FISHER INVESTMENTS™

Dear Employee,

Employee benefits play a very important role in making Fisher Investments a great place to work. They provide protection against the often-unexpected cost of illness and injury. They help us take care of our loved ones if we should die, and they enable us to make financial preparations for events we can anticipate, such as retirement. In a very real sense, they are as much a part of our compensation as our paychecks.

We have an excellent program of benefits at Fisher Investments. We keep the program that way by reviewing it regularly and, when appropriate, making changes. But having good benefits is only part of the story. Unless each of us understands what our benefits are and how they operate, we may not realize their full value.

The reason this booklet has been prepared is to give you and your family an easy-to-understand illustration of your benefits, but please understand, this presents only a Summary Plan Description of your benefits. Full details are contained in the official documents, which legally govern all of their operations.

Please review the following information carefully. We trust these benefits will give you peace of mind every day.

Sincerely,

Your Benefits Team

On-Line Information Access: FIIRE → Global Human Capital → Total Rewards: Benefits or www.myfirewards.com

Company Contact Information: Benefits Department (650) 851-3334 or x808-5886

This wraparound Summary Plan Description (SPD) and Plan Document is intended to provide you with an overview of the benefits that are available under the **Fisher Investments Welfare Benefit Plan** (also commonly referred to as the Fisher Asset Management Group Insurance Plan). This SPD is not a contract and does not guarantee any benefits. Additional terms and conditions of the Plan's component benefits are contained in the insurance plan documents and are incorporated by reference.

If one of the Plan's component benefits is insured and there is a conflict between the specific terms of the insurance plan document issued by the Insurance Company and the terms of the Plan, the insurance plan document will control.

Your Summary Plan Description for the Plan includes this wraparound SPD and the following Certificates/Evidences of Coverage and other Benefit Booklets for the coverages in which you are enrolled:

A. United Healthcare PPO 500 Plan Benefit Booklet, Group # 902747
B. United Healthcare PPO with Health Savings Account Plan Benefit Booklet, Group # 902747
C. United Healthcare EPO Plan Benefit Booklet, Group # 902747
D. Kaiser Permanente CA Evidence of Coverage Traditional HMO Plan, Group ID 61212 Contract 1,
E. Kaiser Permanente CA Evidence of Coverage High Deductible Health Plan, Group ID 61212 Contract 1,
F. Kaiser Permanente of the Northwest Large Group Evidence of Coverage High Deductible Health Plan, Group ID 14509-004
G. Kaiser Permanente of the Northwest Large Group Evidence of Coverage Traditional HMO Plan, Group ID 14509-001, 002
H. Hawaii Medical Service Association Guide to Medical Benefits; Group #121652-1
I. Guardian Life Insurance Company of America Dental Evidence of Coverage, Policy #482174
J. VSP Vision Employee Plan, Policy #30070635
K. Hartford Life and Accident Insurance Company Long Term Disability Certificate of Insurance, Policy # GLT-681018
L. Hartford Life and Accident Insurance Company Short Term Disability CA Employees Certificate of Insurance, Policy # GLT-681018
M. Hartford Life and Accident Insurance Company Short Term Disability Non-CA Employees Certificate of Insurance, Policy # GLT-681018
N. Hartford Life and Accident Insurance Company Supplemental Life Certificate of Insurance, Policy # GLT-681018
O. Headspace Employee Assistance Program (EAP) Flyer
P. Headspace Employee Assistance Program (EAP) Frequently Asked Questions
Q. Carrot Fertility Benefits Summary

This SPD is also intended to provide you with certain information as required by the Employee Retirement Income Security Act of 1974 ("ERISA") as well as other notices required by federal and, when applicable, state law. If there is ever a conflict or a difference between what is written in this summary and the Benefit Booklets with respect to **the specific benefits provided**, the Benefit Booklets shall govern unless otherwise provided by any federal or applicable state law. If there is a conflict between the Benefit

Booklets and this summary with respect to **the requirements of ERISA and any other federal law**, this summary will rule.

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FISHER INVESTMENTS WELFARE BENEFIT PLAN
PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2025

Fisher Asset Management, LLC (dba Fisher Investments) maintains the Fisher Investments Welfare Benefit Plan (the "Plan") to provide benefits to its eligible employees and their eligible dependents.

The Plan provides two groups of benefits. The first group of benefits includes "group health plans"[1] that are subject to certain requirements of the Patient Protection and Affordable Care Act ("PPACA")—see Section 14 for important details. The following group health plan is offered in this first group:

Medical

The second group of benefits includes other group health plans that are exempt from certain requirements, including those under PPACA (referred to as "excepted benefits"), as well as other welfare benefits, as follows:

Dental
Vision
Employee Assistance Program (EAP)
Voluntary Long Term Disability (LTD)
Voluntary Short Term Disability (STD)
Voluntary Life and Accidental Death and Dismemberment (AD&D)
Mental Health Coaching

Each of the component plans is described and regulated under either a Certificate of Coverage or a benefit description ("Certificates"), all of which are available to you.

This document is a Plan Document and a Summary Plan Description. When accompanied by the appropriate Certificates of Coverage (which include all benefit descriptions), this document, along with those Certificates of Coverage, serves as the Summary Plan Description. When accompanied by the appropriate Insurance Contracts (see Appendices), this document, along with those Insurance Contracts, serves as the Plan Document.

Changes in the Plan Document, Certificates of Coverage, Insurance Contracts, and Summary Plan Description may be made from time to time, with notice to each participant, as required by applicable law. Material changes generally will either be shown in new, replacement documents or in a "Summary of Material Modification(s)" (SMM).

[1] As defined by Section 2791(a) of the Public Health Service Act ("PHSA") and Section 733 of ERISA.

The Fisher Investments Welfare Benefit Plan is an employer-sponsored welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (“ERISA”) and is subject to the ERISA reporting and disclosure requirements.

OVERVIEW

Section 1A: Plan Information

Plan Name:	Fisher Investments Welfare Benefit Plan
Plan Number:	501
Employer/Plan Sponsor:	Fisher Asset Management, LLC dba Fisher Investments
Address:	6500 International Pkwy Suite 2050 Plano, Texas 75093
Phone Number:	1-650-851-3334
Sponsor's Employer ID#:	20-2480800
Plan Year:	January 1 through December 31
Effective Date:	The Plan was originally effective January 1, 2000, and has been amended from time to time since that date. This document reflects the provisions of the Plan as in effect on and after January 1, 2025.
Plan Administrator:	The Plan Administrator has authority to control and manage the operation and administration of the Plan. See Section 5 for details. The Plan Administrator's address and phone number are the same as set forth for Employer/Plan Sponsor above. The Benefits Department of Fisher Asset Management, LLC acts on behalf of the Plan Administrator with respect to day-to-day matters. The Benefits Department may be contacted at: Attn: Benefits Department Fisher Asset Management, LLC dba Fisher Investments 6500 International Pkwy Suite 2050 Plano, Texas 75093
Agent for Service of Legal Process:	Attn: Benefits Department, Fisher Asset Management, LLC at the address provided above
Plan Changes or Termination:	The Employer (as Plan Sponsor) or its delegate may terminate, suspend, withdraw, amend, or modify any Plan in whole or in part at any time, subject to the applicable provisions of the Certificates of

Coverage, Insurance Contracts, or corporate policies as outlined in the corporate minutes and/or bylaws.

Other Documents:

Certificate of Coverage: the plan documentation, including all benefit descriptions, provided by the Plan Administrator or Insurance Company, which describes the plan benefits in detail. Certificates of Coverage are sometimes also referred to as Evidences of Coverage, Plan Booklets, etc. by the Plan Administrator or company that issues them. If you do not have a copy of your Certificate of Coverage, you may obtain one from the Plan Administrator.

Insurance Contract: the plan documentation provided by the Insurance Company, which outlines the important elements of the agreements/contracts between the Employer/Plan Sponsor and the Insurance Company. Insurance Contracts are sometimes also referred to as Insurance Policies, Contracts/Policies, etc. by the Insurance Company that issues them.

