Welfare Plan

Plan Document and Summary Plan Description Fact Sheet

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	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	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

Section 1: 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 ProctorU Employee Benefit Plan
Plan Number:	501
Employer/Plan Sponsor:	ProctorU, Inc. dba Meazure Learning
Contact Information:	2200 Riverchase Center, Suite 600 Birmingham, AL 35244 (925) 273-7588
Affiliated Employers:	None
Employer Tax ID Number:	27-1893486
State of Domicile:	AL
Effective Date:	July 1, 2017

Plan Update Date:	July 1, 2025
Plan Year:	January 1 to December 31
Plan Administrator:	ProctorU, Inc. dba Meazure Learning The Plan Administrator has authority to control and manage the operation and administration of the Plan. The Plan Administrator acts as the fiduciary of the plan and maintains fiduciary responsibility over the plan.
Agent for Service of Legal Process:	ProctorU, Inc. dba Meazure Learning
Plan Changes or Termination:	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:	Wendy Hinson, (925) 273-7588
HIPAA Security Officer:	Wendy Hinson, (925) 273-7588
Applicable Large Employer:	ProctorU, Inc. dba Meazure Learning is an Applicable Large Employer (for the purposes of the Pay or Play penalties of the Affordable Care Act).
ACA Eligibility Determination Method:	ProctorU, Inc. dba Meazure Learning is an Applicable Large Employer. ProctorU, Inc. dba Meazure Learning uses the following ACA Safe Harbor protocol for employees: Initial Measurement Period = 11 months from date of hire Initial Administration Period = 30 days Initial Stability Period = 11 months Ongoing Measurement Period = June through May Ongoing Administration Period = 1 months Ongoing Stability Period = July through June
Special 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 21 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. CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Blue Cross Blue Shield of Alabama
Policy Number:	78964
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.*	Blue Cross and Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Blue Cross and Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244
Claims Appeal Address:	Blue Cross and Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244
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:	Regular status 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Blue Cross Blue Shield of Alabama
Policy Number:	78964
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.*	Blue Cross and Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Blue Cross and Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244
Claims Appeal Address:	Blue Cross and Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244
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:	Regular status 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Blue Cross Blue Shield of Alabama
Policy Number:	78964
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.*	Blue Cross and Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	ProctorU, Inc. dba Meazure Learning 2200 Riverchase Ctr., Suite 600 Birmingham, AL 35244 (925) 273-7588
Claims Appeal Address:	Blue Cross and Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244
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:	Regular status employees working 30 or more hours per week are eligible on the first day of full-time employment.
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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan	
Plan Number:	501	
Policy Carrier:	Vision Service Plan	
Policy Number:	30032117	
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.*	Plan Administration: Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670	Claim Processing: Vision Service Plan: Attn: Claims Services P.O. Box 385018 Birmingham, AL 35238-5018
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	ProctorU, Inc. dba Meazure Learning 2200 Riverchase Ctr., Suite 600 Birmingham, AL 35244 (925) 273-7588	
Claims Appeal Address:	Vision Service Plan Attn: Appeals Department P.O. Box 2350 Rancho Cordova, CA 95741	
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:	Regular status 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Lincoln
Policy Number:	10230872
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.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Claims Appeal Address:	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
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:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	Regular status 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Lincoln
Policy Number:	10230874
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.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Claims Appeal Address:	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
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:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	Regular status 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Lincoln
Policy Number:	10230873
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.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Claims Appeal Address:	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
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:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	Regular status 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Lincoln
Policy Number:	400001000 22858
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.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Claims Appeal Address:	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
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:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	Regular status 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Lincoln
Policy Number:	400001000 22858
Type of Plan Benefit:	Accident
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.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Claims Appeal Address:	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
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:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	Regular status 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Lincoln
Policy Number:	400001000 22858
Type of Plan Benefit:	Critical Illness
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.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Claims Appeal Address:	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
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:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	Regular status 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 2: Benefit Plan Information

Plan Name:	The ProctorU Employee Benefit Plan
Plan Number:	501
Policy Carrier:	Lincoln
Policy Number:	400001000 22858
Type of Plan Benefit:	Hospital Indemnity
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.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
Claims Appeal Address:	Lincoln Financial 8801 Indian Hills Drive Omaha, NE 68114
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:	N/A
Grandfathered Plan:	N/A
Employee Eligibility:	Regular status 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.

Welfare Plan

Plan Document and Summary Plan Description Disclosure Document

Multiple Part Document Notice

The complete Plan Document and Summary Plan Description (SPD) are comprised of the elements outlined below. This document is a "wrap-around" Plan Document and Summary Plan Description, meaning the full documents are made up of several different parts.

When the Fact Sheet and the Disclosure Document are accompanied by the corresponding Certificates of Coverage, the combined documents become the complete Summary Plan Description.

When the Fact Sheet and the Disclosure Document are accompanied by the corresponding Insurance Contracts or Employer Agreements, the combined documents become the Plan Document.

This description of the multiple-part construction of the Plan Document and SPD is intentionally repeated at the beginning of both the Fact Sheet and the Disclosure Document. This framing further emphasizes the integral nature of the three component parts that constitute both the Plan Document and the Summary Plan Description.

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 are included in the Plan.
Part #2	Disclosure Document	Contains important disclosures and descriptions of plan details, rights, rules, and responsibilities under the 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, master service agreements, or other contract documents.
Addendum	HIPAA Privacy Notice	HIPAA Privacy Notice which is consolidated with and appended to the end of this disclosure document for convenience and easy reference.

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Section 3: Purpose

Employer/Plan Sponsor and named Affiliated Employers sponsor various Component Benefit Plans as outlined in the accompanying 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 put forth by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Any assets of the Component Benefit Plans shall be held for the exclusive purposes of providing benefits to the Component Benefit Plan participants and their beneficiaries and for defraying reasonable costs of administration.

This Summary Plan Description and Plan Document is intended to satisfy the compliance requirements of ERISA. Where a conflict of language exists between the Insurance Contracts or the Certificates of Coverage, the Insurance Contract will control to the extent such document is not inconsistent with federal law and regulations or unless the Plan provides otherwise.

Section 4: Fact Sheet

This Disclosure Document includes important plan references and disclosures that relate to many different coverages, plan types, and laws pertinent to the employee benefit coverage provided under this Plan. It may be that not all elements of this Disclosure Document apply to Employer/Plan Sponsor's coverage. The specific elements that apply to Employer/Plan Sponsor coverages are referenced in the accompanying Fact Sheet. Notes in each section of this Disclosure Document refer to the accompanying Fact Sheet for information on whether and how the section applies to this Plan as well as coverage details for the Component Benefit Plans.

Section 5: 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 Contract Administrator that issues them. If a copy of any Certificate of Coverage has not been provided, it can be obtained from the Plan Administrator. The applicable Certificate of Coverage describes the coverage provided under the plan, how benefits can be accessed, and how claims can be filed and appealed. For plans that include a network of providers, a list of participating providers may be accessed online at no cost. The Certificate of Coverage also provides information on 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 Employer/Plan Sponsor and the Contract Administrator. Insurance Contracts are sometimes alternately referred to as Insurance Policies, Contracts/Policies, Service Agreements, Master 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 serves as 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 the Certificates of Coverage or Insurance Contracts for each benefit. If a copy of any Certificate of Coverage has not been provided, it can be obtained from the Plan Administrator.

Section 6: Termination/Modification/Amendment of the Plan

A. Permanency

While Employer/Plan Sponsor fully expects this Plan to continue indefinitely, permanency of the Plan is subject to 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

Employer/Plan Sponsor reserves the right, in its sole discretion, to amend or modify the Plan or any element or provision of the Plan at any time, including any Component Benefit Plan elements. This includes amendments that are retroactive in effect to the extent permitted by law. Employer/Plan Sponsor 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. Employer/Plan Sponsor also maintains the ability 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 Employer/Plan Sponsor. All amendments shall be made in writing and shall be approved by 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. Plan Merger

Employer/Plan Sponsor reserves the right to merge the Plan or any Component Benefit Plan at any time in its sole discretion.

D. Right to Terminate

Employer/Plan Sponsor, in its sole discretion, reserves the right, in its sole discretion, to discontinue or terminate the Plan or any Component Benefit 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 Employer/Plan Sponsor. The decision to terminate the Plan shall be made in writing and shall be approved by the Employer/Plan Sponsor, according to the 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.

E. Payment of Claims

Upon termination of the Plan, the Plan shall continue until all pending claims for benefits outstanding as of the date of termination have been paid or otherwise resolved. Any funds remaining in the Plan at termination shall be distributed as if they were insurance company refunds/rebates, as outlined in Section 27: Insuring and Funding Benefits (except where prohibited by statute). Funds for payment of claims are held as a general asset of Employer/Plan Sponsor. Therefore, in the event of bankruptcy, claims liabilities will be addressed as part of bankruptcy proceedings.

F. Contract Administration

Employer/Plan Sponsor may enter into contracts with Contract Administrators to provide coverage. 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 Employer/Plan Sponsor fails to comply with the outlined contract and make contractually required payments in a timely manner. 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.

G. Effect on Participants

A Participant's coverage is adapted accordingly in the event of an amendment or modification of the original Plan. An individual Participant's coverage terminates at the earliest of the following conditions:

- When employment is terminated
- When eligibility criteria under the coverage is no longer satisfied
- When required contributions are no longer being made (if the Plan is contributory)
- 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

Benefits under the Plan are funded by one or more of the methods outlined below. The type of funding is selected by Employer/Plan Sponsor for each Component Benefit Plan. All benefits, regardless of the funding type implemented, are funded by general assets of Employer/Plan Sponsor or from a trust (if applicable). Refer to the accompanying Fact Sheet for details on the funding method of each Component Benefit Plan.

A. Fully Insured Plans

In a fully insured plan, benefits are provided under a group insurance contract entered into between Employer/Plan Sponsor and the insurance company identified in the accompanying Fact Sheet. Claims for benefits are sent to the insurance company or Contract Administrator. The insurance company is solely responsible for paying claims and for the financial risk of paying claims under the plan. However, the insurance company and Employer/Plan Sponsor 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 Employer/Plan Sponsor out of the general assets of Employer/Plan Sponsor.

B. Self-Insured Plans

In a self-insured plan or a partially self-insured plan, Employer/Plan Sponsor hires the Contract Administrator to process claims under the plan. Sometimes the Contract Administrator for a self-insured plan is known as a Third-Party Administrator. 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 Employer/Plan Sponsor to pay the claims and make payment on the claims to health care providers. 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 Employer/Plan Sponsor out of the general assets of 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 Employer/Plan Sponsor out of the general assets of Employer/Plan Sponsor.

C. Pre-Paid Plans

In a pre-paid plan, benefits are provided under a contract entered into between Employer/Plan Sponsor and the Contract Administrator. Pre-paid plans are typically 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 Employer/Plan Sponsor out of the general assets of Employer/Plan Sponsor.

Funding for the Plan in its entirety consists of the collective funding for all Component Benefit Plans and may include funding through a cafeteria plan, thus funding may include contributions made by employees through a salary reduction agreement.

Employer/Plan Sponsor has the right to pay for benefits from its general assets, insure any benefits under the Plan, and establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or as Employer/Plan Sponsor determines advisable in its sole discretion. In addition, Employer/Plan Sponsor has the right to alter, modify or terminate any method or methods used to

fund the payment of benefits under the Plan, including, but not limited to, any trust or insurance policy. If any benefit or portion of the benefit is funded by the purchase of insurance, the benefit or portion of the benefit will be payable solely by the insurance company.

Section 8: Taxation of Benefits

A. Taxation of Benefits

In general, health benefits provided to an Employee and their eligible dependents are tax free, subject to certain limitations for life insurance benefits and for dependent coverage being provided to IRS-eligible dependents.

B. Domestic Partner Taxation

Whether or not an Employee's plan offers coverage for Registered Domestic Partners or Non-Registered Domestic Partners may be found under the eligibility criteria of each Certificate of Coverage. It should be noted that federal tax treatment (and state tax treatment in certain states) of employee benefits is not the same for domestic partners as for spouses. Unless an Employee's domestic partner and/or his or her children, if any, are considered federal tax dependents under the Internal Revenue Code for health benefits, the Internal Revenue Service currently requires that the Employer/Plan Sponsor impute income to the Employee equal to the value of the coverage provided for the Employee's domestic partner and his or her dependent children.

Employees are advised to consult with their tax advisor to determine if the domestic partner and his or her dependent children are the Employee's federal tax dependents and to review the tax consequences of electing coverage for a domestic partner. In addition, Employees are advised to speak to a tax advisor, regarding whether a domestic partner and/or his or her children may qualify for tax qualified treatment at the state level. If a domestic partner and/or the domestic partner's children qualify as tax dependents under Code 152(d), documentation of tax dependency may be required. Otherwise, the value of benefits will be taxed as outlined above.

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 the Employee lives in a jurisdiction that recognizes same-sex marriage or not. In such a case, 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 the Employee as required by the IRS. The value of life insurance depends on the Employee's age and the amount of insurance in excess of $50,000. The imputed income may be added to the Employee's income each pay cycle, or it may be added in a lump sum at the end of the calendar year, depending on the administrative procedures adopted by Employer/Plan Sponsor.

Section 9: Participation, Eligibility, Enrollment, and Contributions

A. Participation

Eligibility for participation and benefits under the Plan is determined under the written terms of the Plan and each Component Benefit Plan. The terms of participation are outlined in the accompanying Fact Sheet of this Plan Document and Summary Plan Description. Specific participation and enrollment requirements for each Component Benefit Plan are outlined in the Certificates of Coverage, Insurance Contracts, or the plan enrollment materials provided for each Component Benefit Plan.

If an Employee previously participated in the Plan and is rehired, such Employee will be eligible to become a Participant on the same terms and in the same manner as if they were a newly hired Employee.

Notwithstanding the above, if the Group Health Plan is one offered by an Applicable Large Employer subject to Section 4980H of the Code, an Employee who returns to employment at Employer/Plan Sponsor after a period during which Employee has not accumulated any Hours of Service may be treated as having terminated employment and been rehired as a new Employee only if the following conditions apply: (i) such Employee had no Hours of Service for a period of at least 13 consecutive weeks (26 for educational organization employers); or (ii) such Employee had a break in service of a shorter period of at least four consecutive weeks with no credited hours of service, and that period exceeded the number of weeks of Employee's period of employment. These provisions are intended to comply with Section 4980H of the Code and are not intended to expand the rights or benefits of employees for any other purpose and should not be so construed.

As to any Component Benefit Plan that is a Group Health Plan (other than one offering only HIPAA-Excepted Coverage), any otherwise eligible Employee must wait no longer than ninety (90) days to begin coverage under such Component Benefit Plan.

Insurance carriers sometimes impose an "actively at work" requirement for certain types of insurance (for example, life and disability). When an actively at work requirement is in place, benefits under the plan may be delayed or otherwise affected. These provisions will be outlined in the Certificate of Coverage for the relevant Component Benefit Plans. These provisions may also apply in the case of a rehired Employee. An "actively at work" requirement is not permitted for Group Health Plans (other than plans offering only HIPAA-excepted coverage) unless there is an exception for individuals who are absent from work due to a health factor. For example, if an individual is out on sick leave on the day coverage would otherwise become effective.

B. Eligibility Requirements

Information regarding specific Employee and Dependent eligibility requirements and any conditions or limitations to eligibility are contained in the Certificate of Coverage or the Insurance Contracts describing each separate Component Benefit Plan. Plan participants must complete the required enrollment process for each Component Benefit Plan (outlined 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:

(a) Employees who are regularly scheduled to work less than the minimum number of hours per week as indicated above for the specific Component Benefit Plan

(b) Employees who are classified as a seasonal employee (according to the ACA definition) when Employer/Plan Sponsor excludes seasonal employees

(c) Employees classified as a leased employee as defined in Section 414(n) of the Code

(d) Individuals classified as independent contractors

(e) Individuals who are classified as consultants or advisors on a retainer or fee basis and paid compensation that is reported on Form 1099 (rather than Form W-2)

(f) Individuals who are members of a collective bargaining unit who are eligible under a separate union negotiated plan.

C. Enrollment

When an Employee begins working for Employer/Plan Sponsor and has satisfied the eligibility and participation requirements as outlined herein, the Employee may become a Participant for a Plan Year by enrolling in the Plan in accordance with procedures established by the Plan Administrator for enrolling in coverage. Employees may elect and enroll in some or all of the benefits available under the Component Benefit Plans. An Employee may also elect not to participate in one or more of the Component Benefit Plans.

Employees will be provided with the information necessary to enroll in the Plan from Plan Administrator. This may include electronic enrollment via an online benefits administration system, paper enrollment forms, or other forms of enrollment. As part of the enrollment, Certain benefits may be provided automatically without a specific enrollment process being required (employer-sponsored disability coverage is a common example). By making elections, Employees authorize any necessary contributions for the cost of coverages

elected to be made via payroll processing (salary reductions or salary deductions, depending on the taxation status of the contributions).

The time and deadlines for completion of enrollment will also be specified. If enrollment is not completed within the prescribed enrollment window, the opportunity to elect coverage will close. Assuming enrollment processing is fully completed within the enrollment period, coverage begins as of the effective date outlined in the Certificate of Coverage for each Component Benefit Plan. Coverage for eligible dependents will begin on the same date as Employee coverage assuming the necessary elections are made within the time required. As a rule, the benefit elections made by an Employee at the beginning of employment will remain in force for the remainder of the Plan Year.

Once made, an enrollment (and the elections made therein) may be revoked or modified during a Plan Year only on account of a termination of employment or the occurrence of a defined event entitling the Employee to an election change in accordance with Section 11: Changing Elections Mid-Year.

D. Annual Election Period

Before the beginning of each Plan Year, Employer/Plan Sponsor often may hold an annual open enrollment period. Employer/Plan Sponsor will notify Employees of the dates for the annual open enrollment period each year. During this time, Employees may make new elections for the upcoming plan year. Some elections from the prior year may roll forward to the current year; some elections may require that a new election be made for each plan year. Open enrollment materials will be provided to Employees describing plan options, changes, premiums, and whether an affirmative election is required.

E. If No Enrollment When First Eligible

There are specific consequences if an Employee does not enroll in benefits when initially offered. This section outlines the initial time periods and the subsequent opportunities for enrollment in benefits.

1. Consequences of No Enrollment. If an Employee does not enroll for benefit offerings:
    (a) When the Employee is first eligible
    (b) Within 30 days of the occurrence of a Change in Status (defined in Section 11: Changing Elections Mid-Year below)
    (c) Within 30 days of another event entitling an Employee to make an election change
    (d) Within 60 days in the event of a Medicaid- or CHIP-related special enrollment event

    The Employee will have to wait until the next annual Open Enrollment period to enroll, unless they meet the criteria to qualify for a Mid-Year Enrollment Opportunity, experience a Qualified Life Event, or qualify for a Special Open Enrollment as outlined below.
2. Open Enrollment. Open Enrollment happens once annually and, during that time, the Employee may typically make changes to benefit plan elections, add dependents to plans, or delete dependents from plans. Any changes made become effective at the beginning of the Plan Year.
3. Mid-Year Enrollment Opportunities. If an Employee initially waived coverage themself or for any eligible dependents either upon initial eligibility or at any annual Open Enrollment, under certain circumstances, they may be eligible to enroll in coverage on a mid-year basis. To be eligible, an Employee must experience a Qualified Status Change or another defined event that qualifies the employee 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, an Employee must notify Employer/Plan Sponsor within 30 days of the event in order to make a mid-year change. Certain 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 their employer within 30 days of the event, to ensure timely enrollment. If an Employee does not make the notification within the prescribed window, they must wait to enroll until the next annual Open Enrollment period. If an Employee enrolls themself or any dependents 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 their event or it may begin on the first of the month following their notification to Employer. Please refer to the Certificate of Coverages for each Component Benefit Plan to confirm the specific coverage effective date for each coverage.

F. Contributions

The cost of the benefits provided through the Component Benefit Plans may be funded in part by Employer/Plan Sponsor contributions and in part by Employee contributions. Contributions may be made as pre-tax salary reductions through a cafeteria plan under Code Section 125 or made via after tax salary deductions. The nature of taxation depends on the nature of the contribution and the Component Benefit Plan, on whether pre-tax payment is allowed by the IRS Code, and/or whether a pre-tax election was made or not made by the Employee.

Employer/Plan Sponsor will determine the Employee and Employer/Plan Sponsor contribution amounts at its sole discretion. In some instances, a Component Benefit Plan may require contributions by only Employer/Plan Sponsor or the Employee. Employer/Plan Sponsor will periodically communicate the Employee share of the cost for each Component Benefit Plan and reserves the right to change that determination at any time. Employer/Plan Sponsor contributions will be at least sufficient to fund the benefits entirely or fund the portion of the benefits that are not otherwise funded by Employee contributions. Employer/Plan Sponsor will pay their contributions and Employee contributions to an insurance company or, with respect to benefits that are self-funded, will use these contributions to pay benefits directly on behalf of Employees or their eligible dependents from the Employer's general assets. Employee contributions will be used in their entirety prior to using Employer/Plan Sponsor contributions to pay for the cost of such benefit.

Where relevant to a Component Benefit Plan, you will receive during the open enrollment period notice of the amount for which you are responsible. If your cost for a Component Benefit Plan is adjusted during the Plan Year, you will be notified of that adjustment unless the Component Benefit Plan provides otherwise.

G. No Eligibility Discrimination Due to Health Status

To the extent required by HIPAA, the Plan shall not establish rules for eligibility (including continued eligibility) for health benefits for any Employee under the Plan that are based on one or more health status-related factors. This includes health status, medical condition (both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability of the Employee or any of his or her Dependents.

