component in question to an equivalent extent outlined for the Plan Administrator relative to self-funded plan components.

Section 27: Statement of Your Rights under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you to the certain rights and protections as a participant in your Employer/Plan Sponsor's employee benefit plan. ERISA provides that all plan participants shall be entitled to the following rights.

A. Receive Information about the Plan. You have a right to 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.

B. Obtain Copies of Plan Documents. You have a right to 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.

C. Continue Group Health Plan Coverage. You have a right to continue health care coverage for yourself, spouse or dependents if there is 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 rights. Additional information about COBRA may be found in Section 12 of this Summary Plan Description.

D. Credit for Pre-existing Condition Exclusion Periods. You have a right to the reduction or elimination of exclusionary periods of coverage for pre-existing 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Section 28: Protection of Your Rights under ERISA

A. Prudent Actions by Plan Fiduciaries. In addition to creating rights of plan participants, ERISA imposes special obligations and duties upon the people who are responsible for the operation of your Employer/Plan Sponsor's welfare benefit plan. The people who operate your Plan, are called "fiduciaries" of the Plan. The fiduciaries of the plan have a duty to operate the plan prudently and in the interest of you and other plan participants and beneficiaries. The fiduciaries also have a duty to protect any plan assets for the benefit of plan participants. No one, including your Employer/Plan Sponsor or any other person, may fire you or otherwise discriminate against you in any way to prevent you from receiving a welfare plan benefit or from exercising your rights under ERISA.

B. Claim Review. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. ERISA gives you the right to file suit in a state or federal court if your claim for benefits under the employee benefit plan is denied or ignored. You can also file suit in a federal court if you request plan documents and do not receive them within 30 days. In such a situation, the court will require the Plan Administrator to give you the plan documents you requested. In some cases, the court could also require the Plan Administrator to pay you up to $110 a day until you receive the requested materials, unless the materials were not sent because of reasons beyond the control of the administrator. 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 a federal court.

C. Assertion of Rights. If it should happen that the fiduciaries have misused the plan's money or assets, or that you have been discriminated against for asserting your rights, you can ask for help from the U.S. Department of Labor. You can also file suit in a federal court. If you file a suit, the court will decide who must pay those costs and legal fees. If you are successful, the court may order the person you have sued to pay those fees. If you lose, the court may order you to pay those costs and fees, if, for example, it finds your claim is frivolous.

Section 29: Questions about the Plan or ERISA

A. 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 (EBSA), a division of the U.S. Department of Labor. Phone listings for the EBSA may be found in your local telephone directory. Alternatively, you may contact the national office of the EBSA. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

B. Contact Information. Contact information for the San Francisco regional office and national offices of the EBSA are listed below:

San Francisco Regional Office
EBSA
90 7th Street, Suite 11300
San Francisco, CA 94103
Phone: (415) 625-2481

Division of Technical Assistance and Inquiries
EBSA
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

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