Note: The above documents are incorporated by reference and if a conflict arises between these documents and the Plan Document, the respective Certificate of Coverage or Insurance Contract governs.

Section 1B: Notices and Administration

Employee Notice Requirements:

Notify Plan Administrator of:	Address Changes
	Changes to Marital Status
	Dependent Status Changes
	Disability Status Changes

It is your responsibility to make these notices to the Plan Administrator within 31 days of the event (or within 60 days, in the case of certain Medicaid- and CHIP-related special enrollment events, as described in Section 14, under "Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)" later in this booklet). **All such changes must be made through Workday**, our system of record, but if assistance is needed please contact the Benefits Department.

Proof of the event may be requested or required by the Plan Administrator.

COBRA Contact Information

To notify the Plan Administrator of a second qualifying event under COBRA, request a disabled extension under COBRA, request termination of COBRA, give a change of address, or request additional information concerning the Plan or COBRA, contact the following:

Health Equity
121 W Scenic Pointe Drove
Draper, UT 84020
1-866-450-5634

Section 2A: Benefit Information Fully-Insured

Medical Insurance – Eligible Oregon & Washington Employees

Policy Number:	14509-001, 002, 004
Type of Benefit:	Medical Insurance
Type of Plan Administration:	Carrier – Traditional, HDHP
Contract Administrator: *(contract and claims)*	Kaiser Foundation National Claims Administration P.O. Box 370050 Denver, CO 80237-9998 1-503-813-2000 or 1-800-813-2000 (Members) 1-877-221-8221 (Medicare Services)
Contract Funding Agent: *(premium payment)*	Kaiser Foundation Health Plan of the Northwest P.O. Box 34178 Seattle, WA 98124-1178
Funding Arrangement:	Fully-Insured
Premium Contribution:	None – Plan Sponsor reserves right to amend
Benefit Year:	January 1 through December 31
Special Notes:	Billing and enrollment issues addressed to: Kaiser Foundation Health Plan of the Northwest P.O. Box 921008 Fort Worth, TX 76121 Urgent Care After Hours – call 1-503-813-2000 or (out of Portland area) 1-800-813-2000

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Insurance Company.

If the terms of this summary document regarding benefits (i.e., amount covered) 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 all other provisions (e.g., eligibility, etc.), this summary document will control.

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 2A: Benefit Information Fully-Insured

Medical Insurance – Eligible California Employees

Policy Number:	61212
Type of Benefit:	Medical Insurance
Type of Plan Administration:	Carrier - Traditional, HDHP
Contract Administrator: *(claims)*	Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004 1-800-464-4000
Contract Funding Agent: *(contract and administration)*	Kaiser Foundation Health Plan, Inc.
Funding Arrangement:	Fully-Insured
Premium Contribution:	None – Plan Sponsor reserves right to amend
Benefit Year:	January 1 through December 31
Special Notes:	Post Stabilization Care using provider other than Kaiser – call 1-800-225-8883

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Insurance Company.

If the terms of this summary document regarding benefits (i.e., amount covered) 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 all other provisions (e.g., eligibility, etc.), this summary document will control.

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 2A: Benefit Information Fully-Insured

Medical Insurance – Eligible Hawaii Employees

Policy Number:	121652-1
Type of Benefit:	Medical Insurance
Type of Plan Administration:	Carrier – PPO
Contract Administrator: *(claims)*	Hawaii Medical Services Association 818 Keeaumoko St P.O. Box 860 Honolulu, HI 96808-0860 1-808-948-6111
Contract Funding Agent: *(contract and administration)*	Hawaii Medical Services Association
Funding Arrangement:	Fully-Insured
Premium Contribution:	None – Plan Sponsor reserves right to amend
Benefit Year:	July 1 through June 30
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Insurance Company.

If the terms of this summary document regarding benefits (i.e., amount covered) 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 all other provisions (e.g., eligibility, etc.), this summary document will control.

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 2A: Benefit Information Fully-Insured

Mental Health Coaching and Clinical Services and Employee Assistance Program – All Eligible Employees

Policy Number:	681018
Type of Benefit:	Mental Health Coaching and Clinical Services and EAP Benefits
Type of Plan Administration:	Carrier
Contract Administrator:	Headspace, Inc. 2417 Michigan Ave Santa Monica, CA 90404
Contract Funding Agent: *(contract and administration)*	Headspace, Inc.
Funding Arrangement:	Fully-Insured
Premium Contribution:	None – Plan Sponsor reserves right to amend
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are provided pursuant to a services agreement between the Employer/Plan Sponsor and the Contract Administrator.

If the terms of this summary document regarding benefits (i.e., amount covered) conflict with the terms of the services agreement or with the Benefits Brochure, the terms of the services agreement will control, unless superseded by applicable law. For all other provisions (e.g., eligibility, etc.), this summary document will control.

For further information about these Plan Benefits refer to the services agreement or Benefits Brochure or contact the Plan Administrator.

Section 2B: Benefit Information Self-Insured

Medical Coverage – All Eligible Employees

Policy Numbers:	902747
Type of Benefit:	Medical Benefits
Type of Plan Administration:	Carrier – EPO, PPO, HDHP
Contract Administrator: *(claims)*	UnitedHealthcare Claims, P.O. Box 30555 Salt Lake City, UT 84130-0555 1-888-585-4961
Contract Funding Agent: *(contract and administration)*	UnitedHealthcare
Funding Arrangement:	Self-Insured; paid from Employer/Plan Sponsor's general assets
Premium Contribution:	None – Plan Sponsor reserves right to amend
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are self-insured by the Employer/Plan Sponsor. This Plan document and summary plan description control the provision of Plan Benefits. For further information about these Plan Benefits, please contact the Plan Administrator.

Section 2B: Benefit Information Self-Insured

Dental Coverage – All Eligible Employees

Policy Number:	482174
Type of Benefit:	Dental Benefits
Type of Plan Administration:	Carrier
Contract Administrator: *(administration and claims)*	Guardian Life Insurance Company PO Box 981572 El Paso, TX 79998-1572 1-800-541-7846
Contract Funding Agent: *(claims payment and risk)*	Fisher Asset Management, LLC
Funding Arrangement:	Self-Insured; paid from Employer/Plan Sponsor's general assets
Premium Contribution:	None – Plan Sponsor reserves right to amend
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are self-insured by the Employer/Plan Sponsor. This Plan document and summary plan description control the provision of Plan Benefits. For further information about these Plan Benefits please contact the Plan Administrator.

Section 2B: Benefit Information Self-Insured

Vision Coverage – All Eligible Employees

Policy Number:	30070635
Type of Benefit:	Vision Benefits
Type of Plan Administration:	Carrier
Contract Administrator: *(administration and claims)*	Vision Service Plan PO BOX 495933 Cincinnati, OH 45249 1-800-622-7444
Contract Funding Agent: *(claims payment and risk)*	Fisher Asset Management, LLC
Funding Arrangement:	Self-insured; paid from Employer/Plan Sponsor's general assets
Premium Contribution:	None – Plan Sponsor reserves right to amend
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are self-insured by the Employer/Plan Sponsor. This Plan document and summary plan description control the provision of Plan Benefits. For further information about these Plan Benefits please contact the Plan Administrator.

Section 2C: Benefit Information Fully-Insured and Employee Funded

Voluntary Life Insurance– All Eligible Employees Who Elect (and, When Applicable, are Approved for) Such Coverage

Policy Number:	681018
Type of Benefit:	Life Insurance
Type of Plan Administration:	Carrier
Contract Administrator: *(claims)*	The Hartford P.O. Box 14298 Lexington, KY 40512-4298 1-888-563-1124
Contract Funding Agent: *(contract and administration)*	The Hartford
Funding Arrangement:	Fully-Insured
Premium Contribution:	Premiums are paid entirely by electing employee
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Insurance Company.

If the terms of this summary document regarding benefits (i.e., amount covered) 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 all other provisions (e.g., eligibility, etc.), this summary document will control.