H. No Premium/Contribution Discrimination Due to Health Status

The Plan will not require an Employee (as a condition of enrollment or continued enrollment in the health benefits offered under this Plan) to pay a premium or otherwise contribute an amount which exceeds the amount paid by a similarly situated Employee solely due to a health status-related factor (including health status, medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability) of the Employee; provided, however, that the rules regarding health status-related factors do not restrict the amount Employer/Plan Sponsor may charge for coverage or prevent premium discounts or rebates or modified deductibles and co-payments in return for adherence to programs of health promotion and disease prevention.

Section 10: Termination of Benefits

This SPD and Plan Document is issued in conjunction with the corresponding Certificates of Coverage or Insurance Contracts for each of the Component Benefit Plans. Information regarding loss of benefits and when benefits terminate can be found in the Certificates of Coverage or the Insurance Contracts describing each separate Component Benefit Plan. Please refer to the Certificate of Coverage for the corresponding Component Benefit Plan for specific details.

A. Effect of Termination

Any termination of a Participant's coverage under a Component Benefit Plan will be considered a termination of that same coverage under this Plan. An Employee's benefits (and the benefits of his or her covered Dependents) will cease when the Employee's participation in the Plan terminates. Benefits will also cease upon termination of the Plan and certain benefits may cease upon termination of a Component Benefit Plan. Other circumstances can also result in the termination of benefits. Coverage for eligible dependents terminates at the same time the Employee’s coverage terminates.

B. Types of Termination Events

Without overriding the specific termination provisions outlined for each Component Benefit Plan, the following is an overview of the general types of provisions governing when coverage will terminate.

(a) The date an Employee is no longer eligible to participate in each Component Benefit Plan, as defined by each Component Benefit Plan. Common examples include termination of employment or the date an employee's hours drop below the required eligibility threshold.

(b) The date that an Employee's 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

(c) The end of the period for which an Employee paid the required contribution, if applicable

(d) The date an Employee reports for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA).

(e) The date that a Component Benefit Plan is terminated to the extent coverage is provided by that specific Component Benefit plan and it is not replaced by a plan of the same type.

(f) The date the Plan terminates.

Section 11: Changing Elections Mid-Year

In general, when a Component Benefit Plan is funded through a cafeteria plan, the benefit plans and coverage level elected upon initial enrollment will remain in effect for the remainder of the Plan. In addition, elections an Employee makes at Open Enrollment generally remain in effect for the entire Plan Year. The general rule is that elections cannot be changed or revoked during the Plan Year except in certain limited situations that are described in the cafeteria plan. Other election restrictions may apply to Component Benefit Plans. For example, if you elect not to participate in the health plan when first eligible, you may need to wait until an open enrollment period as specified in the Component Benefit Plan.

An Employee may change or revoke their elections during a Plan Year on account of termination of employment, upon a Change in Status event, or upon the occurrence of another defined event that permits a mid-year change in election. These events are defined in the cafeteria plan document and are summarized below for reference.

If an Employee experiences one of the events described below and wants to make a change to coverage due to the event, they must notify Employer/Plan Sponsor within 30 days of the event, (within 60 days for Medicaid or CHIP-related events as described under HIPAA Special Enrollments in this document). If an Employee does not notify Employer/Plan Sponsor within the allowed timeframe, they will not be able to make any changes in coverage until the next Open Enrollment period.

If an event occurs that allows an Employee to make a mid-year change of election, the election change must be consistent with change in status or other event that allowed a mid-year election change. The determination of whether event has occurred that would permit an election change and whether the requested election change is consistent with such an event will be made in the sole discretion of the Plan Administrator.

A. Change in Status Events

An Employee may be able to change their plan elections during the Plan Year if they experience a change in status. If an Employee desires to modify benefit elections due to a change in status, the Employee may be required to show proof that the event has occurred; for example, copy of marriage certificate, birth certificate, or divorce decree). The following is a list of changes in status that may allow a change in coverage elections:

1. Legal Marital Status. Any event that changes an Employee's legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment.
2. Domestic Partner Status. If domestic partners are defined as eligible to participate in the Plan, a change such that the Employee has met the criteria for establishing a domestic partnership or for the dissolution of a domestic partnership.
3. Number of Eligible Dependents. Any event that changes the number of eligible dependents, including birth, death, adoption, legal guardianship, and placement for adoption.

4. Employment Status. Any event that changes an Employee or eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include beginning or terminating 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 a covered Dependent to become eligible or ineligible for coverage because of age, student status, or similar circumstances.
6. Residence. If the place of residence changes for an Employee or any eligible dependents that results in a Participant no longer living within the service area of a health plan, then there may be an election change opportunity resulting for the Participants who have newly moved outside of the health plan's network service area. This option is contingent on the Plan including a different Component Benefit Plan that offers coverage in the area to which the Employee or dependent moves.

B. Other Events that Allow an Election Change

There are several other events that are not defined Change in Status events that may allow Employees to make changes in coverage elections.

1. FMLA leave. Beginning or returning from an FMLA leave. This provision applies to elections for health plan coverage, including health FSAs.
2. Judgements, Decrees, or Court Orders. If a judgement, decree, or Qualified Medical Child Support Order (QMSCO) requires the Plan to provide coverage to an Employee's child, then the Plan Administrator automatically may change their election under the Plan to provide coverage for that child. In addition, an Employee may make corresponding election changes as a result of the QMCSO. If the QMCSO requires another person (such as a Spouse or former Spouse) to provide coverage for the child, then an Employee may cancel coverage for that child under the Plan if the Employee provides proof to the Plan Administrator that such other person provides the coverage for the child.
3. Coverage Change Events. In some instances, an Employee can make elections if the type of coverage changes. Please note that if the change occurs to another Employer's plan, they may be required to show proof verifying these events have occurred.
4. Significant Cost Change. If an Employee experiences a significant cost change in existing coverage choices, a change of election may be made to health plans. Elections must be consistent with the significant cost increase or decrease. This provision does not apply to health FSA elections.
5. Restriction or Loss of Coverage. If an Employee's coverage is significantly restricted or ceases entirely, the employee may revoke their existing coverage election 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, the Employee may revoke the existing election.
6. Significant Addition to or Improvement in Coverage. If Employer/Plan Sponsor adds a coverage option or significantly improves a coverage option during the year, an Employee may revoke the existing election and elect the newly added or newly improved option. This provision does not apply to health FSA plan elections.
7. Changes in Coverage under another Employer Plan. If an Employee or eligible dependents are employed and the other employer plan allows for a change in their 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), an Employee may be able to make a corresponding election change under the Plan. For example, if the spouse of an Employee elects family coverage during his or her employer's Open Enrollment period, the employee may request to end coverage under the Plan. The Employee may be required to show proof verifying that such a change in other employer coverage has occurred.
8. Loss of Other Group Health Plan Coverage. If an Employee or their 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, an Employee may enroll for coverage under this Plan.

9. Other Specified Events. Any other event specified under Employer/Plan Sponsor's cafeteria plan that is consistent with IRS regulations and pronouncements.

If the Plan is a Group Health Plan, an Election Change Event also includes the occurrence of a special enrollment event under HIPAA or CHIPRA.

Section 12: HIPAA Special Enrollment

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 to 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: loss of other Employer sponsored coverage, loss of Medicaid or CHIP coverage, or acquisition of a new dependent. If an Employee seeks to enroll under these special enrollment rules, they will not be considered a late enrollee and thus will 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 Health Plan Coverage. If an Employee is covered under another employer sponsored group health plan and involuntarily loses that coverage (due to expiration of COBRA or loss of eligibility under the other group plan), an Employee or eligible dependents may enter the plan under the special mid-year enrollment rights. An Employee 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 an Employee or any eligible dependents are covered under Medicaid or CHIP coverage and they lose eligibility under one of those programs or an Employee becomes eligible for the state's premium assistance program, an Employee and eligible dependents may enter the plan under the special mid-year enrollment rights. An Employee must request enrollment in writing within 60 days after the Medicaid/CHIP event. Upon receiving a request, coverage will be effective on the first of the month following the request for enrollment. Specific restrictions may apply, depending on federal and state law.
3. Acquiring a New Dependent. If an Employee acquires a new dependent (by marriage, birth, adoption, or placement for adoption), they have a right to enroll themself and the new dependent in the group health plan. An Employee must request enrollment in writing within 30 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 the Plan Certificate of Coverage. Please refer to the Certificate of Coverage for the Component Benefit Plan for details.

B. Continuity of Coverage

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

Section 13: ACA Eligibility Method - Lookback Method

This section is only relevant for employers who are Applicable Large Employers (ALEs) under the Affordable Care Act (ACA).

To determine if Employer/Plan Sponsor is an Applicable Large Employer and whether Employer/Plan Sponsor has adopted the optional Lookback Method (for ACA Eligibility Determination), please refer to the accompanying Fact Sheet.

This section explains how health plan eligibility is determined for employees when the ACA Lookback Method is adopted.

A. Basic Rule

The Lookback Method for measuring eligibility means that an Applicable Large Employer determines each new Employee's eligibility status by looking back at the Initial Measurement Period and each ongoing Employee's eligibility status by looking back at the Ongoing Measurement Period.

An Employee will be subject to a measurement period, as outlined in the accompanying Fact Sheet of this Summary Plan Description. During a measurement period, an Employee will not be eligible for health insurance unless they have previously satisfied eligibility requirements. During that period, each Employee's eligibility for health benefits will be determined by tracking their hours of service during an Initial Measurement Period. Hours of service that count towards eligibility for health benefits include: (1) hours for which they are paid for work, and (2) hours for which they are paid for vacation, holiday, illness, disability, layoff, jury duty, military duty, or leave of absence.

B. Initial Measurement Period

The initial measurement period is determined on a personal basis for each newly hired Employee. The initial measurement period is based on a defined lookback period (3 months, 6 months, or 12 months) from an Employee 's date of hire. For example, an Employer's initial measurement period might be stated as follows: 12 months after the Employee's date of hire. Refer to the accompanying Fact Sheet that accompanies this Disclosure Document for the specific lookback measurement period for Employer/Plan Sponsor.

C. Ongoing Measurement Period

The ongoing measurement period is based on defined monthly intervals (3 months, 6 months, or 12 months) within the calendar year. For the ongoing measurement period, the intervals are defined by both duration and starting month. For example, an employer's ongoing measurement period might be stated as follows: 12-month duration with the measurement starting on November 1st each year. Refer to the accompanying Fact Sheet for the specific measurement intervals for Employer/Plan Sponsor.

D. Administration Period

The administration period occurs after the end of the Employee's measurement period (whether the initial measurement period or the ongoing measurement period). It is the period during which the Employer/Plan Sponsor completes necessary administrative tasks, such as calculating the hours for the measurement period, determining eligibility for coverage, providing enrollment materials to eligible employees, conducting an enrollment process, and processing enrollment documents. The administration period can be between one and three months. No coverage is provided during the administration period. Immediately following the administration period, the stability period begins. Refer to the accompanying Fact Sheet for the specific administration period for Employer/Plan Sponsor.

E. Stability Period

The stability period is the period of time that an Employee is either guaranteed to have coverage (so long as the employee remains a full time employee (if an Employee worked an average of 30+ hours during the measurement period) or their Employer is not obligated to provide coverage (if an Employee worked an average of less than 30 hours during their measurement period). Refer to the accompanying Fact Sheet for the stability period for Employer/Plan Sponsor.

F. Averaging 30 Hours or More

If an Employee's average hours worked exceeds the threshold during the initial measurement period, then they will be eligible for health benefits for a period of time equal to the stability period. At that point, an Employee's eligibility for coverage will have been "earned" for the duration of the stability period, and their coverage will be maintained through the stability period, even if their actual average hours worked falls below the threshold. However, they must elect coverage, pay their required share of premiums, and continue to be an employee during this period in order to maintain coverage through their stability period. Please note the administration period falls between the end of the Employee's measurement period and the beginning of their stability period to allow for processing of their coverage eligibility and election.

G. Averaging Less Than 30 Hours

If an Employee's average hours worked does not meet the threshold during the initial measurement period, then an Employee will not be eligible for health benefits for a period of time equal to the stability period. An Employee will not be eligible for health coverage through the entire stability period even if their average hours during the stability period increases above the threshold. If the Employee has a change in employment status, such as if the individual is no longer a variable hour Employee and is placed within a new classification that is eligible for health benefits, an Employee would not be subject to the entire stability period lock out period.

H. Variable Hour Employees

An Employee is a variable hour employee if they work a flexible work schedule such that it cannot be determined in advance whether they will be reasonably expected to work an average of 30 hours per week (the federal minimum threshold to qualify for health plan coverage). Eligibility for Variable Hour Employees for a specific Stability Period of coverage is determined based on the actual hours the Employee works and whether the Employee works an average of 30 hours of service during the measurement period.

I. After the Initial Measurement Period

Regardless of the outcome of an Employee's initial measurement period (eligibility for health coverage earned or not), their hours will be counted toward eligibility for future coverage based on the company's ongoing measurement period. In some cases, their initial measurement period and the standard measurement period will overlap. During any such overlap, an Employee's hours will be counted separately toward each of the measurement periods and their eligibility will accrue *separately* to each of the initial and ongoing measurement periods.

J. Rehires and Leaves of Absence

If an Employee terminates employment and is rehired or goes on a leave of absence such that they have a break in service of 13 continuous weeks or more (26 weeks for an educational organization), the Employee will be subject to a new waiting period. However, if an Employee terminates employment and is rehired or goes on a leave of absence such that the break in service is less than 13 weeks, the Employee will not be subject to a new waiting period.

K. Transitioning from a New Employee to an Ongoing Employee

A new Employee will be measured for the first Ongoing Measurement Period for which the Employee is employed. This means that a new Employee may have hours of service counted during both the Initial Measurement Period and the Ongoing Measurement Period, as these periods may overlap for a new Employee. A new Employee becomes an ongoing employee if the Employee remains employed for an entire Ongoing Measurement Period.

L. Change in Employment Status

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

M. No Expansion of Rights.

These provisions are intended to comply with the look-back safe harbor options permitted under federal regulations relating to the ACA. They are not intended to expand rights relating to coverage or benefits of Employees for any other purpose and should not be so construed. The primary purpose of these provisions is to avoid penalties under Section 4980H of the Code. For this purpose, no Employee who would otherwise be excluded from the Plan shall be included under these provisions except to avoid such penalties.

Section 14: ACA Eligibility Method - Monthly Measurement Method

This section is only relevant for employers who are Applicable Large Employers (ALEs) under the Affordable Care Act. To determine if Employer/Plan Sponsor is an Applicable Large Employer and whether Employer/Plan Sponsor has adopted the Monthly Measurement Method. For ACA Eligibility Determination, please refer to the accompanying Fact Sheet.

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

A. Basic Rule

The actual hours an Employee works each month determines whether they are eligible for coverage during that month.

B. Averaging 30 Hours or More

If an Employee's average hours worked each week exceeds the 30-hour threshold during any given month, Employer/Plan Sponsor is required to either provide coverage for that month or pay a penalty (Shared Responsibility Payment).

C. Averaging Less Than 30 Hours

If an Employee's average hours worked each week does not meet the 30-hour threshold during any given month, the employer is not required to provide coverage for that month.

D. Retroactive Nature of Method

If an Employee's hours exceed the 30-hour threshold for a month, Employer/Plan Sponsor 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 15: ACA 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 the Component Benefit Plan information in the accompanying 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 the 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, which can be found in the accompanying Fact Sheet. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (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 16: Important Disclosures

Certain Federal laws only apply based on factors such as the number of employees or Participants of the Employer or Controlling Employer group or for other reasons. To that end, the following laws may or may not be applicable to Employer/Plan Sponsor. The provisions outlined below are intended to reflect a summary of the laws and are not intended to grant additional rights beyond such laws to any individual, and such language should be interpreted accordingly. These notices are available online or via paper, free of charge, upon request to the Plan Administrator.

This Plan shall be construed, enforced, and administered in accordance with the laws of the state in which the insurance contract is written except to the extent that those laws are superseded by the Federal law of the United States of America, in which case such Federal law shall apply. If any provision of the Plan or the application thereof to any circumstance or Person is invalid, the remainder of the Plan and the application of such provision to other circumstances or persons shall not be affected thereby.

A. Affordable Care Act

The Affordable Care Act (ACA) is also known as the Patient Protection Affordable Care Act (PPACA). The following is an outline of plan provisions implemented in accordance with ACA. Where noted, some provisions may not apply to grandfathered plans. Please refer to the accompanying Fact Sheet to determine the grandfathering status of each Component Benefit 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. Dependents to Age 26. Group health plans (but not HIPAA-excepted plans such as dental and vision coverage) must cover dependent children to age 26.
5. No Annual or Lifetime Maximums. Group health plans (but not HIPAA-excepted plans such as dental and vision coverage) may not impose annual or lifetime dollar limits on coverage of essential health benefits.
6. 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), an Employee holds the right to designate any primary care provider who participates in that plan's network and who is available to accept them or their family members. Until an Employee affirmatively makes this designation, the health plan may designate a primary care provider for the individual.
    (a) For children, an Employee may designate a pediatrician as the primary care provider.
    (b) For individuals seeking gynecological or obstetric care, a prior authorization from the health plan or from any other person (including a primary care provider) is not necessary 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 the accompanying Fact Sheet).

7. Summary of Benefit Coverage. The Summary of Benefits and Coverage (SBC) is a standardized, concise document that group health plans and insurers must provide to participants and beneficiaries. It is designed to help individuals easily understand and compare health plan benefits and coverage options.
8. External Claims Review. This provision does not apply to grandfathered plans. Plans and issuers are required to establish both internal and external review procedures for claims appeals in accordance with state or federal guidelines, as appropriate. Please refer to the Certificate of Coverage for complete claim appeal and review procedures.
9. 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. The 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.
10. Medical Loss Ratio Rebates. This provision applies to all group health plans, regardless of grandfathering status. Insurance Carriers must meet minimum loss ratio standards established by the ACA. Plans that do not meet the minimum requirement must rebate the excess premium to the Employer/Plan Sponsor. Employer/Plan Sponsor is then required to pass through the portion of the rebate that is attributed to any Employee contributions 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.

Generally, grandfathered plans (legacy health plans created prior to the passage of the ACA) and non-grandfathered plans that are not HIPAA-excepted coverage still must follow many of the consumer protection provisions afforded under the ACA. The Plan Administrator will disclose whether the plan is grandfathered.

B. Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) generally applies to employers with 50 or more employees within a 75-mile radius. To be eligible to take FMLA leave, Employees must have worked 1,250 hours during a defined 12-month period. Employees must provide at least 30 days' advance notice of the need for leave. Upon return from FMLA leave, most Employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits and other employment terms and conditions.

FMLA provides eligible Employees up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

(a) A serious health condition that makes the Employee unable to perform their job

(b) Care for the Employee's spouse, child or parent who has a serious health condition

(c) Care for an Employee's child after birth or placement for adoption or foster care

(d) Incapacity due to pregnancy, prenatal medical care, or childbirth

(e) Qualifying exigencies related to the foreign deployment of a military member who is the Employee’s spouse, child or parent.

In addition, the spouse, child, parent, or next of kin of a service member with a serious injury or illness may be eligible to take up to 26 weeks of leave in a single 12-month period to care for the service member.

Employer/Plan Sponsor must continue Employee benefit plan coverage during an FMLA leave on the same terms as if the Employee had continued to work. Any changes to the Plan during an FMLA leave apply to Employees on leave, as well. Employer/Plan Sponsor must also provide notice of any opportunity to change plans or benefits during the Employee’s FMLA leave period (such as during an open enrollment opportunity).

Employees are responsible for continuing to pay required premium contributions during FMLA leave. If an employee is 30 or more days late in making payment and Employer/Plan Sponsor has provided written notice at least 15 days in advance advising that coverage will cease if payment is not received, coverage may be terminated as of the last date of the period for which premium contributions were timely made. Upon return to employment, Employer/Plan Sponsor is required to restore coverage. However, if an Employee takes FMLA leave and does not return to work after the approved FMLA period, then the Employee may be required to reimburse Employer/Plan Sponsor for the payments due but not made during the leave. An Employee may choose not to retain health coverage during FMLA leave.

Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of a leave. In addition, Employer/Plan Sponsor cannot require an Employee to meet any qualification requirements imposed by the plan, including new waiting periods or passing a medical exam to be reinstated.

If an Employee does not return from leave, the 30-day period to request special enrollment in another plan will not start before the FMLA leave ends (unless required premium payments have not been made). If applying for other health coverage, tell the Plan Administrator or new health insurer about any prior FMLA leave.

Coverage provided under FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. However, a COBRA qualifying event may occur when an Employer's obligation to maintain health benefits under FMLA ceases, such as if the Employer is notified of the intent not to return to work or if an Employee fails to return to work at the end of the FMLA leave.

C. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA applies to certain health plans (generally those that are not HIPAA-excepted) and to employers with 15 or more employees. GINA generally prohibits private employers from discriminating on the basis of genetic information collected with respect to eligibility, premiums, or contributions.

As afforded under this law, Employees are not required to provide any genetic information when responding to requests for medical information. “Genetic information,” as defined by GINA, includes an Employee’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.

Under GINA, the plan must provide that an employer cannot request or require that the individual reveal whether genetic testing has or has not occurred relating to an individual, nor can an employer require an individual to undergo any genetic test. An employer cannot use genetic information to set contribution rates or premiums.

D. Health Insurance Portability and Accountability Act (HIPAA)

HIPAA provides specific rights for participants and beneficiaries in group health plans related to preexisting conditions, discrimination based on health status, and special enrollment opportunities. The law requires plans to disclose certain information regarding these rights to participants and beneficiaries, as well as certain other individuals eligible for benefits under the plan.

1. HIPAA Privacy Notice. The HIPAA Privacy Notice provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information (PHI) about the individual, as well as his or her rights, and the covered entity's obligations, with respect to that information. A copy of the Privacy Notice is attached as an addendum to this Disclosure Document. This serves as the required distribution of the Privacy Notice.
2. HIPAA Notice of Special Enrollment. The HIPAA Notice of Special Enrollment describes the requirements for a group health plan to offer special enrollment within 30 days to eligible Employees and their dependents who experience the loss of other coverage based on certain events or special enrollment based on a new dependent as a result of marriage, birth of a child, adoption, or placement for adoption. This provision is described in more detail under Section 12: HPAA Special Enrollment.