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 2C: Benefit Information Fully-Insured and Employee Funded

Voluntary Accidental Death and Dismemberment (AD&D) Insurance – All Eligible Employees Who Elect Such Coverage

Policy Number:	681018
Type of Benefit:	AD&D Insurance
Type of Plan Administration:	Carrier
Contract Administrator: *(claims)*	The Hartford P.O. Box 14298 Lexington, KY 40512-4298 1-888-563-1124
Contract Funding Agent: *(contract and administration)*	The Hartford
Funding Arrangement:	Fully-Insured
Premium Contribution:	Premiums are paid entirely by electing employee
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Insurance Company.

If the terms of this summary document regarding benefits (i.e., amount covered) 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 all other provisions (e.g., eligibility, etc.), this summary document will control.

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 2C: Benefit Information Fully-Insured and Employee Funded

Voluntary Short Term Disability (STD) – All Eligible Employees Who Elect (and, When Applicable, are Approved for) Such Coverage

Policy Number:	681018
Type of Benefit:	Short Term Disability
Type of Plan Administration:	Carrier
Contract Administrator: *(claims)*	The Hartford P.O. Box 14302 Lexington, KY 40512-4302 1-800-549-6514
Contract Funding Agent: *(contract and administration)*	The Hartford
Funding Arrangement:	Fully-Insured
Premium Contribution:	Premiums are paid entirely by electing employee
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Insurance Company.

If the terms of this summary document regarding benefits (i.e., amount covered) 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 all other provisions (e.g., eligibility, etc.), this summary document will control.

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 2C: Benefit Information Fully-Insured and Employee Funded

Long Term Disability (LTD) – All Eligible Employees Who Elect (and, When Applicable, are Approved for) Such Coverage

Policy Number:	681018
Type of Benefit:	Long Term Disability
Type of Plan Administration:	Carrier
Contract Administrator: *(claims)*	The Hartford P.O. Box 14302 Lexington, KY 40512-4302 1-800-549-6514
Contract Funding Agent: *(contract and administration)*	The Hartford
Funding Arrangement:	Fully-Insured
Premium Contribution:	Premiums are paid entirely by electing employee
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Insurance Company.

If the terms of this summary document regarding benefits (i.e., amount covered) 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 all other provisions (e.g., eligibility, etc.), this summary document will control.

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 2D: Benefit Information Self-Insured

Fertility Care Services – All Eligible Employees

Policy Number:	N/A
Type of Benefit:	Fertility Care Platform
Type of Plan Administration:	Carrier
Contract Administrator: *(claims)*	Carrot Fertility, Inc. 101 Jefferson Drive, 1st Floor Menlo Park, CA 94025
Contract Funding Agent: *(contract and administration)*	Carrot Fertility, Inc.
Funding Arrangement:	Self-Insured
Premium Contribution:	None – Plan Sponsor reserves right to amend
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Insurance Company.

If the terms of this summary document regarding benefits (i.e., amount covered) 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 all other provisions (e.g., eligibility, etc.), this summary document will control.

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 2D: Benefit Information Service Contract

COBRA – All Eligible Employees

COBRA Administrator:	HealthEquity 121 W Scenic Pointe Drove Draper, UT 84020
Contract Funding Agent: *(contract and administration)*	HealthEquity
Funding Arrangement:	Service Contract
Premium Contribution:	None – Plan Sponsor reserves right to amend
Benefit Year:	January 1 through December 31
Special Notes:	None

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Insurance Company.

If the terms of this summary document regarding benefits (i.e., amount covered) 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 all other provisions (e.g., eligibility, etc.), this summary document will control.

For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 3: Termination/Modification/Amendment of the Plan

A. Right to Terminate/Modify/Amend

The Employer as the Plan Sponsor has the right to amend or terminate the Plan or any element of the Plan at any future time, by action of its Executive Vice President - Global Human Capital. No consent of any participant is required to terminate, modify, amend, or change the Plan.

Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of any benefits are described in the Certificates of Coverage or Insurance Contracts. Regardless of any Plan provision, any retroactive cancellation of group health coverage subject to the PPACA will comply with the PPACA's limitation and requirements for rescission of coverage (this does not apply to a retroactive cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions (e.g., for COBRA coverage) or that is initiated by the participant without influence by the Employer, Plan Administrator, etc.).

1) Certain New or Divested Employees

To the extent authorized by the Plan Administrator, special provisions or accommodations may be made for individuals who become participants by virtue of an acquisition by, or other transaction involving, the Employer and for individuals who cease to be participants by virtue of a divestiture by, or other transaction involving, the Employer.

B. Other Provisions

The Employer may enter into contracts with a Contract Administrator or Insurance Company to provide coverage and may amend, change, or terminate this relationship at any time.

A Contract Administrator or Carrier may terminate coverage if the Employer fails to pay the required premium in a timely manner as prescribed by the contract. A Contract Administrator may also terminate the Insurance Contract on any premium due date if the number of persons insured is less than the minimum number required or if the Employer fails to meet any other criteria under the Insurance Contract.

Section 4: Eligibility and Benefit Termination Specifications

A. Eligibility Requirements

This SPD and Plan Document is issued in conjunction with corresponding fully-insured and self-funded benefit Schedules, Certificates of Coverage, and Insurance Contracts for each of the benefits identified on the previous pages.

All individuals classified by the Plan Administrator as regular full-time employees are eligible for the Employer's benefit package. The hours requirement for a full-time employee is 30 hours per week for medical, vision, dental, life, and disability coverage. Generally, you are not eligible for most benefits if the Plan Administrator classifies you as one or more of the following categories of workers (even if such classification is later found to be incorrect):

- ineligible bargaining unit employees
- temporary employees or project employees
- foreign exchange personnel
- persons waiving participation
- independent contractors (or a contractor's employees)
- consultants
- non-employees taken into account for discrimination testing or other statutory purpose
- employees on terminal leave
- leased employees
- part-time employees
- interns

Your Eligibility for Medical Benefits

However, any common law employee who is credited, on average, with at least 30 hours of service per week will be eligible for medical benefits. For purposes of crediting the hours of service, the Plan Administrator is using the look-back measurement method under the employer mandate provisions of Code Section 4980H. Those general rules are described below, and the Plan Administrator can answer any questions you may have about this method of crediting hours of service.

Under the look-back measurement method, you will have your hours of service measured during the Measurement Periods to determine your eligibility for medical benefits during the associated Stability Periods. You are eligible for the medical benefits under the Plan, if:

- You are expected to be a full-time employee when hired; or

- You are determined by the Employer not to be a full-time employee as of your date of hire, but are credited with an average of at least 30 hours of service per week during your Initial Measurement Period; or

- You are credited with an average of at least 30 hours of service per week during the Standard Measurement Period.

Full-time means, at the time of hire, that the employee is reasonably expected by the Employer to be credited with an average of at least 30 hours of service per week. Until the employee has been employed for an entire Standard Measurement Period, their medical coverage continues, based on them being hired as a full-time employee. After a full-time employee has been employed with the Employer for an entire Standard Measurement Period, the employee's eligibility for medical benefits for each subsequent Standard Stability Period will be conditioned on the employee remaining employed with the Employer and being credited with an average of at least 30 hours of service per week during each Standard Measurement Period associated with that Standard Stability Period.

Hour of service means each hour for which you are paid, or entitled to be paid, by the Employer for the performance of duties for the Employer and each hour for which you are paid, or entitled to be paid, by the Employer for a period of time during which you perform no duties for the Employer due to vacations, holidays, illness, incapacity, layoff, jury duty, military duty, or leaves of absence.

Standard Measurement Period: November 1st of one calendar year through October 31st of the following calendar year.

Standard Stability Period: January 1st through December 31st of each year. This is the Plan Year of the Plan.

Initial Measurement Period: The 12-month period beginning on the first day of the first calendar month coincident with or next following your date of hire.

Initial Stability Period: The 12-month period beginning on the first day of the second calendar month following the month in which your first anniversary of employment occurs.