E. Medicare Part D - Creditable Coverage

Before October 15 of each year, employers must inform Medicare-eligible participants whether the group health plan's prescription drug coverage is creditable, meaning that the coverage is expected to pay, on average, as much as the standard Medicare prescription drug coverage. Individuals who do not maintain creditable coverage for 63 days or longer following their initial enrollment period for Medicare Part D may be required to pay a late enrollment penalty. For additional information, refer to Section 16(E): Prescription Coverage and Medicare Part D.

F. Mental Health Parity Act

When required by law, it is the intent of this Plan that health 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 an employer who employed an average of between two (2) and 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the Plan Year is exempt.

G. 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.

H. Michelle's Law

Michelle's Law applies to group health plans in limited circumstances. Michelle's Law states that health plans must provide extended coverage to participants who are dependent children and who are full-time students in a postsecondary educational institution when they would otherwise lose coverage because of taking medically necessary leave due to a serious illness or injury. This extension is required for up to twelve (12) months or, if earlier, the date the coverage would otherwise end under such component benefit plan. This extended coverage may be conditioned on the Plan's receipt of a certification from a physician who has examined the Dependent and represents the need for the Dependent's leave or change in enrollment status due to serious illness or injury. The application of Michelle’s Law has reduced applicability due to the passage of the ACA; however, the disclosure requirements of the law still remain, therefore it is included herein.

I. 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 attending provider 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 such plan or insurer 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).

J. No Surprises Act

1. Overview. When an Employee receives emergency care or gets treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, they are protected from balance billing. These bills are sometimes called “surprise bills” giving rise to the name, No Surprises Act. In these cases, Participants are protected from balance billing and requires that only the in-network cost sharing amounts (copayments, coinsurance, or deductible) is paid. Providers are not allowed to balance bill and may not ask individuals to give up protections against being balance billed.
2. Definitions. For this subsection, it is useful to define several terms.

   “Balance billing” occurs when a Participant sees a doctor or other health care provider. Certain out-of-pocket costs, such as copayments, coinsurance, or a deductible may be due. In addition, if an out-of-net network provider is used, costs that are above the amount the plan recognizes for in-network providers will also be payable. Sometimes, this can amount to the entire bill if an Out of Network provider or facility is used.

"Out-of-network" means providers and facilities that haven't signed a contract with the health plan to provide services. Out-of-network providers may be allowed to bill the Employee for the difference between what the 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 the Employee's plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This may happen when an Employee can't control who is involved in their care, for example when an emergency occurs or when a visit at an in-network facility is scheduled but treatment is unexpectedly provided by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

3. Balance Billing Protections. An Employee is *never* required to give up protections from balance billing nor is there a requirement to get out-of-network care. An Employee can choose a provider or facility in the plan's network. Employees are protected from balance billing for the following services:

    (a) Emergency services. If an Employee has an emergency medical condition and gets emergency services from an out-of-network provider or facility, the most they can bill is the plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). An Employee cannot be balance-billed for these emergency services. This includes services received after entering stable condition unless they provide written consent and give up their protections not to be balance-billed for post-stabilization services.

    (b) Certain services at an in-network hospital or ambulatory surgical center. When an Employee gets 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 the Employee is their 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 cannot balance bill and may not ask Participants to give up the protections not to be balance billed.

    If an Employee gets other services at these in-network facilities, out-of-network providers *cannot* balance bill the Employee, unless they give written consent and give up their protections.

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

    (a) An Employee is only responsible for paying their share of the cost (like the copayments, coinsurance, and deductible that they would pay if the provider or facility was in-network). Their health plan will pay any additional costs to out-of-network providers and facilities directly.

    (b) Generally, the health plan must:

    - Cover emergency services without requiring them to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services provided by out-of-network providers.
    - Base what they owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in their explanation of benefits.
    - Count any amount they pay for emergency services or out-of-network services toward their in-network deductible and out-of-pocket limit.

5. Additional Information. If an Employee needs additional information, believes they have been wrongly billed, or has a complaint, they may contact the CMS office which oversees compliance with the No Surprises Act for more information about specific rights under federal law.

    Phone: (800) 985-3059

    Website: https://www.cms.gov/nosurprises/consumers

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 a 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.

L. Premium Assistance Under Medicaid and Children's Health Insurance Program (CHIP)

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

1. Overview

   CHIP was created to provide affordable health coverage to certain individuals and their dependents who are not eligible for Medicaid and cannot get private insurance coverage. Various amendments to CHIP, including CHIPRA, permits some states to offer group health plan premium assistance to subsidize premiums. Employers must inform employees of possible premium assistance opportunities available in the state in which they reside.

2. Special Enrollment Opportunity

   CHIP and Medicaid were expanded under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to include the special enrollment rights of Employees and Dependents beyond acquiring a Dependent by birth, marriage, or adoption or losing other medical coverage that was in place at the time of the original coverage. Employees and Dependents who are eligible but not enrolled in a health plan must also be given the opportunity to enroll when:

   (a) The Employee's or Dependent's Medicaid or CHIP coverage is terminated due to a loss of eligibility. An Employee must request this special enrollment within 60 days of such loss of coverage.

   (b) The Employee or Dependent becomes eligible for a subsidy with respect to this Plan under Medicaid or CHIP. The employee must request this special enrollment within 60 days of when eligibility is determined.

3. State Subsidy May Be Available

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

4. Option to Choose Coverage

   Employees have the option to keep their children covered under the state's health program or enroll them in the employer's health plan. To be "qualified employer-sponsored coverage" under the law,

   (a) The Group Health Plan or health insurance coverage must be creditable coverage for HIPAA purposes;

   (b) The Employer contribution toward the cost of any premium for the coverage must be at least 40%; and

   (c) The coverage must be available to individuals in a manner that would be considered nondiscriminatory for group eligibility purposes under Section l05(h) of the Code.

   CHIP specifically excludes coverage under health care flexible spending accounts and high deductible health plans (HDHPs).

5. State-Specific Subsidy Election

   Each state choose whether or not to implement this optional subsidy. States also decide whether the subsidy will be paid: (i) directly to Employees as a reimbursement of their portion of the Group Health Plan premium and other out-of-pocket expenditures; or (ii) directly to employers on behalf of the Employees. In this latter instance, an employer may opt-out of receiving the premium assistance subsidy so that the subsidy would be paid directly to the Employee. This opt-out will permit the employer to continue to withhold the Employee's full premium obligation and avoid direct involvement with the subsidy program.

   The amount of premium assistance available is the incremental premium cost difference between coverage for the Employee only and coverage for the Employee plus the eligible child or children.

6. Required Notification and Disclosure

   Employers must notify all Employees about the new CHIP special enrollment rights regardless of enrollment status. The enrollment notice may be given to Employees together with the Group Health Plan's eligibility and enrollment information, Open enrollment packets, or summary plan description. An Employer must also provide an annual notice to all Employees residing in impacted states regarding the assistance available and how to apply for such assistance, regardless of enrollment status. Each Employer sponsoring a Group Health Plan must provide the Employer Medicaid/CHIP Notice to applicable Employees.

   CHIP also requires plan sponsors to provide disclosure information to state agencies regarding when a plan Participant or beneficiary is covered under the company's Group Health Plan and Medicaid or CHIP. This disclosure is designed to assist states in determining the cost-effectiveness of providing premium assistance subsidies. The law directs HHS and the DOL to develop a model disclosure form for this purpose. States may not request this information until the first plan year that begins after the date on which the model form is first issued.

7. Steps to Secure Subsidy

   If an Employee or eligible dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, the Employee should contact their State Medicaid or CHIP office to find out if premium assistance is available.

   If an Employee or eligible dependents are NOT currently enrolled in Medicaid or CHIP, and they think the Employee or any of their dependents might be eligible for either of these programs, the Employee should contact a local State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. To find out if the Employee qualifies, they should ask their state if it has a program that might help them pay the premiums for an employer-sponsored plan.

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

8. State Programs and Contact Information

   If an Employee lives in one of the following states, they may be eligible for assistance paying their employer health plan premiums. The following list of states is current as of March 17, 2025. Contact the appropriate state agency directly for more information on eligibility-

ALABAMA – Medicaid
Website: http://www.myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https:health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Medicaid) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – 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)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage:https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

Email DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: http://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/

Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Telephone: 1-800-251-1269

To check if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration (EBSA) www.dol.gov/agencies/ebsa 866-444-EBSA (3272)	Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) www.cms.hhs.gov 877-267-2323, Menu Option 4, Ext. 61565

M. Qualified Medical Child Support Orders (QMCSO)

A QMSCO is a judgment, decree or order issued by a court or through a state administrative process that requires a group health plan to provide coverage for an "alternate recipient." An alternate recipient includes the participant's child, adopted child, or a child placed for adoption with the participant. As such, a dependent child may become eligible for coverage by way of a QMCSO. 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 these procedures must be provided at no charge, if requested.

1. Types of Medical Child Support Orders. Under ERISA, group health plans must establish reasonable procedures to determine whether medical child support orders are QMCSOs and to administer the provision of benefits under qualified orders. There are two types of Medical Child Support Orders that may be received:

    (a) A National Medical Support Notice (NMSN) is the exclusive document a state child support enforcement agency must use to enforce the health care coverage provisions of child support orders. The Child Support Performance and Incentive Act generally requires state child support enforcement agencies to use the standardized notice. ERISA regulation Section 2590.609.2 discusses the requirements of NMSNs.

(b) A QMSCO issued under State Domestic Relations Laws may also be acceptable. These orders must meet the requirements outlined in ERISA Section 609(1a).

2. Acknowledge Receipt. When the Plan administrator receives a medical child support order, it will notify the participant and alternate recipient (through his/her designated representative) that the Plan Administrator has received the medical child support order. The Plan administrator also will send a copy of the notice of receipt to the attorneys, if the attorney's names and addresses are made available. In addition, the Plan Administrator will direct the parties and their attorneys to this SPD for an overview of procedures.

3. Required Elements in the Order. To be a valid QMSCO, the order must clearly identify all the following elements:

   (a) The full name and last known mailing address of the participant

   (b) The full name and last known mailing address of each alternate recipient who will receive coverage under the medical child support order (or state agency official for the alternate recipient). Although not required by ERISA, the medical child support order should contain each alternate recipient's social security number and date of birth which is necessary for proper Plan administration.

   (c) The name and address of the representative designated to receive notices on the alternate recipient's behalf. (This will usually be the alternate recipient's custodial parent or legal guardian.)

   (d) 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.

   (c) The name of the party who will pay the premiums (if any) for the coverage.

   (d) A statement that the child has the right to receive health benefits for which the employee is eligible under the ERISA Plan.

   (e) The period to which the medical child support order applies.

4. Determination of Qualified Status of the Order. The Plan Administrator will determine whether the medical child support order is qualified pursuant to these procedures. The Plan Administrator will make this determination within a reasonable period of time after it receives the medical child support order. This period will not exceed 40 days from the date the Plan Administrator receives the medical child support order, unless extenuating circumstances apply. If the Plan administrator determines that the medical child support order is not qualified, it will advise the parties and their attorneys of this determination. The Plan Administrator will also explain the specific provisions which support the determination and explain how the parties can request a review of the determination. If the Plan Administrator determines the medical child support order satisfies all of the requirements for a QMSCO it will: (i) notify the parties and their attorneys that the medical child support order is qualified; (ii) explain the procedure to request a review of the determination; and (iii) take such steps to enforce the QMCSO, subject to the review procedures described below. An alternate recipient shall be treated as a participant for purposes of meeting applicable reporting and disclosure requirements. An alternate recipient shall be required to comply with all applicable Plan rules and procedures, including procedures relating to application for benefits, disclosure of information by participants and beneficiaries and claims and appeals. Any payment for benefits made by the Plan pursuant to a QMCSO for reimbursement of expenses paid by an alternate recipient or an alternate ((i)recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

5. Determination of Eligibility. The Plan Administrator should determine if each alternate recipient meets the Plan's definition of a dependent child and whether the Employee is eligible to participate in the Plan. The Plan Administrator cannot deny enrollment on the grounds that (i) the child is not claimed as a dependent on the participant's federal income tax; (ii) the child does not reside with the participant; or (iii) the child is receiving benefits under the state Medicaid plan.

6. Determination of Coverage. The plan provides coverage as outlined in the accompanying Fact Sheet. If a medical child support order specifies only that "health coverage" be provided, the Plan Administrator will interpret "health coverage" only as medical, prescription drug, dental, vision, and any applicable employee assistance program coverages. If a medical child support order states the Plan Administrator should enroll the alternate recipient in the "highest level" of benefits or "lowest cost" benefits, the Plan Administrative will determine that the order is not specific enough. The medical child support order specifically should state the level of benefits the alternate recipient will receive under the Plan.

7. Limitations on Coverage. A medical child support order must not require the Plan to provide any type or form of benefit, or any option, not otherwise provided by the Plan. If the participant is not eligible to elect coverage for dependents, a medical child support order cannot force the Plan to provide dependent coverage.
8. Payment for Coverage. The Plan Administrator is not required to make coverage available to the alternate recipient unless the participant (or another individual) pays for the coverage. The medical child support order should provide that the participant will make the necessary arrangements with the Plan Administrator to enroll the child. If another source is responsible for payments, the medical child support order should identify the payer. Any non-participant payer should contact the Plan Administrator to schedule payments. In the absence of any information in the medical child support order on this issue, the Plan Administrator will assume the participant is responsible for payment and will enforce the medical child support order accordingly. The cost of coverage for the alternate recipient will be based on the benefits available to the participant.
9. Period of Coverage. The alternate recipient is treated as a dependent under the terms of the Plan. Therefore, the alternate recipient/child's coverage as a dependent will end when similarly situated dependents are no longer eligible for coverage under the Plan. The Plan is obligated to provide only those benefits that it provides to any dependent of a participant who is enrolled in the Plan.
10. Effective Date. If approved, coverage can become effective no earlier than the date the Plan Administrator requires a valid QMSCO or such later date as specified in the medical child support order, provided contributions are paid on a timely basis. If the Employee is not currently enrolled in the Plan, the Employee will be required to enroll himself or herself in the Plan at the same time the alternate recipient is enrolled in the Plan. The Plan does not allow a child to be covered other than as a dependent of an Employee who is covered under the Plan, except as required by COBRA.
11. Coverage Termination. Coverage for the alternate recipient under the medical child support order will end the earliest of the following dates:
    (a) The date the participant is no longer eligible to cover dependents under the plan.
    (b) The date (including any grace periods) that payment for coverage is due but unpaid.
    (c) The date the alternate recipient dies.
    (d) The date the alternate recipient no longer meets the definition of an eligible dependent under the terms of the Plan.
    (e) The date the alternate recipient experiences a disqualifying event as specified in the order (for example, attaining a limiting age, getting married, or becoming financially self-sustaining). The medical child support order must provide that the participant and/or the alternative recipient's custodial parent, legal guardian, or sponsoring state agency will notify the Plan Administrator when such an event occurs.
    (f) If the alternate recipient's coverage would end due to a COBRA qualifying event, then continuing coverage rights under COBRA may apply.

N. Uniformed Services Employment and Reemployment Rights Act Coverage (USERRA)

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment to undertake military service or certain types of service in the National Disaster Medical System. It also prohibits employers from discriminating against past and present members of the uniformed services. Under USERRA, employees may continue to participate and be eligible to receive benefits. Any continuation coverage provided pursuant to USERRA will run concurrently with COBRA continuation coverage, to the extent permitted by law. Certain requirements must be met for returning service members to be entitled to reemployment. Continuation of group health coverage will be immediately reinstated on the first day of returning to employment if released under honorable conditions and returning to employment within the required time period. Please refer to Section 19: Leaves of Absence for additional information on USERRA rights and responsibilities.

O. Wellness Programs

Please refer to the accompanying Fact Sheet to determine if Employer/Plan Sponsor offers a wellness program and the type that may be offered.

Wellness Programs are health initiatives designed to maintain or improve the wellbeing of Participants' physical, emotional, and mental health. This may include health risk assessments, biometric screenings, weight loss, smoking cessation or fitness challenges, stress management, healthy eating information, illness prevention, and educational seminars. Program elements may be coupled with an incentive to encourage Participants to make healthy decisions. Wellness programs fall into two categories as follows:

- Participatory: No requirement to meet health or activity standards to earn a reward
- Health-Contingent: Must achieve a certain activity level or meet certain health outcomes to earn a reward.

Health Contingent programs (which requires either an activity-only and/or an outcome-based wellness component) must provide Participants with a notice that states the availability of a reasonable alternative standard (or possibility of waiver of the otherwise applicable standard) to earn a reward. The notice must include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated.

Under the Americans with Disabilities Act (ADA), employers that offer wellness programs that collect employee health information must inform employees offered participation in a wellness program what employee health information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. Employees must receive the notice before providing any health information, and with enough time to decide whether to participate in the voluntary program. Reasonable accommodation or an alternative standard may be offered.

P. Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that health plans offering medical and surgical benefits in connection with a mastectomy or coverage of treatment related to mastectomy also provide certain specific services. If an Employee is eligible for mastectomy benefits under health coverage and the Participant elects breast reconstruction in connection with such mastectomy, the Participant is also covered for the following:

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

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 the 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.

Section 17: 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 Employees may be able to continue a portion of coverage after termination of employment or after they 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, costs of coverage, or to obtain information about the availability of a conversion option, employees should refer to the Certificate of Coverage. It is recommended that interested employees reach out to the insurance carriers directly to inquire and obtain information. Contact information may be found in the accompanying Fact Sheet.

Section 18: Continuation Coverage (COBRA)

Please refer to the accompanying Fact Sheet to confirm whether Employer/Plan Sponsor is subject to federal COBRA law.

When required by law, Employer/Plan Sponsor benefit program complies with the Federal COBRA legislation (Public Law 99-272, Title X) which provides a right for Participants to continue health plan coverage under certain circumstances for a specified period of time. Please refer to the accompanying Fact Sheet to confirm whether Employer/Sponsor is subject to federal COBRA law.

It is important that all Participants (Employees, Spouse, any Dependents over the age of 18) read this COBRA section carefully as it outlines Participant rights and responsibilities under the COBRA law.

A. Which Employers are Subject

In general, employers are subject to COBRA if the employer 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, whether for full-time or part-time work. Certain states also require companies with fewer than 20 employees to provide continuation of health coverage for eligible employees and dependents. Check state specific laws for applicable state COBRA or “mini-COBRA" requirements.

B. 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, as it is known, can become available to an Employee when a Participant would otherwise lose group health coverage under the Plan. This Plan provides no greater COBRA rights than the COBRA law requires; nothing in this document is intended to expand an Employee’s rights beyond COBRA’s requirements. The coverage that is provided under COBRA is the same coverage that the Plan provides to similarly situated Employees or Participants under the Plan who have not experienced a Qualifying Event and are not receiving COBRA coverage. COBRA qualified beneficiaries have the same rights under the Plan as other active participants, including annual open enrollment and special enrollment rights.

C. What is a Qualifying Event?

A Qualifying Event is an event that causes an employee or covered spouse/dependents to lose health benefits. The law defines the following events as COBRA Qualifying Events:

(a) Termination of employment (voluntary termination or involuntary termination, except in the case of termination for gross misconduct)

(b) Reduction in work hours

(c) A child no longer satisfying eligibility requirements of a plan (for example, when a child no longer qualifies as a dependent because of age)

(d) Divorce or legal separation

(e) Death of employee

D. Who is a Qualified Beneficiary?

A Qualified Beneficiary is an Employee or Dependent covered by a group health plan on the day before a Qualifying Event occurs that causes the individual to lose coverage.

E. Are Domestic Partners Qualified Beneficiaries?

Neither domestic partners nor the children of domestic partners are generally Qualified Beneficiaries. The federal COBRA law does not recognize domestic partners or children of a domestic partnership as a qualified spouse or dependents under the Code, unless they qualify as IRS dependents under IRC 152(a)(9). They are not considered Qualified Beneficiaries under COBRA, therefore they are not guaranteed the right to COBRA continuation coverage.

However, some Plans arrange for domestic partners and the children of domestic partners to continue coverage under group health plans. If the Component Benefit Plan covers domestic partners or children of

domestic partners and the Plan so allows, those individuals (while not having all the rights of formal COBRA Qualified Beneficiaries) may permit such covered individuals to continue group health coverage in a COBRA-like fashion, but without all the rights bequeathed to formal qualified beneficiaries. Please review the eligibility criteria outlined in the Certificates of Coverage or the Plan enrollment documents for full details about whether the Plan includes continuation rights for domestic partners and the children of domestic partners.

F. What Happens with an FMLA?

In the event an employee takes a leave of absence that qualifies under the Family and Medical Leave Act (FMLA) and does not return to work at the end of the leave, the employee and any covered dependents have the right to elect COBRA:

(a) If covered under group health coverage under the Plan on the day before the FMLA leave begins (or became covered by group health coverage under the Plan during the FMLA leave); and

(b) If group health coverage under the Plan is lost 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: when the employee definitively informs Employer/Plan Sponsor that they are not returning at the end of the leave; or the end of the leave, assuming the employee does not return to work.

G. What Types of Coverage Can be Continued under COBRA?

COBRA continuation rights apply only to health coverage as defined by the law. Typically, this means medical coverage, dental coverage, vision coverage, employee assistance programs, integrated health reimbursement accounts (HRAs), and health Flexible Spending Accounts (health FSAs).

COBRA continuation rights do not apply to any other benefits offered under the Plan (such as Life, AD&D, or disability benefits).

Continuation is available only for coverages that an Employee or their dependents were enrolled in at the time of the Qualifying Event. However, an Employee may enroll new dependents acquired while they 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. Can COBRA Coverage Change?

An Employee's continued health coverage will be the same as the current health coverage provided by the plan for similarly situated employees or dependents who have not had a Qualifying Event. However, if any plan or rate changes are made to coverage for similarly situated employees or family members, the coverage of COBRA Qualified Beneficiaries will be similarly modified.

I. How Long Can COBRA 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 employment or a reduction in work hours is available for up to 18 months. These types of events extend coverage for an Employee and/or their covered Dependents.
2. 36 Month Duration. Coverage may be continued by for up to 36 months for the following types of Qualifying Events:

   (a) Divorce or legal separation of the employee

   (b) Loss of dependent child eligibility

   (c) Death of the employee

   These types of events extend coverage for a covered Spouse or Dependent Child.

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

4. If an Employee becomes entitled to Medicare and, within 18 months, experiences a termination of employment or reduction in work hours resulting in a loss of coverage, covered dependents may elect to continue coverage for the period ending 36 months after the initial date of entitlement for Medicare.

    (a) 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 from that event 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, the disability must have started at some time before 61 days after the initial 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). The Employee must notify Employer/Plan Sponsor of the Social Security 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 the Employee must notify Employer/Plan Sponsor within 60 days of the date of the Qualifying Event.

    (b) Certain states allow for COBRA-like continuation coverage that extends beyond an 18-month COBRA event.

    (c) Cal-COBRA provides an extension of up to 36 months of medical coverage from the date federal COBRA coverage began. Individuals may be eligible for this extension if initially entitled to less than 36 months of continuation coverage under federal COBRA. The premium charged under the Cal-COBRA extension may be up to 110% of the premium cost. To inquire about Cal-COBRA extension coverage, contact the insurance carrier about the availability of this option. Note this extension applies to fully insured medical coverage only. Self-funded plans are not subject to this extension.

    (d) In the event Employer/Plan Sponsor commences a bankruptcy proceeding, covered retirees are entitled to a lifetime of continuation coverage. Upon the retiree's death, dependents of the covered retiree are entitled to up to 36 months of coverage from the date of death.

5. Subsequent Qualifying Events

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

J. COBRA Cost

An Employee is required to pay the entire cost of their continued health coverage. The 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 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 an Employee's COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. An Employee will be notified of COBRA premium changes.

K. 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, an Employee must elect COBRA coverage within 60 days from the later of:

(a) The date coverage would terminate due to the Qualifying Event; or

(b) The date on which the Qualified Beneficiary is provided the notice and election materials.

An election must be postmarked within the 60-day election period. If a completed election form is not received within the 60-day election period, an Employee will lose their right to COBRA. Assuming a timely election is made, their coverage effective date will be retroactive to the date of the Qualifying Event or the date of the termination of coverage. If an election form is returned waiving rights to COBRA and if an election form declining COBRA coverage is returned, this waives the Qualified Beneficiary's rights to COBRA continuation coverage. However, if the Qualified Beneficiary later decides to elect coverage and completes a new election form within the 60-day election period, the initial revocation will be reversed, as long as the new election is received within the original 60-day election period. However, in this situation, COBRA coverage will be effective as of the date the Qualified Beneficiary revokes their initial waiver of coverage, not retroactive to the initial Qualifying Event date.

L. Separate Election Rights for Each Qualified Beneficiary

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, 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, an Employee should take into account that they have special enrollment rights under federal law. An Employee has the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after group health coverage ends because of the Qualifying Event listed above. An Employee will also have the same special enrollment right at the end of continuation coverage if they get continuation coverage for the maximum time available to them.

M. When Are Premiums Due?

If an Employee decides to elect continued coverage, all retroactive and current premiums must be paid within 45 days from the election date. Coverage will be retroactively reinstated once the premium(s) and all required re-enrollment forms are received. If an initial payment for COBRA coverage is not made within 45 days after the date of an Employee's timely election, the Qualified Beneficiary 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 an Employee fails to make a monthly payment before the end of the grace period for that month, the right to COBRA coverage under the Plan will be lost.

N. When Does Coverage End?

1. Standard Rules. COBRA continuation coverage can be terminated prior to the maximum allowable duration outlined above. COBRA continuation coverage will terminate on the earliest of the following dates:

    (a) When no health coverage is provided by Employer/Plan Sponsor for any Employees

    (b) When premium payment for COBRA continuation coverage is not made in the prescribed time limit (inclusive of the grace period allow by the law)

    (c) When, after electing COBRA, any Qualified Beneficiary becomes a covered employee or dependent under any another group health plan (regardless of whether such coverage may be of lesser value)

    (d) When, after electing COBRA, a Qualified Beneficiary first becomes entitled to Medicare

    (e) When an Employee or their 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 the individual is no longer disabled. The Employee is required to notify Employer/Plan Sponsor within 60 days of the date Social Security makes a determination that the Qualified Beneficiary is no longer disabled.

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

2. Order of Elections. A Qualified Beneficiary's COBRA coverage will terminate if, after electing COBRA, the date he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. Coverage gained under such plans after COBRA has been elected is considered a disqualifying Event under COBRA. COBRA covered individuals must notify Employer/Plan Sponsor in writing within 30 days if, after electing COBRA, any COBRA covered individual becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. Employer/Plan Sponsor, Insurance Carriers, or Contract Administrators may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when an Employee provides the required notice. (If a Qualified Beneficiary's coverage under Medicare coverage or under other group health plan pre-dates their COBRA election, such coverage may be continued along with COBRA coverage. However, it is generally not financially advisable to do so.)
3. Partial Payment. 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 paid or 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.
4. Other Reasons. COBRA coverage may also be terminated for any reason the Plan would terminate the coverage of a participant not receiving COBRA coverage (such as fraud).

O. Employee Responsibility to Notify Employer

There are two different categories of events that entail different responsibilities for employees and covered dependents.

1. No Notice to Employer Required. In the event of a termination of employment, reduction of work hours, or death of the Employee, no Employer notification is required by the Employee. A COBRA Qualifying Event notification will be processed by Employer/Plan Sponsor or Contract Administrator. COBRA election materials will be mailed to the Employee's home address via the U.S. Postal Service. In some circumstances, the COBRA Administrator may also send COBRA election materials via email if a personal email address is on file with Employer/Plan Sponsor and provided to the COBRA Administrator. The COBRA election materials will outline coverage costs and options available. To make an election, the guidelines and timelines outlined in the COBRA election materials must be followed.
2. Notice to Employer Required. In the event of a divorce/legal separation or dependent child no longer qualifying as an eligible dependent, it is the responsibility of the Employee (or the spouse/ex-spouse or no longer eligible child) to formally notify Employer/Plan Sponsor that a Qualifying Event has occurred. Absent notification, Employer/Plan Sponsor would have no knowledge of such events. Plan guidelines dictate that this notification must be received in writing in a form specified by Employer/Plan Sponsor. Notification of such a Qualifying Event must be provided to Employer/Plan Sponsor or postmarked to 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.

P. Responsibility to Keep Plan Informed of Address Changes

All COBRA correspondence and notices will be sent to the Employee's last known home address (or the last known address of a spouse or adult dependent, if covered under the plan and alternate address information is provided to the Employer). In order to ensure receipt of important COBRA notifications, Participants must make sure that Employer/Plan Sponsor is informed of any address changes. Any time an Employee address change occurs, notification of the new address must be provided to Employer/Plan Sponsor so that notification of COBRA rights may be sent to the correct address. It is not Employer/Plan Sponsor's responsibility if a COBRA notice or other COBRA correspondence is not received because of an address problem or because of a problem with receiving mail. If a COBRA Qualifying Event occurs and notification as described above is not received, it is the responsibility of the Employee or covered dependent to notify Employer/Plan Sponsor so that duplicate notifications may be forwarded to a corrected address.

Q. COBRA and Group Health Plan Coordination

Although the COBRA rules allow individuals to elect COBRA coverage while covered under another group health plan (if other coverage pre-dated the COBRA election), there are significant complications/reductions

in coverage when an individual is covered under two group health plans. COBRA coverage will generally be the secondary payor of medical expenses and will rarely "fill in" expenses that the other group health plan does not cover, despite paying a full premium for COBRA coverage. Consult with both the group health plan and the COBRA health plan to understand how the plans coordinate (or don't coordinate) prior to continuing COBRA coverage.

R. COBRA and Medicare Secondary Payor Rules

Although the COBRA rules allow individuals to elect COBRA coverage while covered under Medicare (if Medicare coverage pre-dated the COBRA election), there are significant complications/reductions in coverage when an individual is covered under both COBRA and Medicare. COBRA coverage will always pay secondary to Medicare, even if a Medicare-eligible individual has not signed up for Medicare coverage. COBRA coverage will integrate with what Medicare "would have paid" had the individual been enrolled in Medicare, leaving individuals with significant out of pocket expenses that they thought their COBRA coverage would pay. Generally, Medicare pays primary when individuals are active Employees; however, the rules switch such that Medicare pays secondary when an individual is no longer actively employed and on COBRA. This change in the Medicare Secondary Payor Rules can create confusion and cause hardship when it is expected that the health plan and Medicare will behave the same under COBRA as it does for active Employees.

S. Coverage Options Other Than COBRA

Upon the event of a loss of group health coverage, other options may be available in addition to COBRA coverage. The following is an overview of some of the options that an Employee may consider instead of enrolling in COBRA coverage. Employees have a Special Open Enrollment option to elect coverage under any of these options at the time their coverage terminates and when they are initially eligible to continue their coverage under COBRA. Some of these options may cost less than COBRA continuation coverage, so it is worthwhile to carefully review all options.

1. Other Group Sponsored Coverage. An Employee may enroll in other group health coverage (such as a spouse's plan). If a request for enrollment is made within the special Open Enrollment window, the Employee 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 an Employee qualifies for Medicaid coverage, they may enroll by contacting their local Medicaid office.
3. Health Insurance Marketplace. An Employee may purchase health insurance through an online health insurance Exchange (sometimes referred to as the Marketplace) in lieu of electing COBRA or after COBRA coverage ends. Coverage through the Marketplace may cost less than COBRA (depending on age and whether the individual qualifies for a federal premium subsidy). Subsidies may be available if an Employee's household income is between 138% and 400% of the federal poverty level (Additional information on Federal Poverty Level). In certain circumstances their copay and coinsurance amounts may also be lower if they qualify for a premium subsidy. An Employee has a "special enrollment" period 60 days from the date they lose their employer's group health coverage to enroll in the Marketplace. After 60 days an Employee's special enrollment period will end, and they may not be able to enroll until a Marketplace Open Enrollment. Typically, a Marketplace Open Enrollment starts in the fall for coverage starting as early as January 1st. However, if an Employee elects COBRA and their coverage ends involuntarily, such as exhausting the maximum coverage period or if the Employer no longer offers group health plan coverage, an Employee may be able to enroll in the Marketplace via a special enrollment period. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.
4. 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 an Employee qualifies for a federal premium subsidy, an Employee may only access that subsidy if they purchase insurance on an Exchange (Marketplace).
5. Conversion Coverage. In some circumstances and subject to certain state law requirements, an Employee may be eligible to continue health coverage beyond COBRA by conversion to an individual health plan, subject to state law requirements. A conversion privilege can be exercised, subject to all the rules that would apply to conversion privileges. However, benefits and costs will not be the same as coverage under COBRA. Rules requiring conversion policies to be offered predate the ACA provisions

which allow coverage to be purchased under the Exchange. In most cases, health insurance coverage available through an Exchange policy will be more advantageous.

T. Fraudulent Activity

As is the case with active employees, if an Employee (or any covered dependents) submits fraudulent claims to the plan or acts fraudulently toward the health plan while they are covered under COBRA, their coverage may be terminated.

U. Natural Disasters

In certain circumstances, individuals directly affected by a natural disaster may be granted an extension for COBRA election and premium payment deadlines. These extensions are part of broader relief efforts aimed at mitigating the impact of disasters on access to healthcare. Any relief efforts offered are specific to each natural disaster and often to specific areas of a natural disaster where the impact was most significant. When such relief may be available, the IRS/DOL will typically issue a general notification about which natural disasters are covered, the specifics of the relief available, and the timing for the relief. In the event of a natural disaster, please reach out to the Plan Administrator to confirm if any relief may apply.

Section 19: Leaves of Absence

A. Family Medical Leave Act (FMLA)

1. Overview. 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, Employer/Plan Sponsor benefit programs will comply with the Family and Medical Leave Act (FMLA). This FMLA law provides continuation rights for employee benefit coverage assuming Employer/Plan Sponsor meets certain criteria for being subject to the law, and the employee meets the eligibility criteria for the law.
2. Benefits Continuation Premium Requirements. If an Employee takes a paid leave of absence, the employer sponsored portion of the cost of group health coverage will continue to be paid by Employer. If an Employee contributes their portion of the premium during a period of FMLA, they have the ability to continue participation via regular payroll. If an unpaid leave of absence that qualifies under FMLA is taken, the Employee may continue participation as long as continued contributions of the Employee portion of the premium during the leave are made. In either case, the Employee is responsible for paying the regular monthly contributions for benefits plans during any leave. In some cases, the Employee has the ability to make payments on an after-tax basis or suspend health coverage during the leave. If the Employee does not make specific payment arrangements, their benefits coverage has the potential to be wholly terminated.
3. After Tax Premiums. 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 contributions made under the terms of the Plan will continue to be made on behalf of an employee on an FMLA leave.
4. Coverage Election Changes. If an Employee experiences a change in status event while they are on leave, or upon their return from leave, appropriate changes must be made to pre-determined elections. Any coverage that is terminated during FMLA leave will be reinstated upon return without any evidence of good health or newly imposed waiting period. If an Employee loses any group health coverage during an FMLA leave because required contributions were not made upon return, there is a potential option to re-enroll in benefits upon returning to work. On the first day back to work, group health coverage will re-activate, and the required contributions will resume. An Employee may be entitled to COBRA continuation coverage if they do not return to work at the end of FMLA leave.

B. Other Personal Leaves of Absence

In certain circumstances, if an Employee has a personal leave of absence that is approved by Employer, certain benefits may be continued. This provision only applies to the extent of Employer/Plan Sponsor's established corporate policy. The policy must be in writing and approved, in advance, by the insurance carrier in order to constitute continuation. Otherwise, benefits will not be continued in the event of a non-USERRA, non-FMLA leave of absence.

C. Military Leave

1. Overview. 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. Employer/Plan Sponsor's benefit program complies with the Federal USERRA legislation, which requires continuation rights for health expense coverage.

2. Benefits Continuation. If military leave is taken, whether for active duty or for training, the Employee is entitled to extend health coverage for up to 24 months as long as Employer/Plan Sponsor is provided advance notice of the leave, unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable. If coverage would otherwise end because of a military tour of duty, the Employee and any covered dependents may be able to continue that coverage under Employer/Plan Sponsor's Plan for up to 24 months of 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 the Employee does not elect to continue coverage during a military service, the Employee has the right to be reinstated to the benefit plan coverage under the Plan when 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.

3. Duration of Leave. Total leave, when added to any prior periods of military leave from Employer/Plan Sponsor, cannot exceed five years. There are a number of exceptions, 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 a hospitalization or convalescence following service-related injuries after uniformed service ends. If the entire length of the leave is 30 days or less, the Employee will not be required to pay any contributions. If the entire length of the leave is 31 days or longer, the Employee may be required to pay up to 102% of the full premium or premium-equivalent to cover an employee (including any amount for dependent coverage) who is not on military leave.

4. Return to Work. If military leave is taken, but coverage under the Plan is terminated (for instance, because extended coverage is not elected) when Employee returns to work at the Employer, the Employee will be treated as if they had been actively employed during the 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 for 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 the Employee does not return to work at the end of the military leave, the Employee may be entitled to purchase COBRA continuation coverage if benefits are extended for less than 18 months (because military leave benefits continuation period runs concurrently with COBRA coverage period). The laws indicate that COBRA and USERRA coverage begin at the same time. If the Employee does not return to work at the end of the military leave, the Employee 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 the employee and/or dependents may be eligible. The rights under COBRA and USERRA are similar but not identical. Any election made 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 provide different rights or protections, the law that provides the greater benefit will apply.

Section 20: Claims and Appeals Procedures

A. Benefits Administered by Insurers or TPAs

Claims for benefits that are insured or administered by a third-party administrator will be filed in accordance with the specific procedures contained in the insurance policies, Component Benefit Plans or the third-party administrative service agreement. These procedures will be followed unless inconsistent with the requirements of ERISA, in which case the ERISA procedures specified below will be followed. The address of the individual insurance company providing benefits and/or third-party administration (if any), or that reviews claims made under a Component Benefit Plan is set forth in the accompanying Fact Sheet. All other general claims or requests, including claims for eligibility to participate in the Plan, should be directed to the Plan Administrator (and determinations thereon will be made in accordance with the Plan Administrator's reasonable procedures).

B. Personal Representative

A Participant may exercise his or her rights directly or through an authorized personal representative. A Participant may have only one representative at a time to assist in submitting an individual claim or appealing an unfavorable claim determination.

A personal representative will be required to produce evidence of his or her authority to act on the Participant's behalf and the Plan may require such Participant to execute a form relating to such representative's authority before that person will be given access to the Participant's protected health information or allowed to take any action for the Participant.

An assignment or attempted assignment of a Participant's benefits does not constitute a designation of authorized personal representative. Such a delegation must be clearly stated in a form acceptable to the Plan Administrator. This authority may be provided by one of the following:

(a) A power of attorney for health care purposes, notarized by a Notary Public:

(b) A court order appointing the person as the conservator or guardian of the individual; or

(c) Evidence that the individual is the parent of a minor child.

The Plan retains discretion to deny to a personal representative access to any Participant's protected health information to provide protection to those vulnerable people who depend on others to exercise their rights under the rules and who may be subject to abuse or neglect. This provision also applies to personal representatives of minors.

C. Where to Find Information on Claim Filing Processes

Specific claims filing procedures are set forth in the Certificates of Coverage for each Component Benefit Plan. While furnished separately, these booklets accompany this Disclosure Document and are provided 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 procedures, as outlined in the Certificate of Coverage. A claimant can obtain the necessary claim forms from the Plan Administrator. When a claim is submitted, the Insurance Company or Contract Administrator will be responsible for reviewing the claim and determining how to pay the claim on behalf of the Plan. As described in the Certificates of Coverage documents, there may be multiple reasons that a claim for benefits is denied (or not paid in full). For example, a claim may be filed for a service that is excluded by the plan, or a claim may be submitted outside of the time window required for a claim to be considered

D. Types of Claims

Generally, there are two different types of claims, each with specific claims filing and appeals requirements:

- Disability and Non-Health Claims
- Health Claims

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

E. Overview of Disability and Non-Health Claim Procedures and Rights

Specific details of claims filing and processing are found in the Certificate of Coverage for each disability or non-health Component Benefit Plan. If a copy of the Certificate of Coverage has not been provided, it can be obtained from the Plan Administrator, as identified in the accompanying Fact Sheet. This summary provides an overview of the general framework and requirements for disability and non-health claims.

1. Overview

   A disability claim requires the Plan to determine if a claimant is disabled for purposes of eligibility for disability benefits under a Component Benefit Plan.

2. Claim Filing Procedures

   (a) Timing. Claims must generally be filed promptly after the onset of disability, often within 20–30 days, depending on the policy. Policies specify how soon after the disability begins the Employee must notify the insurer.

   (b) Notice of Claim. The claimant must submit written notice to the insurer, including name, policy number, and nature of the disability.

   (c) Proof of Loss. After notification is made, the Employee will need to submit proof of loss (medical records, attending physician's statement, and any required forms) within the timeframe specified by the policy, typically within 90 days of the disability or as soon as reasonably possible. Required documentation for proof of loss includes an attending physician's statement, medical records supporting the disability, employment and income documentation (for own-occupation or income-replacement policies), and any other forms required by the insurer (e.g., claimant statements).

   (d) Ongoing Proof. For continuing benefits, periodic updates and continued proof of disability may be required. This includes updated medical documentation, functional capacity evaluations, or progress notes.

3. Claim Review and Determination

   (a) Review. The insurer will review the claim to determine if it meets the policy's definition of disability, Elements of the review include whether the claimant is unable to perform the material and substantial duties of their occupation (own-occupation vs. any-occupation), whether the condition is excluded by pre-existing condition clauses, and whether the elimination period (waiting period before benefits start) has been satisfied.

   (b) Timeframe for Decision. For group policies, under ERISA guidelines, a decision must be made within 45 days after receipt of the claim. A 30-day extension may be applied if necessary (where notice must be given explaining why additional time is needed). A second 30-day extension may be used under special circumstances. For individual policies, timelines are determined by state insurance laws, often requiring decisions within a reasonable time (typically 30–45 days).

4. Claim Denial Notice

   Claimants will receive a written notice of approval or denial. If a claim is denied, the denial notices must set out the information below in an easy-to-understand manner:

   (a) The specific reason or reasons for the adverse determination;

   (b) Reference to the specific Plan provisions on which the determination was based;

   (c) A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

   (d) A description of the Plan's review procedures and the time limits that apply to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) if the claim is denied on review;

   (e) Where the determination is adverse, a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented to the Plan by the claimant, health care professionals treating the claimant, or evaluations of claimant from vocational-professionals, (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

and (3) a disability determination made by the Social Security Administration regarding the claimant presented by the claimant to the Plan;

(f) If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request of such person or persons who conducted the initial claim determination;

(g) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(h) A statement that claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim.

5. Appeal Process

(a) Right to Appeal. If denied, claimants generally have 180 days to file an appeal. Additional medical evidence or documentation may be submitted to support the claim.

(b) Independent Review. The appeal must be reviewed by a different and independent individual or committee from those involved in the initial denial. If the denial was based on medical judgment, a health care professional with appropriate training and experience must review the appeal.

(c) Timeframe for Decision. Under ERISA for group policies, a decision must be made within 45 days of receiving the appeal. One 45-day extension is allowed, if necessary, with a notice explaining the need for the extension. For individual policies, state laws govern, often requiring decisions within a reasonable period (commonly 30–60 days).