If you are a newly-hired employee and the Employer does not reasonably know if you will be credited with an average of at least 30 hours per week, here is an example of how your hours of service will initially be measured:

> You are hired on May 2, 2024. Your Initial Measurement Period will run from June 1, 2024 through May 31, 2025. Your Initial Stability Period will run from July 1, 2025 through June 30, 2026. In addition, you will be measured during the Standard Measurement Period that runs from November 1, 2022 through October 31, 2024 for the Standard Stability Period that runs from January 1, 2026 through December 31, 2026.

Please note that special rules apply if you are a re-hired employee, have a break in service, take a leave of absence, or change your job classification. For questions regarding eligibility for medical coverage under the Plan, contact the Plan Administrator.

Further, for certain HMO benefits, you also must live or physically work within the applicable service area. Please see the applicable Certificate of Coverage or Insurance Contract for more information.

You must complete an enrollment in Workday in a timely fashion in order to receive certain benefits under this Plan. You must either enroll or decline enrollment for your eligible dependents at that time.

1) For medical, dental, and vision benefits, you are eligible to enroll within the first 30 days of full time employment with coverage beginning on the 31st day of employment. For life and disability benefits, you are eligible to enroll within the first 30 days of full time employment with coverage generally beginning on the first of the month following your first 30 days of hire.

   Certain benefits, as described in the applicable Insurance Contract and/or Certificate of Coverage, require you to be continuously employed after your first day that you are actively at work (as defined in the applicable Insurance Contract/Certificate of Coverage) to be eligible for such coverage.

2) The date of eligibility for employees who declined enrollment in this Plan during the initial enrollment period and later apply for coverage, will be, ***for the medical, dental, and vision plan(s) only,*** on the first day of the Plan Year or as described in #3 below.

3) A late enrollee who declined enrollment during the initial enrollment period shall be eligible for coverage at the Employer's next open enrollment period, unless the enrollee meets the requirements for special enrollment rights (see "Section 12. HIPAA" for more information).

4) A former employee who has been re-employed, for the medical, dental, vision, life, and disability plan(s), generally will not need to wait for the initial waiting period if they meet the following criteria (subject to the terms of any applicable Insurance Contract):

   a) They have resumed active work within six (6) months after such termination; or

   b) If their previous employment was terminated due to entry into the Armed Forces, they have resumed active work within the time set by law for reinstatement of employment rights. However, there will be no waiting periods, as prohibited by the Uniform Services Employment and Re-Employment Rights Act of 1994; or

   c) If termination was due to disability, they have resumed active work within one month after ceasing to be disabled.

5) An employee may add themself or newly acquired dependents to the medical, dental, vision, life, and AD&D components mid-plan year, if the employee meets the requirements under the terms of the Insurance Contract.

B. <u>Dependent Eligibility Requirements</u>

You may enroll the following individuals as your dependents under the Plan:

1) Your legally married spouse who is:

   a) Not covered for benefits under the Plan as an employee;
   b) Not legally separated from you; and
   c) Not a member on active duty with the Armed Forces.

2) Your child (including any natural child, stepchild, adopted child, child placed for adoption, child over whom you have legal guardianship, or foster child) who is not covered for benefits under the Plan as an employee and who is less than 26 years of age, regardless of their marital, student, residency, or financial dependency status.

3) A dependent named in a Qualified Medical Child Support Order (QMCSO). The Plan will extend coverage to your non-custodial child as required by any qualified medical child support order (QMCSO) under ERISA Section 609(a). You may obtain a copy of the Plan Administrator's QMCSO procedures from the Plan Administrator.

4) Your domestic partner and their child(ren), if you and your domestic partner are registered pursuant to state law. A domestic partner will also include a civil union partner if your partnership is established under applicable state law.

5) ***For medical, dental, and vision purposes only***. You may enroll your adult unmarried disabled child of any age, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, under the following conditions: (1) the child must be chiefly dependent upon you for support and maintenance, and (2) you must submit a physician's written certification of such disabling condition. **You must contact the Employer and/or the Contract Administrator at least 90 days prior to the date the dependent child would otherwise lose eligibility.** You must submit the physician's written certification within 60 days of the request for such information by the Employer or by the Plan Administrator. Proof of continuing disability and dependency must be submitted by you as requested by the Contract Administrator but not more frequently than two (2) years after the initial certification and then annually thereafter.

The Plan Administrator has the sole right to determine who is eligible for benefits under the Plan and may request and require documentation proving a dependent's status. If you are unable to provide the required documentation, your dependent will not be eligible for benefits under the Plan. In addition, you may be required to reimburse the Employer for any costs associated with covering an individual who is not an eligible dependent, and your, as well as your dependents', coverage may be terminated.

C. Benefit Termination

This SPD and Plan Document is issued in conjunction with corresponding Certificates of Coverage or Insurance Contracts for each of the benefits identified on

the previous pages. Information regarding loss of benefits and when benefits terminate can be found in the Certificates of Coverage or the Insurance Contracts describing each separate benefit.

Generally, your coverage terminates at the earliest of the following conditions:

1) When your employment ends; however, for medical, dental, and vision benefits, your coverage ends at the end of the month in which your employment ends;
2) When you (or your covered dependents) are no longer eligible (provided, however, that your covered child's medical coverage ends at the end of the month in which the child turns age 26);
3) When you cease to make any required participant contributions; or
4) When the Plan terminates.

If you cease active work, your individual Certificate of Coverage will determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active work. See Sections 10 (COBRA) and 13 (FMLA) for more information.

D. Cost of Coverage

The Employer determines the amount of any participant contributions prior to each enrollment period and will provide you with this information in your enrollment materials. You may also contact the Plan Administrator to receive information about any participant contributions. If there are participant contributions, they may be paid with after-tax dollars.

If you enroll an individual in the Plan who does not meet the federal definition of a dependent, the value of that person's coverage may be taxable to you as income for federal income tax purposes. The Employer assumes all dependents are IRS tax dependents, except domestic partners and their children. You must contact the Plan Administrator if your domestic partner and their children are your IRS tax dependents or if you enroll other eligible dependents who are not IRS tax dependents.

If you enroll an individual in the Plan who does meet the state definition of a dependent in the state in which you reside, the value of that person's coverage may be taxable to you as income for state income tax purposes.

If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

The cost of health coverage does not include your costs for any applicable deductibles, copays, coinsurance, out-of-network charges, or non-covered items.

Section 5: Plan Administration

A. General

The administration of this Plan is under the supervision of the Plan Administrator, which shall be the named fiduciary (as described in ERISA Section 402) and the Plan Administrator (as described in ERISA Section 3(16)(A)) under the Plan. The Plan Administrator is the Executive Vice President - Global Human Capital.

The Plan Administrator may from time to time make certain appointments or delegations with respect to the Plan Administrator's duties and responsibilities hereunder ("delegate(s)"), and any reference in this Plan to the "Plan Administrator" shall include such delegate(s). As of the date of adoption of this amended and restated Plan, these delegate(s) include: (i) for decisions with respect to which the cost impact is not reasonably expected to exceed $50,000, the Senior Vice President - Human Capital Operations; and (ii) for decisions with respect to which the cost impact is not reasonably expected to exceed $10,000, the Associate Vice President of Total Rewards.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan.

The Employer will bear the incidental costs of administering the Plan.

B. Power and Authority of Insurance Company

Certain benefits under the Plan are fully-insured or provided by contract with an HMO, or provided by other service contract. Insurance Contracts with the following carriers are in force:

Kaiser Foundation Health Plan of the Northwest	**Medical**
Kaiser Foundation Health Plan, Inc.	**Medical**
Hawaii Medical Services Association	**Medical**
The Hartford	**Life, AD&D, Disability**
Headspace, Inc.	**EAP**

C. Plan Administrator Authority

1) Powers of the Plan Administrator. The Plan Administrator shall have the following powers, rights, and duties in addition to those vested in it elsewhere in the Plan:

   a) To adopt rules of procedure and regulations it determines may be necessary for the proper and efficient administration of the Plan, consistent with the provisions of the Plan.

   b) To enforce the Plan in accordance with its terms and with rules and regulations adopted by the Plan Administrator.

c) To determine all questions arising under the Plan, including claims for benefits, interpret the Plan, and to remedy ambiguities, inconsistencies, or omissions. In granting this authority, it is the intent of the Employer to confer upon the Plan Administrator the broadest possible powers of interpretation and discretion so that maximum deference is given to the Plan Administrator's decisions by any court or other reviewing body.

d) To maintain adequate records concerning the Plan and its administration.

e) To furnish the Employer with such information with respect to the Plan as it may require for tax or other purposes.