(d) Final Decision. If the appeal is denied, a detailed written notice must be provided, including specific reasons for denial, references to the policy provisions, and a statement outlining the right to request documents or to bring legal action. For ERISA plans, the notice will include a statement of the right to request an external review or to file a lawsuit under Section 502(a) of ERISA.

6. External Review and Legal Action

(a) For ERISA-covered group disability insurance (most employer-sponsored plans), these timing and procedure rules are governed by Department of Labor regulations under 29 CFR § 2560.503-1, requiring full and fair review of claims and appeals. If the plan fails to follow claims procedures, claimants may be deemed to have exhausted administrative remedies as required under ERISA, allowing them to proceed to court. Legal action for denied claims under ERISA must generally be brought within the period specified in the plan, or within the applicable state's statute of limitations for breach of contract under individual policies.

(b) For individual policies, many states provide for an external review after a final denial, where an independent review organization (IRO) will review the denial.

(c) Failure to adhere to the requirements described under this section will allow the claimant to deem the claims and appeals process non-compliant (and exhausted), and the claimant may proceed to pursue any remedies (including court action) available under ERISA. Notwithstanding the preceding sentence, action or inaction relating to the above rules that is (i) de minimis, (ii) non-prejudicial to the claimant, (iii) attributable to good cause or matters beyond the Plan's or Claim Fiduciary's control, (iv) in the context of an ongoing good-faith exchange of information, and (v) not reflective of a pattern or practice of non-compliance, will not be considered non-compliant. This paragraph will be interpreted and administered in accordance with 29 CFR 2560.503-1(1)(2).

7. Additional Requirements for Disability Claims

(a) All claims and appeals for disability benefits must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

Thus, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support a denial of benefits.

(b) Before a decision on review of a denied claim for disability benefits may be made, the Plan Administrator shall provide to the claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which a notice of adverse benefit determination on review is required to be provided under applicable DOL regulations to give the claimant a reasonable opportunity to respond prior to that date.

8. Special Considerations

(a) Pre-Existing Condition Clauses: Many policies exclude coverage for disabilities caused by conditions existing within a lookback period before the policy became effective.

(b) Mental Health Limitations: Some policies limit benefits for mental/nervous conditions to 24 months.

(c) Offsets: Benefits may be reduced by other income received while disabled (e.g., Social Security Disability benefits, workers' compensation).

(d) Elimination Periods: Benefits begin only after a waiting period of continuous disability.

F. Overview of Health Claim Procedures and Rights

For a full description of the required procedures for filing claims, 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, please refer to the Certificates of Coverage for each of the separate Component Benefit Plans. If a copy of the Certificate of Coverage has not been provided, it can be obtained from the Plan Administrator, as identified in the accompanying Fact Sheet. This summary provides an overview of the general framework and requirements for health claims.

1. Full and Fair Review

Under PPACA, DOL, and ERISA regulations, claimants are entitled to full and fair review of any health claims made under the Plan.

2. Four Categories of Claims

As required by law, the Plan recognizes four categories of health benefit claims as described below. Each of the different types of claims has different timing requirements for approval, request for additional information, and denial of the claim. The four categories of claims are as follows.

(a) Urgent Care Claims. An urgent care claim is defined as a claim where failing to make a determination quickly could seriously jeopardize the life or health of the patient or the ability to regain maximum function, or, in the judgement of a physician, could subject the claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the claimant's medical condition or an insurance company or TPA (applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine) may determine if a claim is an Urgent Care Claim. 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.

(b) Pre-Service Claims. Pre-service claims are claims for which the claimant is required to get advance approval or pre-certification before obtaining service or treatment for the medical services.

(c) Post-Service Claims. Post-service claims are claims involving the payment or reimbursement of costs for health care services that have already been provided.

(d) 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 care the claim is filed. However, the

Plan must give the claimant sufficient advance notice of the initial claims determination so that they may appeal the claim before a concurrent care claims determination takes effect.

3. Time for Decision on Claims.

The period of time for the Plan to review an appeal request and to provide notice of the decision depends on the type of claim.

Time Limit	Urgent Care	Pre-Service	Post-Service
To make an initial claim determination	72 hours	15 days	30 days
Extension (with proper notice and if delay is due to matters beyond Plan's control)	None	15 days	15 days
To request missing information from claimant	24 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days

The Claim Fiduciary will decide the appeal of Concurrent Care Claims within the time frame set forth above depending on whether that claim is also an Urgent Care Claim and the request to extend care is not made at least 24 hours prior to the scheduled expiration of treatment, a Pre-Service Claim, or a Post-Service Claim and before the expiration of any previously approved course of treatment. For an Urgent Care Claim that is a Concurrent Care Claim, if the request to extend care is made at least 24 hours prior to the scheduled expiration of the treatment, the initial claim determination will be made no later than 24 hours after such claim is filed with the Claim Fiduciary.

4. Claim Determination Process

The claimant will be notified of any claim determination (whether favorable or unfavorable) as soon as possible, but within the time frames outlined above. If an Urgent Care Claim is denied, the claimant will be notified verbally, and written notice will be provided within three days.

Note that fully insured plan claims (if any) may be subject to an even more accelerated response time by the insurance company handling the claim. See Certificates of Coverage for details.

If additional information is needed because necessary information is missing from the initial claim request, a notice requesting the missing information will be sent to the claimant within the timeframes outlined above and will specify what information is needed. The claimant must provide the specified information to the Claim Fiduciary within 45 days after receiving the notice. The determination period will be suspended on the date the Claim Fiduciary sends a notice of missing information, and the determination period will resume on the date the claimant responds to the notice.

Under special circumstances with respect to pre-service and post-service claims, the Claim Fiduciary may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the claimant will be notified before the end of the initial claim determination time period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The notice of extension will include (i) an explanation of the standards on which entitlement to benefits is based; (ii) the unresolved issues that prevent a decision on the claim; and (iii) any additional information needed to resolve those issues.

5. Notification of Denial

Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, the claimant will receive written notice if a claim is denied. The notice will contain the following information:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination was made;

(c) A description of any additional material or information necessary to perfect the claim and an explanation of why this material or information is necessary;

(d) A description of the Plan's review procedures and the time limits that apply to these procedures, including a statement of the right to bring a civil action under ERISA Section 502 if the claim is denied on review;

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

(f) If an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided free of charge upon request; and

(g) If the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request of such person or persons who conducted the initial claim determination. The Plan fiduciary will provide an independent, full and fair review of the claim being reviewed and will not give any deference or weight to the initial adverse determination. The claimant will receive written notice of the decision on review.

6. How to Appeal a Denied Claim

If a claim is denied, the claimant, the claimant's attorney or the claimant's Personal Representative will have 180 days following the date the claimant receives written notice of the denial in which to appeal such denial. If a claimant fails to file an appeal for review within 180 days of the denial notification, the claim will be deemed permanently waived and abandoned, and the claimant will be precluded from reasserting it under these procedures or in a court or any other venue. Unless the claimant is appealing the denial of an Urgent Care Claim, the request for review should be made in writing. If a request for review of an Urgent Care Claim is being made, the claimant may request review orally or by facsimile. A request for review must contain the claimant's name and address, the date notice the claim was denied was received, and the reason(s) for disputing the denial. Submissions may include written comments, documents, records, and other information relating to the claim. If requested, the claimant will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

7. Process for Denied Claims Determination and Notification

The claim review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether that information was submitted or considered in the initial claim determination. The review will be conducted by a Plan fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. In addition, if the denial of the claim was based, in whole or in part, on a medical judgment in reviewing the claim, the Claim Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person or a subordinate of a person consulted by the Claim Fiduciary in deciding the initial claim. The Plan fiduciary will provide an independent, full and fair review of the appealed claim and will not give any deference or weight to the initial adverse determination. The Participant will receive a written notice of the decision on review which will contain the following information:

(a) The specific reason or reasons for the appeal denial;

(b) Specific references to the pertinent plan provisions on which the appeal denial is based;

(c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (whether a document, record or other information is relevant to a claim for benefits shall be determined in accordance with the ERISA claims procedures);

(d) A statement, if applicable, describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following any final adverse benefit determination;

(e) a statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;

(f) a statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claim Fiduciary will, upon request, provide the claimant, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the plan to your medical circumstances; and

(g) the following statement, if and to the extent applicable and required by law: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way *to* find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Upon request, the Claim Fiduciary will provide the claimant with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

G. Special Appeals Review Procedures under the ACA

For a full description of the ACA Special Appeals procedures, please refer to the Certificates of Coverage for each of the separate Component Benefit Plans. If a copy of the Certificate of Coverage has not been provided, it can be obtained from the Plan Administrator, as identified in the accompanying Fact Sheet. This summary provides an overview of the general framework and requirements for ACA Special Appeals procedures.

1. Special Internal Appeals Review Procedures

Under the ACA, the following internal claims provisions apply to any "non-grandfathered," non-HIPAA-excepted coverage of the Plan based upon, generally whether the Plan is (1) fully-insured or (2) self-funded for any "Adverse Benefit Determination" (i.e., any medical claim or any claim involving a rescission of coverage).

(a) A rescission is allowed only upon a finding of fraud or intentional misrepresentation of a material fact;

(b) The claimant must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The Plan must also provide any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity to respond to the new evidence or rationale.

(c) Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual by a claims adjudicator or medical expert may not be based on the likelihood that that person will support the denial of benefits due to that influence (this prohibition is to avoid conflicts of interest).

(d) Notices to claimants by the Plan or Claim Fiduciary must also include additional content as follows:

(1) Any notice of Adverse Benefit Determination or final internal Adverse Benefit Determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable) and state that, upon request, the diagnosis code and treatment code and their corresponding meanings will be provided as soon as practicable.

(2) Any notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination must include the denial code and corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision.

(3) A description of available internal appeals and external review processes, including information about how to initiate an appeal.

(4) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

(e) Notices of any Adverse Benefit Determination must be provided in a culturally and linguistically appropriate manner, consistent with the DOL regulations, to any claimant in

the health plan who resides in a county in which ten percent or more of the population is literate only in the same non-English language as determined by guidance published by the DOL (a "10 Percent Non-English County"). For a health plan that has a claimant in a 10 Percent Non-English County, notices regarding the internal and external claims review must appear in both English and in that other relevant non-English language and, once a request has been made by a claimant, all subsequent notices to such person must be in the applicable non-English language as well. Also, the Plan or Claim Fiduciary must maintain oral language services in the non-English language (such as a telephone customer assistance hotline) to answer questions or provide assistance with filing claims and appeals.

(f) Generally, the Plan's or Claim Fiduciary's failure to adhere to the requirements of the ACA will allow the claimant to deem the internal claims and appeals process "not in compliance" under the ACA, therefore claimant may declare the claim procedure "exhausted." At this point, the claimant may proceed to pursue any external review process or remedies available under ERISA or under State law, if applicable.

Determinations may be appealed by requesting external review described in more detail, as described below.

2. Special External Appeals Review Procedures

Claimants should be aware that the Department of Labor ("DOL") has given States a number of options to implement protections included in the external review process for any Adverse Benefit Determination that involves medical judgment (including, but not limited to, a determination regarding medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) or any claim involving a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at this time), relating to insured health benefits (and certain self-funded arrangements which have been allowed by State law to be subject to the State's review rules). Please refer to the external appeals table identified here: https://acacmsresources.com/r/appeals.

(a) A State may meet the "strict standards" included in the DOL rules, which set forth 16 minimum consumer protections;

(b) Where the State meets the "strict standards," the health plan is subject to the external review procedures reflected in the underlying Certificates of Coverage or to a separate claims document to be provided to the claimant by the insurance company or the Plan.

3. Special Federal External Appeals Review Procedures

Generally, Plans that are either self-funded (are not provided through insured health benefits) or have not elected or are not eligible to qualify for the State review external appeals process for any Adverse Benefit Determination are subject to Federal review process described below.

(a) The claimant will have four months after the day notice is received or is deemed notified of the final internal Adverse Benefit Determination to request an external review of any final internal Adverse Benefit Determination.

(b) The Plan or Claim Fiduciary has five business days from the date a claim is made to complete a preliminary review to determine if the claim is eligible for external review (determining whether the claimant was covered (eligible) at the time the service was provided), whether the appeal relates to a medical judgment, and whether the internal appeals process has been exhausted (e.g., all relevant information requested from the claimant was provided) and, therefore, considered fully.

(c) Within one business day after the preliminary review, the Plan or Claim Fiduciary will notify the claimant in writing of its decision. If the claim is complete but not eligible for external review, the claimant will be provided with the reason for its ineligibility as well as contact information for the Employee Benefits Security Administration. If the claim is incomplete, the claimant will be provided with an explanation of what is necessary to complete the claim, and the Plan Administrator or Claim Fiduciary must provide a reasonable time to complete the claim (i.e., the remainder of the four-month appeal period or, if later, 48 hours after the notice of incompletion).

(d) If the claimant appeals an appealable final internal adverse benefits determination (or challenges whether or not it is appealable), the claim must be referred to an Independent

Review Organization (IRO) accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar nationally-recognized accrediting organization to conduct external reviews. The referral will occur through an unbiased selection process involving several IROs.

(e) Once assigned to the IRO, the IRO must make a determination on a non-Urgent Care Claim within forty-five (45) days after the IRO receives the assignment.

(f) If the IRO reverses the decision of the Plan or Claims Administrator, the payments or coverage must begin immediately, even if the Plan or Claims Administrator expects to appeal the IRO's decision to a court of law.

(g) The claimant must also have a right to expedited review for an Urgent Care Claim upon request. Once assigned to the IRO, the IRO must make a determination as expeditiously as possible but in no event more than seventy-two hours (or forty-eight hours if the request was not in writing) after its receipt of the request. If the IRO's notice of its determination is not provided in writing within 48 hours after the date of providing that notice, it must provide written confirmation to the claimant and the Plan.

(h) The contracts with the IROs must include the requirements contained in the DOL Technical Releases, and the IROs must agree, among other things, to the following: de novo review of all information and documents timely received (including the Plan document, claims records, health care professional recommendations, and clinical review criteria used, if any), retaining its records for six years and making them available to the applicable claimant (or to State and Federal government agencies, to the extent not in violation of any privacy laws) for examination upon request, and inclusion of certain information in notices to claimants.

The Plan intends and is taking steps in good faith to comply with the claims and appeals rules.

4. External Review Under the No Surprises Act

The No Surprises Act (the "Act"), part of the broader Consolidated Appropriations Act of 2021, effective January 1, 2022, extended these external claims provision requirements to any Adverse Benefit Determination that involves consideration of whether a plan or insurer is complying with the Act for both grandfathered and non-grandfathered plans.

(a) On December 30, 2021, the Centers for Medicare and Medicaid Services (CMS) issued guidance on state-law external review procedures that cannot accommodate external reviews of Adverse Benefit Determinations involving surprise medical billing requirements, which outlined two alternatives:

- The state may refer the matter to the federal external review procedure, which is administered by the Department of Health and Human Services (HHS); or
- Plans or insurers may request external review of Act-related issues using an accredited independent review organization that conducts external review for Act-related issues only under the federal process, if applicable requirements are met. These alternatives may be used until the state review procedure is changed to accommodate external review of Act-related surprise billing issues.

(b) Reviews under the federal external review process are typically performed by a contractor or contracted entity. Refer to the HHS website (Link) for the current federal contractor for this purpose and for details on the required process.

(c) States will generally have four months from the receipt date of an Adverse Benefit Determination to refer the matter to the federal contractor for external reviews. The contractor must provide its determination within 45 days of receiving the request for review.

The Plan intends and is taking steps in good faith to comply with the claims and appeals rules under the ACA and the provisions herein should be interpreted accordingly.

H. Acts of Third Parties

1. Overview

When an Employee or their covered dependent is injured or becomes ill due to the actions or inactions of a third party, the Plan may cover eligible health care expenses. However, to receive coverage, an Employee must notify the Plan that the illness or injury was caused by a third party and must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery by the Plan. Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek recovery for any 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 the Employee 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, an Employee agrees to the following rights of the Plan:

(a) May place an equitable lien on any and all monies paid (or payable) to an Employee or for their benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury

(b) May appoint the Employee as constructive trustee for any and all monies paid (or payable) to themselves or for their benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury

(c) 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.

2. Responsibility for Benefits Payment

If an Employee (or their attorney or other representative) receives any payments from the sources earlier in this section from a judgment, settlement, or otherwise, they have two options to store the funds. They must either place the funds in a separate account so that the plan has an equitable lien on the funds or 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 the Employee will be deemed to be in control of the funds. The Employee 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. The Employee must pay the Plan back up to the full amount of the compensation they receive from the responsible party, regardless of whether the settlement or judgment says that the money received (all or part of it) is for health care expenses. Furthermore, the Employee must pay the Plan back regardless of whether the third party admits liability and regardless of whether they have been made whole or fully compensated for the Employee's injury. If any money is left over, the Employee 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) the Employee incurs in obtaining the funds. The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

(a) Money from a third party that the Employee, their guardian or other representatives receive or are entitled to receive

(b) Any constructive or other trust that is imposed on the proceeds of any settlement, verdict, or other amount that the Employee, their guardian or other representatives receive

(c) Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid

(d) 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 the Employee, their guardian, or other representatives.

3. Participant Responsibility

As a Plan participant, the Employee is required to:

(a) 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.

(b) Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of the Employee's intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.

(c) Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

4. Failure to Comply

The Plan may terminate the Employee's Plan participation and/or offset future benefits in the event that the employee fails 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 the right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the contract will govern.

I. Right to Recovery of Overpayment

The Plan Administrator shall have the right to recover any payment made exceeding the amount necessary to satisfy the provisions of the Plan that should not have been made or that was made to an individual or organization not entitled to payment. The Plan has the right to recover these expenses from any individual (including a Participant or any other individual or organization or anyone else benefiting from the improper payment or receiving excess payments. The Plan may seek recovery from any monies then payable or which may become payable in the future, in the form of salary, wages, or benefits payable, or payments withheld from future benefits until the erroneous payment or overpayment is fully recovered by the Employer-sponsored benefit program to the full extent permitted by applicable law. In addition, whenever payments have been made based on fraudulent information provided, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

J. 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/Plan Sponsor to the extent of such payment.

K. Misstatement of Fact

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

L. 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.

M. Pre-existing Conditions Limitations – Non-Health/Disability Plan Coverage

The prohibition on pre-existing condition limitations 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. Refer to the Certificate of Coverage for full details on lookback periods, exclusion periods, and when the exclusion applies.

Section 21: Privacy of Protected Health Information (HIPAA Privacy Rule)

This section outlines the Use and Disclosure of Protected Health Information as required by the HIPAA Privacy Rule.

The following section, in conjunction with the detailed Privacy Notice (provided at the end of this document), describes how medical information about an Employee and their dependents may be used and disclosed and how they can obtain access to this information. Employer/Plan Sponsor is required by law to maintain the privacy of "Protected Health Information." Protected Health Information (PHI) includes any identifiable health information obtained from the health plan by the Employee or others that relates to his or her physical and mental health, the health care they have received, or payment for their 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 verbal communication.

A. Duties with Respect to Protected Health Information

The following information addresses the uses and disclosures the Plan may make of an individual's protected health information. It is important to note that these rules apply to the Plan, not to the Employer - that's the way the HIPAA rules work. If an Employee participates in an insured plan or an HMO option, they 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 Employer/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. An Employee can always request a copy of the most current privacy notice from the Privacy Officer.

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 Employer/Plan Sponsor only to permit 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 Employer/Plan Sponsor of Protected Health Information will be subject to and consistent with this Section 21.

C. Participant Disclosure

This Plan complies with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For questions about the privacy of Protected Health Information under the Plan, please contact the Plan Administrator or the Privacy Officer named in Employer/Plan Sponsor's Privacy Policy.

D. Types of Privacy Rule Applications

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. The type of compliance methodology is determined based on the measure of access to participant Protected Health Information (PHI). Regardless of compliance methodology, the Covered Entity is required to maintain the confidentiality of any PHI to which it has access and provide Employees with a Privacy Notice that describes rights under HIPAA as well as how the Covered Entity may use and disclose PHI. Following is an overview of the key elements of the two types of compliance measures.

1. Incidental PHI. Incidental PHI status applies when a Covered Entity has only incidental access to PHI. This is most often the case when health plans are fully insured such that Employer/Plan Sponsor generally only maintains enrollment and disenrollment information and receives summary claims information. When this is the case, the fully insured carrier will be the primary Covered Entity for HIPAA privacy purposes. In addition to keeping PHI secure and confidential, the Covered Entity must provide a Privacy Notice. When Employer/Plan Sponsor has Incidental PHI status, Employees will receive and should reference the Privacy Notice provided by each of the insurance carriers.
2. Full PHI. Full PHI status applies when a Covered Entity has full access to participant PHI. This is the case if any of the component health plans are self-funded. When this is the case, Employer/Plan Sponsor is the primary Covered Entity for any such self-funded plans for HIPAA privacy purposes. In addition to keeping PHI secure and confidential, the Covered Entity must provide a Privacy Notice. When Employer/Plan Sponsor has Full PHI status, the Privacy Notice appended to the end of this Disclosure Document serves as the formal Privacy Notice of an Employee's rights under the Plan. As

such, distribution of the Summary Plan Description also serves as distribution of the HIPAA Privacy Notice.

The HIPAA Covered Entity Status is identified in the accompanying Fact Sheet.

The Funding Arrangement for each Component Benefit Plan (which identifies whether a plan is self-funded or fully insured) is identified in the accompanying Fact Sheet.

If an Employee is covered by one or more fully insured group health plans offered by their Employer, he or she will receive a separate notice directly from each insurance carrier.

For additional details about the HIPAA Privacy Rule and Employer/Plan Sponsor's policies regarding safeguarding Protected Health Information, please refer to the HIPAA Privacy Notice (provided at the end of this document).

Section 22: 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 Full PHI Security measures as identified in the accompanying Fact Sheet of this Summary Plan Description.

A. Participant Disclosure

This Plan complies with the Security Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For questions about the privacy or security of health information under the Plan, please contact the Plan Administrator or the Privacy/Security Officer named in Employer/Plan Sponsor's Privacy Policy and reiterated in the accompanying Fact Sheet.

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 of which it becomes aware. Report to the Security Officer 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 protection 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 23: 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 options under Medicare's prescription drug coverage. This information can help employees decide whether or not to join a Medicare drug plan. When considering joining the group health plan or Medicare, it is important to compare current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage available. Information about where to get help making decisions about prescription drug coverage is provided at the end of this notice.

There are two important things an Employee needs to know about their current coverage and Medicare's prescription drug coverage:

A. Rx Coverage Availability

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. An Employee can get this coverage if they 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 accompanying Fact Sheet to confirm whether Component Benefit 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 an Employee's group health plan offers prescription drug benefits that are "creditable" under Medicare. To be considered "creditable", the prescription drug benefit of their 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.

C. For Plans with Creditable Prescription Drug Coverage

If an Employee's coverage is at least as good as the standard Medicare prescription drug coverage, the Employee has the ability to keep the coverage and not pay extra if they later decide to later apply for Medicare.

The Employee must apply for Medicare prescription drug coverage within 63 days of terminating creditable group sponsored plans.

Each year, an Employee will have the opportunity to enroll in a Medicare prescription drug plan between October 15th and December 7th. However, if an Employee loses a current creditable prescription drug coverage, through no fault of an Employee, they will also be eligible for a two (2) month Special Enrollment Period to join a Medicare drug plan. If an Employee drops their employer sponsored coverage and enrolls in a Medicare prescription drug plan, they may not be able to get the employer sponsored coverage back later. Employees should compare current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

Information about an Employer's group health plans and prescription drug benefits is available in their health plan certificate. In addition to prescription drugs, an Employee's current health plan coverage pays for other health expenses. There is a potential to lose current health and prescription benefits if an Employee chooses to drop their Employer sponsored coverage in order to enroll in their Medicare and a Medicare prescription drug plan.

D. For Plans with Non-Creditable Prescription Drug Coverage

Because 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, important decisions must be made regarding the Employee's prescription drug coverage. Most likely, an Employee will get more help with their drug costs if they join a Medicare drug plan than if they only have prescription drug coverage from the employer plan. This is important because it could potentially cause the Employee to pay a higher premium. This penalty may be incurred if they do not join a Medicare drug plan as soon as they are 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 an Employee did not purchase Medicare prescription drug coverage or equivalent coverage before May 15, 2006, they may have to pay a higher premium if they join later. An Employee will pay that higher premium as long as they have Medicare prescription drug coverage.

E. For all Medicare-Eligible Individuals

1. Periodic Notice. Medicare eligible individuals are entitled to receive notice of their rights under Medicare before each annual enrollment period. An

Employee will also receive notification if the prescription benefit under their group health plan ends or changes so that it is no longer creditable or becomes creditable. A request may be made for a certificate of Medicare prescription drug plan creditability from the plan sponsor at any time.

2. Premium Surcharge for Late Enrollment. If an Employee goes 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, the Medicare base beneficiary premium will go up at least 1% per month for every month that they did not have that coverage. An Employee will have to pay this higher premium as long as they have Medicare prescription drug coverage. For example, if they go 19 months without coverage, their premium will always be at least 19% higher than what most other people pay. In addition, an Employee may have to wait until the following October to join.
3. Annual Enrollment Period for Medicare Prescription Drug Plans. Generally, an Employee can only join a Medicare prescription drug plan between October 15 and December 7 of any year. This may mean the number of months required to wait for coverage will be longer, which could make their premium higher.
4. Group Health Plan Considerations. A current employer-sponsored coverage pays for other health expenses in addition to prescription drugs. An Employee will still be eligible to receive all current health and prescription drug benefits if they choose to enroll in a Medicare prescription drug plan. Upon finalization of a decision, an Employee should compare the current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in the geographic area of the Employee's residence.
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. Employees may also be contacted directly by Medicare prescription drug plans. Additional information about Medicare prescription drug plans may be obtained from the following resources:
    - Visit www.medicare.gov
    - Call the State Health Insurance Assistance Program (Refer to the Medicare & You Handbook for the telephone number)
    - Medicare & You Handbook
    - Call (800) MEDICARE, (800) 633-4227, or TTY (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 (800) 772-1213 or TTY (800) 325-0778.

Section 24: Health Savings Accounts (HSA)

This section only applies to the extent that a Health Savings Account option is offered through the Plan and outlined in the accompanying Fact Sheet.

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 an Employee with the Custodian/Trustee (through Employer/Plan Sponsor contributions and/or pre-tax salary reductions elected by the Employee). Employer/Plan Sponsor has no authority or control over the funds deposited in an Employee's 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. An Employee is eligible for Plan contributions to their HSA during any month if they satisfy the following conditions on the first day of that month:

1. Covered Under Qualifying HDHP Policy. The Employee is covered under a qualifying High Deductible Health Plan (as defined in Code 223) maintained by Employer.
2. Employee Certification. The Employee certifies/confirms, in accordance with policies and procedures established by the Employer, that they satisfy all of the requirements to be an Eligible Individual as set forth in Code Section 223. Employees are required to notify Employer/Plan Sponsor if they fail to satisfy these conditions by the first day of the month following the date that they first fail to meet these requirements. In the event an Employee fails to satisfy these conditions by the first day of the month following the failure, a notice is to be sent to the Employer/Plan Sponsor. In addition to being covered under a qualifying High Deductible Health Plan maintained by Employer, an Employee 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. Eligible. The Employee is 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 income tax plus a 20% penalty.

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 own the accounts personally, so termination of employment does not impact the account in any way.

Section 25: Health Reimbursement Arrangements (HRA)

This section only applies to the extent that a Health Reimbursement Arrangement option is offered through the Plan and outlined in the accompanying Fact Sheet.

A. Overview

A Health Reimbursement Arrangement (HRA) reimburses Participants, up to certain limits, for their own and their covered Spouses' and Dependents' medical care expenses. Reimbursements for medical care expenses paid by the HRA Plan generally are excludable from taxable income.

B. Definition

This plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45. The expenses reimbursed under this Component Benefit Plan are intended to be eligible for exclusion from Participants' gross income under Code §105(b). This Plan is intended to be an Employer-provided medical reimbursement plan under Code §105 and §106 and regulations issued thereunder.

C. Integration

In some cases, the HRA will be integrated with an underlying medical plan (wherein only Employees covered under a group health plan will be eligible. When this is the case, the plan is intended to satisfy the minimum value method of integration described in IRS Notice 2013-54 and DOL Tech. Rel. 2013-3. Such a plan is not intended to be integrated with Medicare Parts B and D. In some cases, the HRA may be an Excepted Benefit HRA which will not be integrated with a group health plan. This means that employees may be eligible for the plan, even if they are not covered under a group health Component Benefit Plan.

D. Election to Suspend/Opt Out of HRA Account

A Participant may elect to temporarily suspend or permanently opt out of his or her HRA Account for any future Plan Year by notifying Employer/Plan Sponsor before the beginning of that Plan Year. In certain circumstances this would benefit a Participant in order to retain eligibility to make contributions to an HSA. The opportunity to make an opt-out election will be offered to each Participant at least annually.

The Participant's suspension election will remain in effect for the entire Plan Year to which it applies, and the Participant may not modify or revoke the election during that Plan Year. The Participant will not receive reimbursements for any expenses incurred during the Plan Year to which the suspension election applies except for limited-scope dental or vision expenses that qualify as excepted benefits for HIPAA purposes. If a Participant suspends his or her HRA Account for a Plan Year, Employer/Plan Sponsor will suspend contributions to the HRA Account for that Plan Year.

E. Participant Contributions

Employer/Plan Sponsor funds the full amount of the HRA account. There are no Participant contributions under the Plan, except in the case of COBRA continuation coverage.

F. No Funding Under Cafeteria Plan

Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

G. Plan Funding

All amounts payable under an HRA Component Benefit Plan will be paid from the general assets of the Employer. Nothing herein will be construed to require Employer/Plan Sponsor or the Contract Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in any fund, account or asset

from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

H. Health Reimbursement Benefits

The Plan will reimburse Participants for certain Medical Care Expenses up to the unused amount in the Participant's HRA Account.

1. Period of Coverage. Under the HRA Account, a Participant may receive reimbursement for certain Medical Care Expenses incurred during a Period of Coverage, known as the Plan Year.
2. Timing of Incurred Expenses. A Medical Care Expense is generally considered to be incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible.
3. Medical Care Expenses in General. “Medical Care Expense” means expenses incurred by a Participant, his or her Spouse or Dependents for medical care, as defined in Code §213 but will not include expenses that are excluded as outlined below. Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents will be charged against the Participant's HRA Account. In order for a Spouse's or Dependent’s medical expenses to be Medical Care Expenses, the Spouse or Dependent, respectively, must be covered by the HDHC Plan at the time the expense was incurred. Employer/Plan Sponsor may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.
4. HRA-Eligible Medical Care Expenses. Not all medical care expenses (as defined/allowed by the IRS) are eligible under an HRA plan. Employer/Plan Sponsor defines specific Medical Care Expenses to be eligible under this HRA plan. Refer to the accompanying Fact Sheet and HRA plan documentation for information on the specific Medical Care Expenses that are eligible under the Plan.
5. Ineligible Expenses. Medical Care Expenses will not include (i) health insurance premiums for individual policies or for any other group health plan, (ii) cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, “cosmetic surgery” means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease); (iii) any expense that is not legally provided under applicable state or federal law; or (iv) any other expense excluded under Appendix B or otherwise under the terms of this Plan. Notwithstanding the foregoing, an HRA Account may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health plan sponsored by the Employer.
6. Cannot Be Reimbursed or Reimbursable from Another Source. Medical Care Expenses may be reimbursed from the Participant's HRA Account only to the extent that the Participant or other individual incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the HDHC Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the HDHC Plan imposes copayment or deductible limitations), the HRA Account may reimburse the remaining portion of such expense if it otherwise meets the requirements of this section.

I. Maximum Benefits

1. Maximum Benefits. The maximum dollar amount that may be credited to an HRA Account for an Employee who participates is outlined in the accompanying Fact Sheet. For subsequent Plan Years, the maximum dollar limit may be changed by Employer/Plan Sponsor and will be communicated to Employees through the Enrollment Form, the SPD, or another benefit communication method or document.
2. Nondiscrimination. Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by Employer/Plan Sponsor in its sole discretion.

J. HRA Accounts

1. Establishment of Accounts. When an Eligible Employee becomes a Participant, a notional HRA Account will be established for the Participant for the reimbursement of eligible expenses. The Contract Administrator will establish and maintain an HRA Account with respect to the Participant, but Employer/Plan Sponsor will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts. In no event, will Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.
2. Crediting of Accounts. A Participant's HRA Account will be credited as outlined in the accompanying Fact Sheet (typically in an annual, quarterly, or monthly cadence). No amount will be credited for any period if the Participant is not actively employed and an Eligible Employee on the first day of that calendar month.
3. Debiting of Accounts. A Participant's HRA Account will be debited for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.
4. Available Amount/HRA Balance. The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's HRA Account under subsection, plus any unused balance carried over from a preceding Period of Coverage (if applicable), reduced by prior reimbursements debited during the Period of Coverage.

K. Carryovers

Certain plans may allow for a carryover if any balance remains in the Participant's HRA Account after all reimbursements have been made for the Period of Coverage. Carryover balances may be used for eligible expenses in a subsequent Period of Coverage. However, if an individual ceases to be a Participant, expenses incurred after such time will not be reimbursed unless COBRA continuation coverage is elected. Certain plans do not include a carryover feature. Refer to the accompanying Fact Sheet for details on whether any carryover of unused expenses is available and/or any restrictions on the carryover under this HRA Component Benefit Plan.

L. Forfeitures

Any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks or unreimbursed balances when there is no carryover provision included) by the close of the Plan Year following the Period of Coverage will be forfeited.

M. Reimbursement Procedure

1. Submission Procedures and Timing. Procedures for submitting a claim for reimbursement and requirements for timing of submission of claims are outlined in the Plan Detail Documents or other plan description materials provided by the Contract Administrator.
2. Claims Substantiation. All claims must be substantiated with sufficient written documentation to affirm the eligibility of the expense. Substantiation requirements include:
    (a) The individual(s) on whose behalf Medical Care Expenses have been incurred
    (b) The nature or type of Medical Care Expense incurred
    (c) The date of the Medical Care Expense
    (d) The amount of the charge and/or requested reimbursement; and
    (e) A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source, and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted.

The reimbursement request must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred and the amount of such Medical Care Expenses, together with any additional documentation that the Contract Administrator may request.

N. Reimbursements After Termination and COBRA

When a Participant ceases to be a Participant, the Participant will not be able to receive reimbursements for expenses incurred after participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim by the claim submission deadline outlined by the Contract Administrator.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the HRA Account because of a COBRA qualifying event, will be given the opportunity to continue the same coverage that he or she had under the HRA Account on the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). If COBRA is elected, HRA coverage is continued on a self-pay basis, with a premium that is an actuarial equivalent premium for the benefit provided.

Section 26: Definitions

Where the following words and phrases appear in the Plan, they will have the respective meanings set out in this section, unless their context clearly indicates otherwise. Capitalized terms not defined in this Plan will have the meaning given to them in the applicable documents describing the particular Component Benefit Plan documents. All other defined terms in the Plan will have the meanings specified in the various sections of the Plan in which they appear.

A. Affiliated Employer

A business entity that is under common control with Employer/Plan Sponsor and considered to be a single Employer according to Code Section 414(b) or (c); a member of an affiliated service group or portfolio company with Employer/Plan Sponsor as determined under Code Section 414(m); an entity required to be aggregated with Employer/Plan Sponsor pursuant to Code Section 414(o); or any other entity that the Controlling Employer permits participation in the Plan. Affiliated Employers are listed in the accompanying Fact Sheet.

B. Affordable Care Act

The Patient Protection and Affordable Care Act (ACA), as amended.

C. Applicable Large Employer

With respect to a calendar year, an Employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. In making the Applicable Large Employer (ALE) determination, all persons/entities treated as a single employer under Code Section 414 (b), (c), (m), or (o) are treated as one employer.

D. Board of Directors

The Board of Directors or other governing body of Employer/Plan Sponsor (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.

E. Certificate of Coverage

A document given to an insured that describes the benefits, limitations and exclusions of coverage provided by an insurance company.

F. Code

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

G. Component Benefit Plan

The specific benefit arrangement, identified in the accompanying Fact Sheet, by which the Plan provides welfare benefits to plan participants. A Component Benefit Plan includes any applicable insurance policies and Certificates of Coverage relating thereto and may be amended from time to time by Employer/Plan Sponsor. Component Benefit Plans are listed in the accompanying Fact Sheet.

H. Contract Administrator

The term Contract Administrator is used to refer to an outsourced administration firm that handles administration of self-insured Component Benefit Plan. In some cases, the Contract Administrator may be named as the Employer/Plan Administrator if administration is not outsourced and is handled internally by Employer/Plan Sponsor. Please refer to the accompanying Fact Sheet for the details on the Contract Administrator for any specific Component Benefit Plan. The Contract Administrator can be found in the accompanying Fact Sheet.

I. Controlling Employer

Employer/Plan Sponsor. If the Controlling Employer merges or is otherwise consolidated with any Affiliated Employer, the surviving Employer, as to the group of Employees covered by the Plan immediately before such merger or consolidation and to the group of Employees of Affiliated Employers thereafter adopting the Plan, shall become the Controlling Employer, unless the Controlling Employer that will be merged out of existence specifies in writing to the contrary.

J. Dependent

A Dependent of a Plan Participant within the meaning of Code Section 152 and the regulations issued under Code Section 106 unless otherwise specifically provided in the Plan or in a Component Benefit Plan (to the extent such provisions are in compliance with Federal law). This includes a natural or adopted child, stepchild, foster child, child for whom the Employee and/or the Employee's spouse are the legal guardian or for whom the Employee or Employee's Spouse has legal custody, or any other person as expressly specified in the Component Benefit Plan documents. In addition, Dependent also includes an individual to whom a Participant is legally married and who is treated as a spouse under the Code.

K. Effective Date

The effective date or Restatement Date as specified in the accompanying Fact Sheet. The stated Plan effective date supersedes any prior versions of all Plans providing similar benefits as of such date.

L. Employee

An individual who is classified as a common-law employee of Employer/Plan Sponsor and is treated as an Employee for income and employment tax purposes. Specifically, this means individuals who Employer/Plan Sponsor classify as common-law employees and who are on the Employer's W-2 payroll.

Employee does not include:

(a) Any leased Employee (including but not limited to those individuals defined as leased employees in Code Section 414(n) or an individual classified by Employer/Plan Sponsor as a contract worker or independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll.

(b) Any individual who performs services for Employer/Plan Sponsor but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the Internal Revenue Service (IRS), any governmental agency or authority, or a court or agency (including any reclassification by an Employer or in settlement of any claim or action relating to such individual's employment status) to be a common-law employee of Employer.

(c) Any individual who is a former Employee.

(d) Any individual who is a non-resident alien.

(e) Any Employee subject to a collective bargaining agreement, unless specifically included by an articulated amendment to the Plan and outlined in the accompanying Fact Sheet.

Notwithstanding the above, any of the individuals listed in the categories above may be included if so specified in the accompanying Fact Sheet or are required to be included pursuant to the terms of the ACA Lookback provisions of the Plan.

M. Employer/Plan Sponsor

Employer/Plan Sponsor indicated in the Plan Information of the accompanying Fact Sheet and any Affiliated Employer who is authorized by Employer/Plan Sponsor 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 accompanying Fact Sheet.

N. ERISA

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

O. Group Health Plan

An employee welfare benefit plan within the meaning of ERISA Section 3(1) to the extent that such plan provides “medical care” within the meaning of ERISA Section 733(a)(2).

P. Highly Compensated Individual

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

Q. HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended.

R. HIPAA-Excepted Coverage

Any benefit that is not subject to the HIPAA portability provisions, as set forth at 26 CFR 54.9831-1(c), including but not limited to, accident only coverage, disability income coverage, liability insurance, worker’s compensation, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, and retiree-only health plans.

HIPAA-Excepted Coverage also includes, under certain circumstances, limited-scope dental or vision benefits as well as long term care, nursing home care, home health care, or community-based care benefits provided that they are:

(a) Under a separate policy, certificate or contract of insurance, or

(b) Otherwise not an integral part of the Group Health Plan.

That is, Participants may decline coverage if claims for the benefits are administered under a contract separate from the claims administrator for any other benefits under the Group Health Plan.

In addition, benefits under a health care flexible spending account and/or health reimbursement arrangement are HIPAA-Excepted Coverage if:

(a) Employer/Plan Sponsor offers other Group Health Plan Coverage (not limited to excepted benefits) to Employees’ and

(b) The maximum benefit payable to any Participant cannot exceed two times the Participant’s salary reduction election for the year or, if greater, $500 plus the amount of the Participant’s salary reduction election.

HIPAA-Excepted Coverage also includes non-coordinated excepted benefits such as coverage for only a specified disease or illness and hospital indemnity or other fixed indemnity insurance if:

(a) The benefits are provided under a separate policy, certificate or contract of insurance;

(b) There is no coordination between the provision of such benefits and any exclusion of benefits under any Group Health Plan maintained by the same plan sponsor; and

(c) The benefits are provided under any Group Health Plan maintained by the same plan sponsor.

S. Insured Benefits Program

A fully insured benefit plan where Employer/Plan Sponsor pays a fixed premium to a third-party commercial insurance carrier that pays the claims and administers the plan.

T. Participant

Any Participant with respect to this Plan means any Employee or beneficiary who meets the eligibility requirements of one of the Component Benefit Plans offered in accordance with the terms and conditions established for that specific Component Benefit Plan and has not, for any reason, become ineligible to participate in the Component Benefit Plan or the Plan. An Employee, dependent, or beneficiary shall be a Participant in this plan if he or she properly and timely elects coverage under one or more of the Component Benefit Plans or if that employee becomes covered by one or more of the Component Benefit Plans by virtue of automatic administrative processing.

Participants must fall into one of the following categories:

3. An individual who is an Employee of the Employer, eligible Dependent of an Employee, or beneficiary.
   (a) An individual who was previously enrolled as an Employee or Dependent who elected continuation coverage under the terms of the Plan (for example under COBRA or USERRA).
   (b) An individual 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).
   (c) 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 or other plan documents in a manner that is consistent with the insurance carrier or Plan understanding of eligibility criteria under the Plan.

U. Plan

The ERISA group health and welfare plan as outlined in the accompanying Fact Sheet, as amended from time to time.

V. Plan Administrator

The person(s) or Committee identified in the accompanying Fact Sheet that is appointed by Employer/Plan Sponsor with duty, authority, discretion, and responsibility to manage and direct the operation and administration of the Plan, and, if applicable, the Component Benefit Plans. If no such person is named, the Plan Administrator is Employer/Plan Sponsor.

W. Plan Year

For recordkeeping purposes, the Plan Year for a Plan is the 12-month period beginning and ending as specified in the accompanying Fact Sheet. For this purpose, the Plan Year identified herein shall override any ERISA plan Year reference in any other documents incorporated by reference and inconsistent herewith.

X. Premiums

The actual premium charged by an insurance carrier with respect to an insured product or the “premium equivalent” amount (i.e. an actuarial equivalent cost) for non-insured benefits.

Y. Self-Funded Benefit Program

A benefit plan in which Employer/Plan Sponsor assumes the financial risk for providing benefits to its Employees. Self-Funded plans are also referred to as Self-Insured plans or benefits.

Z. Spouse

An individual who is legally married to an Employee.