A written statement by the Plan Administrator or its duly authorized designee that the Plan Administrator has taken or authorized any action shall be conclusive in favor of the person relying on the statement.

2) Delegation by the Plan Administrator. The Plan Administrator may employ agents and counsel (who may also be employed by or represent the Employer) and delegate to them such powers as the Plan Administrator deems desirable. Any such delegations shall be in writing and shall describe the advice to be rendered or the functions and duties to be performed by the delegate.

3) Uniform Rules. The Plan Administrator shall uniformly apply rules and regulations adopted by it to all persons similarly situated.

4) Information to be furnished to Plan Administrator. The Employer shall furnish the Plan Administrator such information as may be required by the Plan Administrator. The records of the Employer as to an Employee's or participant's period of employment, termination of employment, and compensation will be conclusive on all persons unless determined by the Plan Administrator to be incorrect. Participants and other persons entitled to benefits under the Plan shall furnish to the Plan Administrator such evidence or information as it considers desirable to carry out the Plan.

5) Plan Administrator Decisions Final. To the extent permitted by law, any interpretation of the Plan and any decision on any matter within the discretion of the Plan Administrator made by it in good faith are binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable.

6) Compensation and Expenses. Other than the usual salary of any employee serving as or on behalf of the Plan Administrator (including as a committee member thereof), no compensation shall be paid to any individual acting as the Plan Administrator. However, the reasonable expenses of an individual incurred in the performance of a Plan Administrator function shall be reimbursed by the Employer in such proportions as the Employer decides. Further, reasonable compensation may be paid to third parties the Employer or Plan Administrator engages to carry out the administration of the Plan.

7) Interested Individual. An individual may not decide any matter or question concerning their own benefits under the Plan unless such decision would be made by them under the Plan if not a participant.

8) Resignation or Removal of Plan Administrator. An individual may resign as a Plan Administrator at any time by giving advance written notice to the Employer. The Employer may remove an individual at any time by giving advance written notice to them and the other individuals acting as Plan Administrator.

9) Appointment of Successor Plan Administrator Member. The Employer shall fill any vacancy in the membership of the Plan Administrator committee within a reasonable period of time and shall give prompt written notice thereof to the Plan Administrator committee members. While there is a vacancy in the membership of the Plan Administrator committee, the remaining Plan Administrator committee members shall have the same power as the full Plan Administrator committee until the vacancy is filled.

10) Indemnification of the Plan Administrator. To the extent permitted by law, the Plan Administrator (committee and its individual members, where applicable) shall be indemnified by the Employer, and held harmless by the Employer against, any and all liabilities, losses, costs, or expenses (including legal fees and expenses) of whatsoever kind and nature that may be imposed on, incurred by, or asserted against the Plan Administrator committee or its members at any time by reason of the performance of a Plan Administrator function, but only if the Plan Administrator committee or its designated members did not act dishonestly or in a willful violation of the law or regulation under which such liability, loss, cost, or expense arose.

11) Funding. The costs of the Plan may be borne by the Employer and paid out of the Employer's general assets or paid via an Insurance Contract as specified in Section 2. Neither the Employer nor the Plan Administrator shall be required to maintain any fund or segregate any amount for the benefit of a participant. Participants may be required to contribute toward the cost of certain benefits, as described under "Cost of Coverage" above.

12) Supplies or Services Not Covered by the Plan. If the Plan Administrator determines in its discretion that payment for medical supplies or services not otherwise covered by the Plan can be made by the Plan and will result in an overall savings to the Plan because such payment will reduce payments required for covered services, the Plan Administrator may direct that the Plan pay for such supplies and services.

D. Bonding

Only if and to the extent required by ERISA or other applicable law with respect to the benefits, every fiduciary of the Plan and every person handling funds of the Plan shall be bonded. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary duty at the Plan's expense and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

Section 6: Claims Procedures

This section describes how the Plan will handle claims for benefits. Informal inquiries about benefits or the circumstances under the under which benefits might be paid will not be considered claims for benefits.

Any person who wishes to pursue a claim ("you" or the "Claimant", as defined below) should carefully review these procedures. Use of these procedures is mandatory, and you may not pursue other remedies that may be available to you without first exhausting your remedies under these procedures.

The Claimant, at all steps of the claims process, may be represented by another person (who may be, but is not required to be, a lawyer)—this person is called an "authorized representative" or "representative." The Claimant will be responsible for paying the fees and expenses of their representative. The Insurance Company and/or the Plan Administrator may require evidence that it considers reasonable to establish that an individual is actually the authorized representative of the Claimant. Even though you may use a representative in the claims procedure process, they generally may not assign the right to receive benefits. See "Non-Alienation and Assignment" in Section 15 for important details.

The Plan Administrator has exclusive responsibility for deciding claims for benefits under the Plan and for deciding appeals of denied claims, unless the benefit program is fully-insured, in which case, the Insurance Company has such exclusive responsibility. The Plan Administrator has the authority, in its complete discretion and within the scope of its authority, to interpret the terms of the Plan, including any Certificates of Coverage or Insurance Contracts, to decide questions of eligibility for coverage or benefits under the Plan and to make any related findings of fact. All decisions made by the Plan Administrator shall be final and binding on the Claimant to the fullest extent permitted by law. Notwithstanding any provision of this Plan to the contrary, to the extent that an Insurance Company (or other Contract Administrator) administers claims under an Insurance Contract or Certificate of Coverage, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such Insurance Company or Contract Administrator. In such cases, the Plan Administrator has delegated to the Insurance Company or other Claims Administrator the discretionary authority to decide such claims under this section and will be the "named fiduciary" for purposes of such Benefit Program, as permitted under 29 C.F.R. § 2560.503-1(g). The Employer in its settlor capacity reserves the right to change these procedures at any time (subject to the requirements of ERISA and other applicable law).

No Claimant shall file suit unless and until the Claimant exhausts their remedies under the Plan's internal claim procedures, and any such suit must be filed within one (1) year after the Claimant exhausts those remedies. The Plan and all rights under the Plan shall be governed by and construed according to the laws of the state of Texas, except to the extent preempted by federal law. Any legal action (whether in law, in equity or otherwise) must be brought in Texas.

To the extent that the Plan Administrator properly delegates its claims authority to a Contract Administrator, the Contract Administrator may apply alternative timeframes than that set forth in this section. Where alternative timeframes are specified in the applicable Insurance Contract, Certificate of Coverage, or Benefit Booklet, such

alternative timeframes will control. In any case, each claims procedure set forth in this section or applied by the Claims Administrator is intended to comply with 29 C.F.R. § 2560.503-1 and, as applicable, the Affordable Care Act (e.g., at 29 C.F.R. § 2590.715-2719), the Consolidated Appropriations Act, and any other applicable law, the applicable provisions of which are hereby incorporated into the Plan by reference.

Please refer to Section 2 or the applicable Certificate for the proper address to file a claim for each individual contract/policy. Claims related solely to eligibility may be submitted to the Plan Administrator. Please refer to Section 1A for the relevant contact information.

Definitions

"Adverse Benefit Determination" means a denial, reduction, or termination of a benefit, including a failure to pay all or part of a benefit claim, whether based on a determination that the Claimant is ineligible to participate in the Plan or based on a utilization review. The term also includes failure by the Plan to cover an item or service for which benefits are otherwise provided, because it is found to be experimental or investigational or because it is found not to be medically necessary or appropriate. To the extent required by the PPACA, the term also includes a "rescission" of medical coverage with respect to a participant or beneficiary (e.g., a Dependent), whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time. The term also includes any "rescission" of disability coverage with respect to a participant or beneficiary, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

"Claimant" means participant, beneficiary, or dependent making a claim for a benefit.

"Concurrent Claim" means any benefit claim for group health plan benefits where the Contract Administrator has approved an ongoing course of treatment over a set period of time, or a set number of treatments, but the Contract Administrator cancels the treatment before the end of that time period or reduces the number of treatments.

"Post-Service Claim" means any request for a group health plan benefit under the Plan that is not a Pre-Service Claim and does not involve Urgent Care.

"Pre-Service Claim" means any group health plan benefit claim on account of which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"Urgent Care" or "Urgent Care Claim" means claim for medical care or treatment under the Plan if application of time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the Claimant or ability of the Claimant to regain maximum function; or, in the opinion of a physician knowledgeable of Claimant's medical condition, would subject Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Contract Administrator will determine if a claim involves Urgent Care by applying the judgment of a prudent layperson possessing an average knowledge of health and medicine. Nevertheless, if a physician with knowledge of the Claimant's medical condition determines that the claim involves Urgent Care, this decision will control.

Claims for Health Benefits

Incorrectly Filed Pre-Service (Including Urgent Care) Claims

If the Claimant does not follow the correct procedures for filing a Pre-Service Claim (including an Urgent Care Claim), the Contract Administrator will notify the Claimant as soon as possible, but no later than five (5) days after it receives the incorrectly filed Pre-Service Claim and no later than 24 hours after it receives the incorrectly filed Urgent Care Claim. The notification will describe the proper procedures for filing the claim.

Urgent Care Claims

If a Claimant submits an Urgent Care Claim, the Contract Administrator shall notify Claimant of its determination on the claim as soon as possible, but no later than 72 hours after the claim is filed. If the Claimant does not provide the Contract Administrator with enough information to decide the claim, the Contract Administrator shall notify the Claimant within 24 hours after receipt of claim of further information needed. The Claimant shall have 48 hours to provide that information. If the needed information is provided, the Contract Administrator shall notify the Claimant of its decision within 48 hours after the Contract Administrator received the information. The Contract Administrator may notify the Claimant of its decision by phone and later mail a written note if the claim is denied.

Concurrent Care Claims

If the Claimant wants to extend the course of a treatment beyond the initial time period or increase the number of treatments and the claim involves Urgent Care, the Contract Administrator shall notify the Claimant of its decision within 24 hours of receipt of the claim, provided that the claim has been made by the Claimant at least 24 hours prior to the end of the treatment time period. If the Claimant wants to extend the course of treatment beyond the initial time period or increase the number of treatments and the claim is not an Urgent Care Claim, then the Contract Administrator must notify the Claimant of its decision within a time sufficiently in advance of the end of the treatment time period to allow the Claimant to appeal and obtain a determination on appeal before the end of the treatment time period.

Pre-Service Claims

If a Claimant submits a Pre-Service Claim, the Contract Administrator shall notify the Claimant of its determination on the claim within a reasonable period, but no later than 15 days after the claim is filed. If an extension of this 15-day period is required due to matters beyond the control of the Plan, the Contract Administrator shall notify the Claimant in writing, prior to the end of the 15-day period, of the circumstances requiring the extension and the date that the Contract Administrator expects to make a decision. The extension period will be no longer than 15 days. If such as extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant will have at least 45 days from the receipt of the notice within which to provide the necessary information.

Post-Service Claims

If a Post-Service Claim is filed, the Contract Administrator shall have a reasonable period of time, up to 30 days, in which to review the claim and to notify the Claimant of its decision on the claim. If an extension of this 30-day period is required due to matters beyond the control of the Plan, the Contract Administrator shall notify the Claimant in writing, prior to the end of the 30-day period, of the circumstances requiring the extension and the date that the Contract Administrator expects to make a decision. The extension period will be no longer than 15 days. If such as extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant will have at least 45 days from the receipt of the notice within which to provide the necessary information.

Claims for Life Insurance Benefits

In the case of claims for life insurance benefits, written notice of a claim must be given within 20 days after the loss occurs or as soon as reasonably possible after that. When notice of claim is received, the Contract Administrator will send claim forms for filing the required proof within 15 days. The Contract Administrator must be given written proof of claim within 90 days after the date of the loss or as soon as reasonably possible after that.

The Contract Administrator shall notify the Claimant of its determination on the claim no later than 90 days after receipt of the acceptable proof by the Contract Administrator, unless the Contract Administrator determines that special circumstances require an extension of time for processing the claim, in which case the determination shall be provided no later than 180 days after receipt of the acceptable proof of claim.

Claims for Disability Benefits

In the case of claims for short term disability benefits, written notice of a claim must be given within 20 days after the loss occurs or as soon as reasonably possible after that. When notice of claim is received, the Contract Administrator will send claim forms for filing the required proof within 15 days. The Contract Administrator must be given written proof of claim within 90 days of the end of each period for which the Contract Administrator is liable.

For information regarding claim and appeal procedures please see the Hartford Certificate. If there is a conflict between the procedures described in this Section 6 with respect to claims for disability benefits and the procedures described in the Hartford Life and Accident Insurance Company Short Term Disability Certificate of Insurance, the Hartford Certificate and procedures will prevail.

Notice of Claim Decision

If a claim is denied, in whole or in part, the Claimant will be sent written notice of the decision from the Contract Administrator, including the following information:

- For medical claims, sufficient information to identify the claim.
- The reasons for the decision.

- Reference to the Plan provisions on which the decision is based.
- For health or disability claims, if the reason for the denial is an internal rule, protocol, guideline, or other similar criterion, a copy of it or a statement that it will be provided to the Claimant free of charge on request.
- A description of any additional information needed to support the claim and an explanation of why that information is necessary.
- For health or disability claims, if the reason for the denial is medical necessity, 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 an explanation will be provided to the Claimant free of charge on request.
- A description of the Plan's review (i.e., appeal) procedures and the time limits applicable to such procedures (and, if it is an Urgent Care Claim, a description of the expedited review procedures).
- Information concerning the Claimant's right to bring a civil action for benefits under ERISA Section 502(a) following denial of an appeal.

A claim will be deemed to be "denied" and thus trigger these notification requirements if the claim decision denies, reduces, terminates, or fails in whole or in part to provide or pay for a benefit, including determinations made on the basis of eligibility, utilization review, and restrictions involving medical necessity or experimental treatments, and will include an reduction or termination of reimbursement for a course of treatment before the expiration of a previously approved time period or before completion of a previously approved number of treatments. A claim will be deemed to be at least partially denied whenever the Plan pays less than the total amount of expenses submitted for reimbursement, even if the reduction is required under the terms of the Plan (for example, because of copay or deductible requirements).

Appealing a Claim Denial

In the case of claims involving medical, dental, vision, and disability claims, the Claimant has 180 days to appeal following the date on which they receive notice of an Adverse Benefit Determination. In the case of claims involving life insurance, the Claimant has 60 days to appeal following the date on which they receive notice of an Adverse Benefit Determination.

The Claimant will be provided, upon request and free of charge, with copies and/or reasonable access to all documents, records and other information relevant to their appeal. The Contract Administrator's review must take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Contract Administrator's review must not give any deference to the initial Adverse Benefit Determination. No individual who took part in the initial Adverse Benefit Determination, nor a subordinate of anyone who took part in the initial Adverse Benefit Determination, may participate in the appeal decision.

If an appeal is based in whole or in part on a medical judgment, including a determination with regard to whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Contract Administrator will

consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the judgment. This professional may not be an individual who was consulted in connection with the initial Adverse Benefit Determination, nor the subordinate of anyone consulted in connection with the initial Adverse Benefit Determination. The Contact Administrator shall identify and disclose to the Claimant any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, regardless of whether the advice was relied upon in making the determination.