Section 27: Insuring and Funding Benefits

A. Plan Funding

Funding for the Plan will consist of the sum of the funding for all Component Benefit Plans and may include funding through a cafeteria plan which, if available, is identified as a funding source in the accompanying Fact Sheet as Employee Salary Reductions. The wording in the accompanying Fact Sheet reads: “This benefit is paid by Employer/Plan Sponsor contributions, including, in some cases, those made at employee direction through a salary reduction agreement.”

Employer/Plan Sponsor has the right to pay benefits from its general assets, insure any benefits under the Plan, and establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or as Employer/Plan Sponsor deems advisable in its sole discretion. In addition, Employer/Plan Sponsor shall have the right in its sole discretion to alter, modify or terminate any method or methods used to fund the payment of benefits under the Plan, including, but not limited to, any trust or insurance policy. If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the insurance carrier.

B. Rebates and Refunds

1. Overview. With respect to any insurance company refunds/rebates received by Employer/Plan Sponsor including those that are subject to the Medical Loss Ratio (MLR) provisions of the ACA, such refunds/rebates must be treated consistently with the provisions of ERISA and the applicable guidance thereunder, including the Department of Labor (DOL) Technical Release 2011-04. The allocation of insurance refunds that are not "Plan assets" are to be used, allocated, and/or distributed among one or more of the Employer(s) as the Controlling Employer in its sole discretion determines is appropriate. As to any other amounts, fiduciary decisions by the Plan Administrator are required based on the facts and circumstances relating to such refund.
2. General Rebate Rules. Generally, the following rules will apply with respect to MLR (note that these rules do not apply to self-funded plans):
    (a) If Employer/Plan Sponsor pays the entire premium applicable to the Component Benefit Plan, the entire refund amount will be retained by Employer/Plan Sponsor.
    (b) If the Participants pay the entire premium applicable to the Component Benefit Plan, the entire refund amount will be used to benefit the Participants.
    (d) If Employer/Plan Sponsor and Participants shared premiums based on a fixed percentage, the rebate is divided based on that percentage.
    (c) If Employer/Plan Sponsor paid a fixed amount of premiums and Participants paid the rest, the rebate is a Plan asset (and must be used for the benefit of the Participants) to the extent it does not exceed total Participant contributions in the relevant MLR period.
    (d) If the Participants paid a fixed amount and Employer/Plan Sponsor paid the rest, the rebate belongs to Employer/Plan Sponsor to the extent it does not exceed the total Employer/Plan Sponsor contributions in the relevant MLR period.
    (e) Allocation among Participants of their portion of any refund need not be pro rata and may not include all Participants. For example, former participants may be excluded based on a cost-benefit analysis (provided the allocation must be based on a reasonable, fair, and objective method).
    (e) If the rebate is applied toward a benefit enhancement or as an offset to Participants' share of future premiums, verification of the additional benefit or how the premium offset will be applied (e.g., will there be a one-time premium holiday, or will the Participants' share of premiums be reduced over a period of months) should be provided in a written policy.
3. Plan Asset Provisions. Despite the general rules previously discussed above, the following conditions apply with respect to Plan assets:
    (a) A "Plan Fiduciary" (as defined in ERISA Sections 3(16), 3(21) or 3(38)) in all cases must act prudently, solely in the interest of the Plan Participants and beneficiaries, and in accordance with the terms of the Plan to the extent consistent with the provisions of ERISA and is prohibited by ERISA from receiving a rebate amount greater than the total amount of premiums and other Plan expenses paid by the Employer; and the use of any refunds for

expenses should be limited to those necessary and reasonable expenses paid to a third-party or for reimbursing inhouse expenses, but in such case, only upon the advice of outside counsel.

(b) With respect to refunds to Participants of a Group Health Plan, premiums must be allocated among Participants in the same policy. The following rules will generally apply unless extraordinary circumstances determined by the fiduciary dictate otherwise apply. First, refunds will be used within 90 days of receipt by the Plan to reduce future premiums. Second, refunds will be used within 90 days of receipt by the Plan to enhance benefits, pay expenses, or make distributions to Participants as determined by the fiduciary after considering all of the facts and circumstances.

4. Plan Sponsor Discretion. In addition, with respect to any other insurance company rebate or similar refund not subject to the MLR rules, Employer/Plan Sponsor may apply similar rules or any other rules it determines in its sole discretion are advisable under the circumstances, subject to ERISA (including any fiduciary duties it may have thereunder).

Section 28: Plan Document-Specific Provisions

A. Incorporated Documents

The Plan incorporates the documents, including without limitation any insurance contracts and related Certificates of Coverage, containing the substantive provisions governing the Component Benefit Plans provided under this Plan and further identified in the accompanying Fact Sheet**.** If the Component Benefit Plan documents are amended or superseded, the amended or successor documents will automatically become incorporated documents. If there is no provision in an incorporated document corresponding to a provision of this Plan, to the extent applicable, the Plan provisions will apply to the incorporated document. Where a conflict of language exists between the Component Benefit Plan and this Plan, the Component Benefit Plan will control to the extent not inconsistent with Federal law and regulations thereunder or unless the Plan specifically provides otherwise.

B. Benefits Available

The benefits available under the Plan will consist of the benefits available under the Component Benefit Plans, including all limitations and exclusions with respect to each Component Benefit Plan's benefits. The benefits available under each Component Benefit Plan are set forth in the Component Benefit Plan Certificates of Coverage or other plan documents. The availability of any specific benefit is subject to payment by the Participant of all applicable contributions and satisfaction of any eligibility or other requirements of a particular Component Benefit Plan. If Employer/Plan Sponsor provides for a cafeteria plan under Code Section 125, certain benefits thereunder may be paid for by an Employee on a pre-tax basis. If such a cafeteria plan is provided, it will be identified with a separate SPD document or within the accompanying Fact Sheet for this Plan. Nonetheless, such cafeteria plan which is a premium-only plan ("POP") (and any dependent care assistance plan that may be offered thereunder) will not be subject to the requirements of ERISA, even though the POP cafeteria plan (and any dependent care assistance plan that may be offered thereunder) may be considered part of the Plan.

C. Named Fiduciary

The Plan Administrator is the primary named fiduciary of the Plan for purposes of ERISA and has the exclusive and express discretionary authority to interpret the terms of the Plan and the terms of all the Component Benefit Plans to the extent not delegated to another named fiduciary.

For insured and pre-paid Component Benefit Plans, the respective insurance company (as outlined in the accompanying Fact Sheet) is also a named fiduciary under the Plan, with the full power to interpret, apply the terms of, determine the amount of and entitlement to benefits of the applicable insurance policy.

For self-insured Component Benefit Plans, the Contract Administrator is also a named fiduciary under the Plan, with the full power to interpret, apply the terms of, determine the amount of, and entitlement to benefits of the applicable Component Benefit Plan.

D. 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.

E. Fiduciary Authority

The Plan Administrator has the power and authority, and in its sole and absolute discretion, to determine eligibility for benefits or interpret the terms of the plan. The Plan Administrator acts as the fiduciary of the Plan.

F. Allocation of Authority

The Board of Directors or applicable governing body of Employer/Plan Sponsor (or an authorized officer of 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:

(a) To require any person to provide information in order to properly administer the Plan

(b) To make and enforce rules and regulations necessary to efficiently administer the Plan

(c) To decide all questions concerning the Plan, the eligibility of the Plan, according to the Plan's provisions

(d) To determine the amount of benefits payable, according to the Plan's provisions; to inform 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

(e) 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

(f) To keep all records, books of account, data and other documents necessary to properly administer the Plan

(g) To do everything necessary to operate and administer the Plan according to its provisions.

G. Delegation

The Plan Administrator may delegate to any committee, person, or Employee, officer or agent of Employer/Plan Sponsor or an Affiliated Employer or Portfolio Company any one or more of its powers, functions, duties or responsibilities with respect to the Plan. Any such delegation of responsibilities may be amended from time to time in writing by the Plan Administrator and may be revoked in whole or in part at any time by written notice from one party to the other. Unless the Controlling Employer has delegated such responsibility to another party, the Controlling Employer shall be the Plan Administrator. The provisions of this section control any inconsistent provisions of any Component Benefit Plan.

H. Interpretation and Findings of Fact

The Plan Administrator shall have the sole and absolute discretion to interpret the provisions of the Plan. The Plan Administrator has discretion to interpret the provisions of the Plan and any Component Benefit Plan, to make factual determinations, and to delegate such authority. The Plan Administrator's and/or delegate's interpretations and decisions are conclusive and binding on all Plan participants, Employers, and all other persons.

Each insurance company providing insured benefits under a Component Benefit Plan, to the extent necessary to pay or adjudicate claims with respect to any Component Benefit Plan for which it provides benefits, shall have sole and absolute discretion to interpret the provisions of the Component Benefit Plan. This includes, without limitation, supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in, the language of the Plan or the Component Benefit Plan, determining the rights and status under the Plan or the Component Benefit Plan of Participants and other persons, to decide disputes arising under the Plan or the Component Benefit Plan, to make factual determinations, and to make any determinations and findings with respect to the benefits payable and the persons entitled to benefits as may be required for the purposes of the Plan or the Component Benefit Plan.

I. Adoption by Affiliated Employers

Legally Affiliated Employers of Employer/Plan Sponsor may adopt the Plan and become an Employer thereunder at the sole discretion of Employer/Plan Sponsor and provided Employer/Plan Sponsor approves the adoption of the Plan by the Affiliated Employer and designates the Affiliated Employer as an Employer. Any Affiliated Employer agrees to be bound by the terms of the Plan and any other terms and conditions that may be required by Employer/Plan Sponsor or its delegate, provided that such terms and conditions are not inconsistent with the purposes of the Plan.

1. Adoption Agreement. If Employer/Plan Sponsor requires the adoption of the Plan by any Affiliated Employer, it may be made subject to a written Adoption Agreement.
2. Employer/Plan Sponsor Reimbursement. Each Affiliated Employer shall, upon demand from Employer, reimburse Employer/Plan Sponsor for the Affiliated Employer's appropriate share of any expenses, insurance premiums or funding necessary to provide benefits under the Plan. The amount of such reimbursement shall be the sole discretion of Employer and binding on any adopting Affiliated Employer.
3. Withdrawal as an Affiliated Employer. Any Affiliated Employer that adopts the Plan may withdraw from the Plan, but only with the express written approval, and at the sole discretion, of Employer/Plan Sponsor, and such withdrawal shall constitute a termination of the Plan as to such Affiliated Employer. Any such withdrawal and termination must be in writing and filed with Employer/Plan Sponsor or its delegate and shall become effective when received by Employer/Plan Sponsor unless there is a written agreement between Employer/Plan Sponsor and the Affiliated Employer as to another effective date. Unless waived by Employer/Plan Sponsor, an Affiliated Employer shall be responsible as to Participants and covered Dependents for any such person's claims incurred but not presented for payment as of the date of withdrawal.
4. Controlling Employer's Right to Terminate Adoption. Employer/Plan Sponsor has the right to terminate any Affiliated Employer's adoption of or participation in the Plan at any time.

Section 29: General Plan Information and Plan Administration

A. Exclusive Benefit

The Plan is established and maintained for the exclusive benefit of Plan Participants.

B. Nondiscrimination

Employer/Plan Sponsor intends to administer the Plan on a reasonable and nondiscriminatory basis and will apply uniform rules to all similarly situated individuals. Contributions and benefits under the Plan will not discriminate in favor of "highly compensated employees" or "key employees" as defined under the Code. Employer/Plan Sponsor may limit or deny a compensation reduction agreement to tax benefits to the extent necessary to avoid such discrimination in compliance with federal law. Participants impacted by a reduction in salary reductions or benefits or by taxation of benefits will be notified.

C. Tax Qualification

The benefits provided by the Plan are intended to qualify as 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).

D. No Guarantee of Non-Taxability

The Plan provides benefits often intended to be non-taxable. However, neither the Plan Administrator nor Employer/Plan Sponsor makes any commitment, guarantee, or other representation that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant’s gross income for Federal or state income tax purposes. Likewise, neither the Plan Administrator nor Employer/Plan Sponsor makes any commitment, guarantee, or other representation that any other Federal or state tax treatment will apply to or be available to any Participant. It is the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant’s gross income for Federal and state income tax purposes, and to notify Employer/Plan Sponsor if the Participant has reason to believe that any such

payment is not excludable from taxation. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary is 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, Employer/Plan Sponsor, or the Third Party Administrator, with respect to any increased taxes or other losses or damages suffered by the Employee.

E. Tax Withholding

To the extent Employer/Plan Sponsor is required to withhold Federal, state, local or foreign taxes in connection with any payment made to a Participant under a Component Benefit Plan, Employer will withhold the amount from the payment as determined by Employer/Plan Sponsor in its sole discretion.

F. No Guarantee of Employment/Not an Employment Contract

Nothing contained in the Plan shall be construed as a contract of employment between Employer/Plan Sponsor and an Employee or Participant, or any other individual, or as a right of any Employee or Participant, or any other individual to continue in the employment of the Employer, or as a limitation of the right of an Employer to discharge any of the Employees or Participants, or any other individuals with or without cause or change the terms and conditions of employment of the Employees or Participants.

G. Incapacity to Receive Payment

If the Plan Administrator finds that any Participant entitled to receive benefits under the Plan is, at the time such benefits are payable, unable to care for his or her affairs because of a physical, mental, or legal incompetence, the Plan Administrator may, in its sole discretion, pay the benefits to which the Participant was entitled to one or more persons chosen by the Plan Administrator from among the following: the institution maintaining or responsible for the maintenance of such Participant, his or her Spouse, his or her children, or other relative by blood or marriage. Any payment made under these circumstances shall be a complete discharge of all liability under the Plan with respect to such payment.

H. 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 will 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.

I. Plan Administration Assistance

The Plan Administrator, along with the approval of Employer/Plan Sponsor, may employ services in connection with the operation of the Plan. Such services include clerical, legal, actuarial, accounting, tables, valuations, certificates, reports, opinions, or other assistance or services that it believes are reasonable and necessary or advisable in connection with the performance of its duties. These services may be provided by a contract administrator or a third-party administrator. Unless otherwise provided in a Service Agreement with a contract administrator or third-party administrator, obligations under this Plan will remain the obligation of Employer/Plan Sponsor.

J. Subrogation and Right of Reimbursement

1. Plan Consistency. To the extent not inconsistent with the provisions of any underlying documents incorporated by reference in the Plan, the following provisions will control as to any Component Benefit Plan.
2. Plan Rights. The Plan Administrator shall have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual or organization or anyone else benefiting from the improper payment, including any monies then payable, or which may become payable, in the form of salary, wages, or benefits payable under the applicable Employer-sponsored benefit program to the extent permitted by applicable law.
3. Definitions. For the purposes of this subsection J, Subrogation and Right of Reimbursement, the following definitions will apply:

(a) “Covered Individual” includes an Employee, Spouse, or Dependent, or any other covered person under any Component Benefit Plan.

(b) “Injury” means any injury, illness, or accident caused or worsened by the action of any third party.

(c) “Reimbursement” includes all direct and indirect payments to a Covered Individual for Injury from any source, by way of settlement, judgment, or any other means, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no-fault automobile insurance coverage, and homeowner's insurance.

4. Subrogation Overview. The Plan does not provide primary coverage for expenses associated with an Injury which gives rise to a claim against that party, nor does it provide primary coverage for such expenses to the extent that there is other applicable coverage from a source other than the Plan (including, but not limited to, medical benefits under an automobile insurance policy). If a Covered Individual incurs expenses and receives benefits from the Plan (including but not limited to from an Insurance Company, from a self-funded third-party administrator, from a Pre-Paid Plan, or from a Contract Administrator of any Component Benefit Plan) as a result of an Injury, immediately upon payment of any benefits under the Plan, the Plan will be subrogated (substituted) to all rights of recovery against any person or organization whose conduct or action caused or contributed to the loss for which payment was made by the Plan. This means any other payor will pay first or, if the Plan has made any payment, the Plan will be reimbursed by the other payor or any Participant who received any benefit payment from the Plan.

5. Conditions of Plan Participation. As a condition to participation in or the receipt of benefits under the Plan, a Covered Individual agrees that if such person receives or is entitled to any reimbursement or any other financial recovery from any source, including such Covered Individual’s own insurance carrier or another welfare benefit plan (such as a disability plan, if any) sponsored by an employer, whether by judgment, settlement, award, government or worker's compensation benefits, or otherwise, on account of such Injury, the Plan has the right to recover the amounts the Plan has paid or will pay as a result of that Injury, from any amounts a Covered Individual received from any party, and the Plan has a lien on any such recovery. Similarly, if any person, including any natural person or entity, other than a Covered Individual has possession of funds recovered from a third party as to which any Covered Individual has or had a claim, then the Plan will be subrogated to that claim and will have a right to recover directly from the person that is holding the funds. By participating in and accepting benefits under the Plan in connection with such an Injury, a Covered Individual agrees and is bound to assist the Plan in its attempt to recover from that person, assigns any recovery to the Plan and authorizes such Participant’s attorney, personal representative, or insurance company to reimburse the Plan. In the event that a Participant is deceased, the Plan has a right to recover funds from such Participant’s estate pursuant to this reimbursement provision. The Plan will not pay attorney fees or costs associated with any Participant’s claims without prior express written authorization by the Plan, which the Plan may grant or withhold in its sole discretion. In this regard, the Plan will not be subject to any "make whole" or other subrogation rule that may otherwise apply by law that reduces its right to recover the full amount of its loss unless the Plan has expressly agreed to do so in writing. Rather, the Plan is entitled to full reimbursement:

(a) Before the Participant is entitled to retain any part of such financial recovery, regardless of the stated reason for the financial recovery or whether the Participant has other costs or suffered other injuries not paid for or compensated by the Plan (notwithstanding any "make whole doctrine" by whatever name called);

(b) Without regard to any claim of fault on the part of the Covered Individual, whether under comparative negligence or otherwise;

(d) Without reduction for attorneys' fees and other costs incurred by making a recovery without the prior express written consent of the Plan (notwithstanding any "fund doctrine," "common fund doctrine," or "attorneys' fund doctrine" by whatever name called); and

(c) Notwithstanding that the recovery to which the Plan is subrogated is paid to a decedent, a minor, a decedent's estate, or an incompetent or disabled person.

6. Cooperation. A Covered Individual, and individuals acting on a Covered Individual's behalf, including without limitation attorneys, will do nothing to prejudice the Plan's subrogation and reimbursement rights and will, when requested, provide the Plan with information and cooperate with the Plan in the enforcement of its subrogation and reimbursement rights. It is the Employee’s

duty, and the duty of individuals acting on their behalf, to notify the Plan Administrator within 45 days of the date of the Injury or the date when the Employee gives notice to any other party, including an attorney, of their intention to pursue or investigate a claim to recover damages on behalf of a Covered Individual. The payment of benefits under the Plan on account of an injury or illness as a result of an action of a third party is contingent on the Covered Individual:

(a) Informing the Plan Administrator of the action to be taken by the Covered Individual;

(b) Agreeing (in such form and to such documents as the Plan may from time to time require) to the Plan being reimbursed from any recovery from a third party and subrogated to any right of recovery the Participant has against a third party;

(c) Refraining from action which would prejudice the Plan's subrogation rights (including, but not limited to, making a settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan); and

(d) Cooperating in doing what is reasonably necessary to assist the Plan in any recovery.

If a Covered Individual should fail or refuse to comply with these subrogation and right of reimbursement provisions, the Covered Individual is not entitled to benefits under the Plan and must reimburse the Plan for any and all costs and expenses, including attorneys' fees, incurred by the Plan in enforcing its rights hereunder. The Plan may determine not to exercise all of the reimbursement and/or subrogation rights described here in certain types of cases, with respect to certain covered groups, or with respect to certain geographic areas, without waiving its right to enforce its rights in the future as to other groups or in other geographic areas.

K. Compensation of Plan Administrator

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

L. Bonding

Unless otherwise determined by 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.

M. Payment of Administrative Expenses

Employer/Plan Sponsor may decide to pay the Plan’s administrative expenses or pass the expenses on to the Plan’s Participants.

N. Funding Policy

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 Employer/Plan Sponsor’s general assets.

O. Indemnification

The Plan Administrator shall be indemnified by 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, willful misconduct, or lack of good faith. Notwithstanding the above, the indemnification provisions of this section shall not apply to any person (or entity) compensated for providing a fiduciary service (such as an insurance company or third-party administrator who has accepted fiduciary responsibility for claims). The provisions of this section control any inconsistent provisions of any Component Benefit Plan.

P. 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.

Q. Post-Mortem Payments

Any benefit payable under the Plan after the death of a Participant shall be paid to their surviving Spouse, otherwise, to their 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.

R. Non-Assignment of Benefits

Except as expressly provided by the Administrator, no legal or beneficial interest under the Plan may be assigned, alienated, pledged, sold, transferred, or encumbered, 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. The payment of benefits directly to a health care provider, if any, shall be accommodated as a convenience to the participant and shall not constitute an assignment of benefits under the Plan.

S. 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 their estate has been appointed.

T. 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 they 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.

U. 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.

V. Source of Payments

Employer/Plan Sponsor and any insurance company contracts held by 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 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.

W. Gender and Number

Pronouns and nouns of one gender include the other gender. Singular references shall include the plural references and vice versa, unless indicated otherwise by the context.

X. Headings

The headings, titles, and numbers contained in this document are provided for convenience of reference and to make the document easier to read. They shall not be construed as defining or limiting the matter contained thereunder. In addition, headings, numbering, and paragraphing shall not in any case be deemed material or relevant to the Interpretation of the Plan or its contents. The words "herein," "hereof," and "hereunder" shall refer to this Plan.

Y. Statutory and Regulatory References

Any reference herein to any statutory provision (e.g. of the Code, ERISA, etc.) shall include any corresponding or succeeding provision(s) of any applicable legislation that amends, supplements, or replaces such provision, and for which compliance by or with respect to the Plan is required. Furthermore, any such reference shall include the regulations promulgated, and any other interpretive guidance issued and effective thereunder and in effect with respect to the Plan. Any reference herein to a section of the Code of Federal Regulations (CFR) shall mean the cited section as in effect or such may be amended or replaced from time to time and for which compliance by or with response to the Plan is required.