Before the Contract Administrator makes its appeal determination for medical claims, the Claimant will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the Contract Administrator (or at the direction of the Contract Administrator) or any new or additional rationale as soon as possible and in sufficient time to allow the Claimant the opportunity to respond before the Contract Administrator issues its appeal determination.

Special Timing Rule Governing Appeals of Urgent Care Claims

In the case of a claim involving Urgent Care under the Plan, the Contract Administrator shall allow the Claimant to submit an expedited appeal either orally or in writing. If an expedited appeal is requested, all necessary information, including the Contract Administrator's determination on review, will be transmitted between the Contract Administrator and the Claimant by telephone, facsimile, or other expeditious method.

Time the Contract Administrator May Take To Decide an Appeal

Life Insurance Claims. The Contract Administrator will decide an appeal from a denied life insurance claim no later than 60 days after receipt of the Claimant's request for appeal, unless the Contract Administrator determines that special circumstances require an extension of time for processing the claim. If so, the Contract Administrator must provide the Claimant written notice of the extension prior to the termination of the initial 60-day period. This written notice must describe the special circumstances requiring the extension and the date upon which the appeal will be decided. In no case will the extension exceed 120 days after the appeal is filed.

Disability Claims. The Contract Administrator will decide an appeal from a denied disability claim no later than 45 days after receipt of the Claimant's request for appeal, unless the Contract Administrator determines that special circumstances require an extension of time for processing the claim. If so, the Contract Administrator must provide the Claimant written notice of the extension prior to the termination of the initial 45-day period. This written notice must describe the special circumstances requiring the extension and the date upon which the appeal will be decided. In no event will such extension exceed a period of 45 days from the end of the initial 45-day period.

Health Claims. If the appeal involves an Urgent Care Claim, the Contract Administrator will notify the Claimant of its decision on appeal as soon as possible taking into account pertinent medical matters and considerations, but in no event later than 72 hours after receipt of the request for appeal.

If the appeal involves a Pre-Service Claim, the Contract Administrator will notify the Claimant of its decision on appeal within a reasonable period of time, which will not

exceed 30 days after the date upon which the Contract Administrator received the request for appeal.

If the appeal involves a Post-Service Claim, the Contract Administrator will notify the Claimant of its decision on appeal within a reasonable period of time, which will not exceed 60 days after the date upon which the Contract Administrator received the request for appeal.

Notice of Appeal Decision

The Contract Administrator's decision will be furnished to the Claimant in writing within the time periods described above. If an appeal is denied in whole or in part, the notice of decision shall set forth, in a manner calculated to be understood by the Claimant:

- For medical claim appeals, sufficient information to identify the claim.
- The reasons for the appeal denial.
- Reference to the Plan provisions on which the appeal denial is based.
- 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.
- For health or disability claims, if the reason for the appeal denial is an internal rule, protocol, guideline, or other similar criterion, a copy of it or a statement that it will be provided to the Claimant free of charge on request.
- For health or disability claims, if the reason for the appeal denial is medical necessity, 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 an explanation will be provided to the Claimant free of charge on request.
- For medical claims, information about the Plan's external review procedures and how the Claimant may take advantage of this external review process.
- Information concerning the Claimant's right to bring a civil action for benefits under ERISA Section 502(a) after the Claimant's internal claims and appeals process is exhausted.

All Other Claims Including Eligibility

Time Limits for Initial Claims. Any person who believes that they are entitled to receive a benefit under the Plan, including one greater than that initially determined by the Plan Administrator, may file a claim in writing with the Plan Administrator. The Plan Administrator (or the Plan Administrator's designee) will, within 90 days of the receipt of a claim, either grant or deny the claim in writing. An extension of 90 days will be allowed for processing the claim if special circumstances are involved and the Claimant is notified of such extension before the expiration of the initial 90-day period. The notice will state the special circumstances involved and the date a decision is expected. If no notice is received during that period, the claim will be deemed denied and the Claimant may request a review of the decision.

Notice of Initial Denial. The Plan Administrator's denial of a claim will be written in a manner calculated to be understood by the Claimant and will include: the specific reason

or reasons for the benefit determination; references to specific pertinent Plan provisions on which the benefit determination is based; a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; a 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 Claimant's claim; an explanation of the appeal procedure; and a statement that the Claimant has the right to bring civil action under Section 502(a) of ERISA following a denial upon appeal.

Claimant's Right to Appeal. Claimant (or the Claimant's duly authorized representative) whose claim is denied in whole or in part by the Plan Administrator may, within 60 days after receipt of denial of their claim: submit a written request for review by the Plan Administrator; receive reasonable access to, copies (free of charge) of all documents, records and other information relevant to the Claimant's claim; and submit written comments, documents, records and other information relating to the claim for benefits.

Time Limits for Appeal. The Plan Administrator will furnish the Claimant with a written decision providing the final determination of the claim. The decision will be issued as soon as reasonable after the date the request for appeal was submitted, and usually within 60 days of the date in which the written appeal was submitted. The Plan Administrator may take an additional 60 days to make this decision if special circumstances are present. The Plan Administrator will give the Claimant notice if this extension is necessary before termination of the initial 60-day period. The notice will state the special circumstances involved and the date a decision is expected. In no event will such extension exceed a period of 60 days from the end of the initial 60-day period.

Notice of Appeal. The decision concerning an appeal of a claim will be written in a manner calculated to be understood by the Claimant and will include:
the specific reason or reasons for the denial; references to specific Plan provisions on which the benefit determination is based; 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 Claimant's claim; an explanation of the voluntary appeal procedures offered by the Plan, if any; and a statement that the Claimant has the right to bring civil action under Section 502(a) of ERISA following a denial upon appeal.

Section 7: Statement of Your Rights under ERISA

As a participant in Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants will be entitled to:

A. Receive Information about Your Plan and Benefits

1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including Insurance Contracts, and a copy of the latest annual report (Form 5500 Series) 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").

2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Insurance Contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3) Receive a summary of Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report for a Plan Year.

B. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the other documents governing the Plan and the COBRA notices that you receive on the rules governing your COBRA continuation coverage rights.

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people, who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising you rights under ERISA.

D. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

1) If you request, in writing, a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay you up to $110 a day (as indexed) until you receive the materials, unless the requested materials were not sent because of reasons beyond the control of the Plan Administrator.

2) If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. No action at law of in equity may be brought to recover under the Plan until the internal appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part.

3) If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

4) If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. Assistance with Your Questions

This Summary Plan Description contains a summary of your Plan rights and benefits. If you have you have questions about the Plan or you have difficulty understanding any part of the document, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory, or write to:

Division of Technical Assistance and Inquires
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the EBSA.

Section 8: Description of Types of Funding Arrangements

A. Fully-Insured Plan

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

Subject to the applicable fiduciary obligations under ERISA, any refund, rebate, dividend, experience adjustment, or other similar payment under an Insurance Contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such Insurance Contract.

B. Self-Insured Plan

In a self-insured Plan option or a partially self-insured Plan option, the Employer/Plan Sponsor hires the Contract Administrator to process claims under the Plan. The Contract Administrator does not serve as an insurer, but merely as a claims processor and administrator. Claims for benefits are sent to the Contract Administrator. The Contract Administrator processes the claims, then requests and receives funds from the Employer to pay the claims and make payment on the claims to health care providers. The Employer is ultimately responsible for providing Plan benefits, not the Contract Administrator. (However, the Contract Administrator and Employer share the responsibilities for administering the Plan.) Plan benefits are paid by the Employer out of the general assets of the Employer. There is no special fund or trust from which benefits are paid. Employee contributions (pre-tax or after-tax, as applicable) are also paid by the Employer out of the general assets of the Employer.