Z. Severability Provision

Should a court of competent jurisdiction invalidate any part of this Plan or application of a provision to any circumstance or person, the remainder of the Plan and its application to other circumstances or persons shall be given effect to the maximum extent possible and not affected thereby.

AA. 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 they are properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or Employer/Plan Sponsor from Compensation paid by Employer/Plan Sponsor.

Section 30: Discretionary Authority

A. Self-Funded Plan Components (SPD 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 31: Statement of Rights under ERISA

This statement of ERISA Rights is required by federal law and regulation. The ERISA entitles Participants to certain rights and protections as a participant in 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

An Employee has the 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 (if any), 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 Employee Benefits Security Administration (EBSA).

B. Obtain Copies of Plan Documents

An Employee has the 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 (if any), and copies of the latest annual report (Form 5500 Series), Summary Annual Report, and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

C. Receive Copy of the Summary Annual Report

An Employee has the right to receive a copy of the Summary Annual Report (SAR) which is a summary of the annual financial report (if required by ERISA to be prepared). Where the annual financial report must be prepared, the Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

D. Group Health Plan Coverage Continuation

An Employee has the right to continue health care coverage for the Employee, spouse, or dependents if there is loss of coverage under the Plan as a result of a Qualifying Event. An Employee or eligible dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing COBRA continuation rights. Additional information about COBRA may be found in Section 18: Continuation Coverage (COBRA) of this Disclosure Document.

E. Credit for Pre-existing Condition Exclusion Periods

An Employee has the right to the reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan if they have creditable coverage from another plan. An Employee should be provided a certificate of creditable coverage, free of charge, from their group health plan or health insurance issuer upon losing coverage under the plan, when they become entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a request is made before losing coverage or if requested up to 24 months after losing coverage. Without evidence of creditable coverage, Participants may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

Section 32: Protection of Rights under ERISA

A. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes special obligations and duties upon the people who are responsible for the operation of an Employer/Plan Sponsor's welfare benefit plan. The people who operate a Participant's 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 the Participants and beneficiaries. The fiduciaries also have a duty to protect any plan assets for the benefit of plan participants. No one, including Employer/Plan Sponsor or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent the Employee from receiving benefits under the welfare benefit plan or from exercising rights under ERISA.

B. Claim Review

If a claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. A Participant has the right to have the Plan review and reconsider their claim. Under ERISA, there are steps they can take to enforce the above rights. ERISA gives the Participant the right to file suit in a state or federal court if their claim for benefits under the employee benefit plan is denied or ignored. A Participant can also file suit in a federal court if a request is

made for plan documents and they do not receive them within 30 days. In such a situation, the court will require the Plan Administrator to give the Participant the plan documents they requested. In some cases, the court could also require the Plan Administrator to pay up to $110 a day until the Participant receives the requested materials, unless the materials were not sent because of reasons beyond the control of the administrator. In addition, if the Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, they may file suit in a federal court.

C. Assertion of Rights

If the fiduciaries have misused the plan's money or assets, or the Participant has been discriminated against for asserting personal rights, a request can be made with the U.S. Department of Labor for assistance. If the Participant files a suit, the court will decide who must pay court costs and legal fees. If the Participant is successful, the court may order the person they have sued to pay those fees. If a Participant loses, the court may order them to pay those costs and fees, if, for example, it finds the claim is frivolous.

Section 33: Questions about the Plan or ERISA

A. Questions

For any questions about the Plan, contact the Plan Administrator. If there are any questions about this statement or about an individual's rights under ERISA, or if assistance is needed in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration (EBSA), a division of the U.S. Department of Labor. Phone listings for local EBSA offices may be found online by searching "EBSA office near me." Alternatively, the national EBSA office can be contacted as outlined below. Certain publications about rights and responsibilities under ERISA can be obtained by calling the publications hotline of the Employee Benefits Security Administration.

B. Contact Information

Contact information for the national EBSA office as well as the web links for the national and local EBSA offices are listed below:

Weblink: Regional EBSA Offices

Weblink: National EBSA Office

Division of Technical Assistance and Inquiries
EBSA
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210
866-444-3272

Addendum: HIPAA Privacy Notice

THS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Short Summary of Privacy Notice

A. Overview

This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed by your Employer/Plan Sponsor's group health plan (the "Plan") or others in the administration of your claims, and certain rights that you have. For a complete, detailed description of all privacy practices, as well as your legal rights, please refer to the Full Privacy Notice (also known as the Notice of Privacy Practices) below.

B. Our Pledge Regarding Health Information

The Plan is committed to protecting your Protected Health Information (PHI). With respect to your PHI and your electronic protected health information (ePHI), the Plan is required by law to:

- Maintain the privacy of any health information that identifies you
- Provide you with certain rights related to your health information
- Provide you with a copy of this Notice detailing our legal duties and privacy practices
- Follow all privacy practices and procedures currently in effect (as detailed in this Privacy Notice)
- Notify you in the event of a breach of Protected Health Information

C. Use and Disclose Protected Health Information

The Plan may use and disclose your protected health information without your permission to facilitate your medical treatment, for payment of any medical treatments, and for any other health care operation. The Plan will disclose your health information to employees of Employer/Plan Sponsor as necessary for plan administration functions; but those employees may not share your information for employment-related purposes. An Employee's protected health information may also be used or disclosed without your permission as allowed or required by law. Otherwise, the Plan must obtain written authorization for any other use and disclosure of your health information. Neither the Plan nor your Employer/Plan Sponsor can retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given.

D. Your Rights Regarding Your Protected Health Information

You have the right to inspect and copy your health information, to request corrections of your health information, and to obtain an accounting of certain disclosures of your health information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your medical information, or that communications about your medical information be made in different ways or at different locations.

E. How to File Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us or with the Office for Civil Rights. The Plan will not retaliate against you for making a complaint.

Full Privacy Notice

A. Introduction

Employer/Plan Sponsor sponsors an employee benefits Plan that is subject to the Employee Retirement Income Security Act (ERISA). This plan includes various benefits that constitute group health plans under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including, but not limited to medical, dental, vision, and health care flexible spending account benefits. The Plan has been established and maintained to provide benefits to our employees, their dependents, and other participants. The Plan provides this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that they receive.

B. The Plan vs. Your Employer

The information in this notice 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 to your employer - that’s the way the HIPAA rules work. If you participate in a fully 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 the 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 Officer.

C. This Notice

The Plan is required by law to maintain the privacy of your Protected Health Information (PHI). This notice describes the legal obligations of the Plan relative to your information and your legal rights regarding your PHI held by the Plan under HIPAA. Among other things, this Privacy Notice describes how your PHI may be used or disclosed to carry out treatment, for claim payment, for health care operations, or for other purposes that are permitted or required by law. It describes your rights with respect to your PHI and how you can exercise those rights. The Plan is also required to provide this Notice of Privacy Practices (the “Privacy Notice”) to you.

D. Protected Health Information (PHI)

The HIPAA Privacy Rule protects only certain health information known as protected health information. This means 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. The definition includes demographic information and health information that relates to a past, present, or future physical or mental condition that is collected from you or created or received by a health care provider, by the plan, or by Employer/Plan Sponsor on behalf of a group health plan. It is health information that relates to the provision of health care to you, or to the past, present or future payment for the provision of health care. Further, it is health information that could be used to identify an individual or for which there is a reasonable basis to believe that it could be used to identify an individual. PHI includes information about persons living or deceased. PHI includes almost all individually identifiable health information held by this Plan, whether received in writing, in an electronic medium, or as verbal communication.

E. General Rules for Use and Disclosure of PHI

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). For each category of use and disclosure, several examples are provided, however, not every use or disclosure in a category will be listed. It is also possible that some of the examples presented below may not be applicable because they don’t typically apply to Employer sponsored welfare benefit plans. Regardless, the following is an overview of how your PHI may be used and/or disclosed without authorization.

1. For Treatment: Your PHI may be used or disclosed to facilitate medical treatment or services by providers. This includes providing, coordinating, or managing health care by one or more health care providers (doctors, nurses, technicians, medical students, pharmacists, or other hospital personnel who are involved in taking care of you). Treatment can also include coordination or management of care between a provider and third party, as well as consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

2. For Payment: Your PHI may be used or disclosed to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. This 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, with a utilization review or pre-certification service provider, with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments, or, at your request, to verify that claims were paid correctly or to advocate for a correction in how claims were paid.
3. For Health Care Operations: Your PHI may be used or disclosed for other Plan operations. These uses and disclosures are necessary to run the Plan. This includes 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 medical information in connection with conducting quality assessment and improvement activities, underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss coverage, conducting or arranging for medical review, legal services, audit services, and fraud/abuse detection programs; business planning and development such as cost management and plan renewal management so that informed decisions can be made regarding any such prospective changes to benefit plans; and business management and general Plan administrative activities, including evaluating an employee’s eligibility and administering the employee benefit plans or to providing you with information about benefits available to you under your current benefits plans. The Plan is prohibited from using or disclosing PHI that is genetic information about an individual for underwriting purposes.

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 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.

F. Disclosure for Plan Purposes

There are several additional types of use and disclosure that are allowed under the Privacy Rule:

1. To Employer/Plan Sponsor: The Plan and any contract administrator, health insurance issuer, or business associate servicing the Plan will disclose Protected Health Information to Employer/Plan Sponsor only to permit 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 Employer/Plan Sponsor of Protected Health Information will be subject to and consistent with this Privacy Notice. The Plan may use or disclose your health information to provide coverage under the Plan, or for modifying, amending, or terminating the Plan.
2. To Business Associates, Subcontractors, Brokers, or Agents: The Plan may contract with individuals or entities known as Business Associates to perform various functions on behalf of the Plan Sponsor or to provide certain types of services to the Plan. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree, in writing with us, to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or to provide support services such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us. Our Business Associates are required to have each of their subcontractors or agents agree in writing to provisions that impose at least the same obligations to protect PHI as are imposed on Business Associates by the Business Associate Agreement required by HIPAA regulations.
3. To Plan Sponsor Employees: For the purpose of administering the Plan, your PHI may be disclosed to certain employees of the Plan Sponsor. However, those employees will only use or disclose that information as necessary to perform plan administrative functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

4. Summary Health Information: Summary Health Information is plan information that summarizes participants' claims or demographic information, from which names and other identifying information have been removed. Summary Plan Information may be used or shared by the plan as it does not contain protected health information.

G. Other Allowable Uses or Disclosures of Your Health Information

In addition to the use and disclosure categories above, the following categories describe other possible ways that your PHI may be shared and/or disclosed outside of the Plan and/or outside of your 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:

For each category of use or disclosure, an explanation is provided of what is meant, and some examples are presented. Not every use or disclosure in a category will be specifically listed. However, all of the ways your PHI may be used and disclosed will fall within one of the categories.

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. As Required by Law: The Plan may disclose your PHI when required to do so by federal, state, or local law for law enforcement or specific government functions. This assumes such disclosure complies with and is limited to the relevant requirements of such law. For example, the Plan may disclose your PHI when required to do so by national security laws or public health disclosure laws, or to a governmental agency or regulator with health care oversight responsibilities.
3. Disclosures Required by Law: Disclosures of your health information as required by law
4. To Avert a Serious Threat to Health or Safety: The Plan may use and disclose your PHI when it is perceived to be necessary and under a good-faith belief that releasing your protected health information will prevent or lessen a serious and imminent threat to public or personal health or safety. This assumes such disclosure is made to someone reasonably able to prevent or lessen the threat (or to target of the threat) and 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.
5. 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. These actions generally include, but are not limited to, the following:
    - To prevent or control disease, injury or disability
    - To report births and deaths
    - To report child abuse or neglect
    - To report reactions to medications or problems with products
    - To notify people of recalls of products they may be using
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
    - To notify state or local health authorities, as required, regarding particular communicable diseases.
6. Victims of Abuse, Neglect or Domestic Violence: Disclosures to government authorities, including social services or protective 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).

7. Lawsuits, Judicial, and Administrative Proceedings: Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process by someone else involved in the dispute (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).
8. Law Enforcement Purposes: Disclosures to law enforcement officials required by law or legal process. These actions generally include, but are not limited to, the following disclosures:
    - In response to a court order, subpoena, warrant, summons, or similar process
    - To identify or locate a suspect, fugitive, material witness, or missing person
    - About the victim of a crime, if you agree or, under certain limited circumstances, the Plan is unable to obtain the victim's agreement, but disclosure is necessary for immediate law enforcement activity
    - About a death that may have been the result of criminal conduct
    - About criminal conduct
    - To provide evidence of criminal conduct on the Plan's premises
    - In emergency circumstances to report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.
9. Coroner, Medical Examiners and Funeral Directors: 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.
10. Organ, Eye, or Tissue Donation: Disclosures to organ procurement organizations, organ banks, or other entities to facilitate organ, eye, or tissue donation and transplantations after death.
11. Research Purposes: Disclosures of PHI to researchers when (1) individual identifiers have been removed, or when an institutional review board or privacy board has reviewed the research proposal, and (2) established protocols to ensure the privacy of the requested information and approved the research. Certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project must be met.
12. Health Oversight Activities: Disclosures to health oversight agencies for activities authorized by law. These oversight activities include, for example: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with regulatory programs or civil rights laws.
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. 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.
15. Inmates: Disclosures to correctional facilities, or custodial law enforcement officials about inmates of a correctional institution or persons who are under the custody of a law enforcement official. In this case, your PHI may be disclosed to the correctional institution or law enforcement official, if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
16. National Security and Intelligence Activities: Disclosures to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
17. Military and Veterans: Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command to appropriate military commands.

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 unsecured health information as required by law.

H. Required Disclosures.

The following is a description of disclosures of your PHI the Plan is required to make.

1. Government Audits: The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy and Security rules.
2. Disclosures to You: Upon request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan is also required, when requested, to provide you with an accounting of most disclosures of your PHI where the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.
3. Notification of a Breach: The plan is required to notify you in the event that the Plan (or one of our Business Associates) discovers a breach of your unsecured PHI, as defined by HIPAA.

I. Other Disclosure Rules

Other uses and disclosures of PHI not covered by this Notice, or the laws that apply to us will be made only with your written authorization.

1. Authorizations: Other uses or disclosures of your PHI not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of PHI for fundraising or marketing purposes, will not be made without your written authorization. If you provide us with an authorization to use or disclose PHI about you, you may revoke that authorization at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, the Plan will no longer use or disclose PHI about you for the reasons covered by your written authorization. However, such revocation will only be effective for future uses and disclosures; it will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You should understand that all revocations are prospective, and the Plan is unable to take back any disclosures the Plan has already made under your authorization and that the Plan is required to retain our records of care provided to you.
2. Personal Representatives: The Plan will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc. so long as you provide us with written authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA Privacy and Security rules, the Plan does not have to disclose information to a personal representative if the Plan has a reasonable belief that:
    - You have been, or may be, subjected to domestic violence, abuse or neglect by such person;
    - Treating such person as your personal representative could endanger you; or
    - In the exercise of our professional judgment, it is not in your best interest to treat the person as your personal representative.
3. Spouses and other Family Members: With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications. Such information includes, but is not limited to, Plan statements, benefit denials, and benefit debit cards and accompanying information.
4. Authorizations for Psychiatric Notes, Genetic Information, Marketing, and Sale: In general, and subject to specific conditions, the Plan will not use or disclose psychiatric notes without your authorization; the Plan will not use or disclose PHI that is genetic information for underwriting purposes; the Plan will not sell your PHI, i.e. receive direct or indirect payment in exchange for your PHI, without your authorization; the Plan will not use your PHI for marketing purposes without your authorization; and the Plan will not use or disclose your PHI for fundraising purposes unless the Plan discloses that activity in this Notice.

J. 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. Use and Disclosure Only as Permitted. 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 Plan-to-Employer/Plan Sponsor Sharing. 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/Plan Sponsor 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. Business Associate Agreements. 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. No Use or Disclosure for Employment Purposes. Not use or disclose protected health 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/Plan Sponsor cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Employer/Plan Sponsor 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. Reporting Requirements. 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. Safeguards to Protect PHI. 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. PHI Available Upon Request. 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. PHI Amendments. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with the Privacy Rule.
9. Accounting of Disclosures. 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. Internal Practices. 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. Return/Destroy PHI. 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. Separation of Plan and Employer/Plan Sponsor. 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 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 Employer/Plan Sponsor's separate Privacy Policy. The Plan Administrator or the Privacy Officer named

in 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 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 Employer/Plan Sponsor's Privacy Policy will have access to Protected Health Information only to perform the plan administration functions that Employer/Plan Sponsor provides for the Plan.

13. Disciplinary Action. The classes of employees or other workforce members identified in 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 as required by law. Employer/Plan Sponsor 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. Privacy Notice. Provide participants in the Plan with notice of privacy practices as required pursuant to the Privacy Rule.

K. Your Individual Rights

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

1. Right to Request Restrictions: 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 also have the right to request restrictions on your PHI that is disclosed to someone who is involved in your care or the payment for your care, for example, a family member or friend. 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 restrictions. The plan will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.
2. Right to Inspect and Copy: 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 by the Privacy Officer. 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 Request Confidential Communication: You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location if you tell us that such alternate communication in necessary to protect you from endangerment. For example, you can ask that the Plan only contact you at work or by mail. To request confidential communications, you must make your request in writing to the HIPAA Privacy Officer as provided in the accompanying Fact Sheet. The Plan will not ask the specific reason for your request. Your request must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

4. Right to Amend: With certain exceptions, you have a right to request that the Plan amend your health information if it is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the HIPAA Privacy Officer. In addition, you must provide a reason that supports your request. Your request for an amendment may be denied if it is not in writing or does not include a reason to support the request. In addition, your request may be denied if you ask to amend information that:
    - Is not part of the medical information kept by or for the Plan
    - Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment
    - Is not part of the information that you would be permitted to inspect and copy
    - Is not part of a designated record set or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).
    - Is already accurate and complete.

    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.

    If your request is denied, you have the right to file a statement of disagreement with us, and any future disclosures to the disputed information will include your statement.

5. Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your PHI made by the Plan. 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 the right to receive an accounting of any disclosures made in the following circumstances:
    - Disclosures for purposes of treatment, payment, or health care operations
    - Disclosures made to you about your own health information
    - Disclosures made pursuant to an authorization
    - Disclosures made to friends or family in your presence or because of an emergency (where disclosure is permitted without authorization)
    - Disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
    - Disclosures incidental to otherwise permissible or required disclosures
    - Disclosures made 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. Your request must state the time period through which you want to receive a list of disclosures. The time period may not be longer than six (6) years or commence before the initial effective date stated in this Notice. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan may charge you the costs of providing the list. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. Right to Obtain a Paper Copy of this Notice: 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.
7. Right to Notice of a Breach: You have the right to be notified in the event of any breach that impacts your 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 or Security Officer(s). In the event of any breach, you will be notified at your last known address of the nature and details of such breach and of the corrective action taken.

L. Security Breach

In the event of a security breach, the Plan will comply with regulatory notification requirements. As such, if a breach occurs, the Plan (or a Plan representative) will notify affected individuals of the breach of unsecured PHI and notify the Department of Health and Human Services (as required by regulations). If more than ten individuals are affected and cannot be contacted directly, the Plan will post a general notification of the breach on our web site and notify local print media. If more than 500 individuals are affected by the breach, the Plan will report the breach to well-known media outlets of the breach. The Plan is also required to keep a log of all security breaches and all individuals affected by such breaches.

M. Changes to this Privacy Notice

The plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change or revise the terms of its privacy policies, as described herein 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 as well as 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 by a means consistent with how other employee benefit plan information is disseminated (typically by mail, e-mail, or hand delivery).

N. HIPAA Privacy and Security Officers

1. HIPAA Privacy Officer: The Privacy Officer is an appointed person who is responsible for the development and implementation of the HIPAA Privacy policy and procedures. In some circumstances certain responsibilities may be delegated to a Privacy Contact Person who is designated to provide information and receive complaints regarding HIPAA privacy issues. These positions may change over time and may be designated as the same or different individuals. Contact information for the HIPAA Privacy Officer may be found in the accompanying Fact Sheet.
2. HIPAA Security Officer: The Security Officer is an appointed person who is responsible for the development and implementation of the Plan's policies and procedures relating to security and the safeguarding of protected health information and electronic protected health information. This position may change over time and may be held by the same individual as the Privacy Officer. Contact information for the HIPAA Security Officer may be found in the accompanying Fact Sheet.

O. Complaints

If you believe your privacy or security rights have been violated or your Plan has not followed its legal obligations under HIPAA, or you wish to file a complaint, you may contact the Privacy Officer and/or the

Security Officer. Alternatively, you may file a complaint with the Office for Civil Rights (a division of the Department of Health and Human Services). All inquiries and correspondence regarding the complaint should be forwarded to the HIPAA Privacy Officer. All complaints must be submitted in writing. You should keep a copy of any notices you send to the Plan for your records.

Information on filing a complaint with the Office of Civil Rights may be found on the Department of Health and Human Service website, at http://www.hhs.gov/ocr/contact.html. Complaints filed with the Office of Civil Rights should be sent to the appropriate regional office. A reference list of all regions may also be found on their website. The west coast regional office contact information is as follows:

Office for Civil Rights
U.S. Department of Health & Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102
(415) 437-8310 Phone
(415) 437-8329 Fax
(415) 437-8311 TDD

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Plan or with the Office of Civil Rights.

P. Survival

The provisions of this Privacy Notice shall survive the expiration or termination of the Plan.

Q. 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.

R. 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.

S. Questions

If you have any questions about this Privacy Notice or about our privacy practices, please contact the HIPAA Privacy Officer. Contact information for the Privacy Officer and Security Officer can be found in the accompanying Fact Sheet.

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