Section 9: Subrogation, Coordination with Other Benefits, and Benefit Limitations

In addition to the summaries below, these topics will be outlined in the Insurance Contracts and Certificates of Coverage:

1) Subrogation and Right of Reimbursement
2) Coordination of Benefits
3) Fraud
4) No Responsibility for Outcomes

A. Subrogation and Right of Reimbursement

This Plan is not intended to pay benefits for services or supplies which relate to claims caused in whole or in part by the acts of third parties, or for which insurers or other third parties are liable or make payment. This Section contains the rules governing such claims.

1) Liable Third Parties. The term "Liable Third Party" means, without limitation, any individual or entity (and their insurers, guarantors, or those who indemnify them) who caused or are responsible for the illness, injury, or other condition for which the Plan has or will make payment. Liable Third Parties include workers compensation insurers and the insurers of any Covered Person, including automobile, casualty, and no-fault insurers.

2) Covered Person. The term "Covered Person" means the individual receiving benefits under the Plan, including (without limitation) their guardian, estate, legal representative, attorney, or those acting on behalf of a Covered Person.

3) General Rule. Benefits paid as a result of the acts or omissions of a Liable Third Party are not payable under the Plan, regardless of whether or not such benefits are otherwise covered under the terms of the Plan. Nevertheless, the Plan Administrator, acting in its discretion, may pay such benefits if the Covered Person puts in writing, in such form as the Plan Administrator may determine, acknowledgement of the Plan's rights to reimbursement and agreement (a) to reimburse the Plan for benefits paid with respect to the illness, injury, or other condition; (b) to cooperate with the Plan in recovering such amounts from a Liable Third Party, including providing all information necessary to determine the circumstances of the injury, sickness, or condition, and the potential for recovery from a Liable Third Party; and (c) that all amounts the Covered Person may collect from the Liable Third Party, up to the amount of benefits paid, shall be held in trust for the Plan. The Covered Person will have 14 days from receipt of the writing to execute it and return it to the Plan.

4) Rights of the Plan. In cases in which the Plan Administrator determines that a Liable Third Party may be involved, the Plan may choose to subrogate itself to the rights of the Covered Person to receive payment from the Liable Third Party. In such cases, and as a condition precedent to receipt of benefits from the Plan, the Covered Person agrees to assign and transfer to the Plan all or their rights to recovery on account of their illness, injury, or other condition. Alternatively, the Plan may choose to recover directly from the Covered Person, and/or their legal

representative, the amount of benefits paid by the Plan. The source of this recovery shall be any payment the Covered Person has received or may receive (by way of judgment, settlement, arbitration, or otherwise) from the Liable Third Party, regardless of how such recovery may be designated (for example, for pain and suffering rather than for physical injury), or regardless of who receive it (for example, a special needs trust for the benefit of the Covered Person or the Covered Person's attorney). If the Covered Person makes any recovery from a Liable Third Party and fails to repay the Plan for any associated benefits, then the Covered Person is personally liable to the Plan for benefits paid by the Plan. In addition to all other rights in law and equity, the Plan shall have the right to set off any future benefits payable to the Covered Person, until such amounts are fully recovered.

5) Plan's First Lien Upon Recovery from a Liable Third Party. The Plan shall have a first lien against any recovery by whatever means obtained that the Covered Person receives from a Liable Third Party. This lien shall be in an amount which shall not exceed the amount of benefits paid by the Plan, plus its costs of collection, including attorneys' fees, from the Covered Party. The Plan's right to recovery shall not be reduced on account of the Covered Party's attorneys' fees or costs associated with their recovery from the Liable Third Party or because the Covered Person has not been made whole with respect to their illness, injury, or other condition.

6) Other Matters. The Plan is not subject to the make whole doctrine or similar concepts, which limit the Plan's recovery if the Covered Person has not been made whole with respect to their illness, injury, or other condition, and is not subject to the common fund doctrine or similar concepts, which would require the Plan to reduce its recovery by a portion of the Covered Party's attorneys' fees and costs incurred in recovering for their illness, injury. or similar condition. Further, the Plan is entitled to recover its attorneys' fees and costs associated with any recovery under this subrogation/reimbursement provision. In addition, the Plan has the right to receive interest on all amounts owing to it pursuant to this subrogation/reimbursement provision at the applicable judgment rate, dating from the time the Covered Person collects any amounts from the Liable Third Party.

B. Coordination of Benefits

Coordination of benefits procedures will be as described in the incorporated documents. To the extent that the incorporated documents do not have any provisions for coordination of benefits, the procedures described below shall govern.

When an employee or an employee's dependents are covered under more than one group health plan, the combined benefits payable by this Plan and all other group health plans will not exceed 100% of the eligible expenses incurred by the individual. The Plan assuming primary payor status will determine benefits first without regard to benefits provided under any other group health plan.

When this Plan is the secondary payor, it will reimburse, subject to all Plan provisions, the balance of remaining eligible expenses, not to exceed normal Plan liability if this Plan had been primary.

For purposes of coordination, eligible expense means any usual and customary charge considered in part or full by this Plan.

There is no coordination between one HMO and another or between an HMO and a PPO or indemnity plan (an EPO substitutes for HMO for purposes of this section).

1) Government Programs and Other Group Health Plans

   The term group health plan, as it relates to coordination of benefits, includes the government programs Medicare, Medicaid, and Tricare/CHAMPUS. The regulations governing these programs take precedence over the determination of benefits under this Plan. For example, in determining the benefits payable under the Plan, the Plan will not take into account the fact that an employee or an employee's dependents are eligible for or receive benefits under a Medicaid plan.

   The term group health plan also includes all group insurance and group subscriber contracts, such as union welfare plans, and benefits provided under any group or individual automobile no-fault or fault-type policy or contract. Individual policies or contracts are not included.

2) Automobile Insurance

   This Plan provides benefits relating to medical expenses incurred as a result of an automobile accident on a secondary basis only. Benefits payable under this Plan will be coordinated with and secondary to benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance.

   Any benefits provided by this Plan will be subject to the Plan's reimbursement and/or subrogation provisions.

3) Order of Payment When Coordinating With Other Group Health Plans

   Any group health plan which does not contain a coordination of benefits provision will be considered primary.

   When all plans covering an employee or an employee's dependents contain a coordination of benefits provision, the first of the following rules that describes which plan will pay benefits before another plan is the rule to follow:

   a) The plan covering an individual other than as a dependent (for example, as an active employee or retiree) will be primary to a plan covering the same individual as a dependent. However, if the individual is covered by a group health plan and Medicare and, under federal law, Medicare is:

      - Secondary to the plan covering the individual as a dependent; and
      - Primary to the plan covering the individual as other than a dependent (for example, a retiree);

then the order of payment is reversed so the plan covering the individual as an employee or retiree is secondary and the other plan is primary.

b) If a dependent child is covered under more than one plan, the primary plan is the plan of the parent whose birthday (month and day) is earlier in the calendar year if:

- The parents are married; or
- The parents are not separated (regardless of whether they ever have been married); or
- A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

If both parents have the same birthday (month and day), the plan that has covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care coverage or expenses and the plan of that parent has knowledge of the decree, that plan is primary. If the parent designated by the decree has no coverage for the child but that parent's spouse does, the spouse's plan is primary.

If the parents are not married, are separated (regardless of whether they were ever married), or are divorced and there is no court decree allocating responsibility for the child's health care coverage or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; then
- The plan of the spouse of the noncustodial parent.

c) The plan that covers an individual as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. However, the order of benefit determination for an individual covered both as a retiree and as a dependent of that individual's spouse will be determined under paragraph a) above.

d) The plan covering the individual as an employee or retiree (or as that individual's dependent) will be primary to the plan providing continuation coverage under federal (COBRA) or state law.

4) Coordination of Benefits for Active, Medicare Eligible Employees/Dependents

If an employee continues to be actively employed by the Employer after reaching age 65, the employee's health benefits remain in effect even though they are eligible for or enrolled in Medicare (any Part). The employee's spouse may also continue to be covered under this Plan if they reach age 65 and is eligible for or enrolled in Medicare (any Part). The employee may voluntarily elect Medicare as

their primary coverage, but only if the employee waives all medical and prescription drug benefits under this Plan. Note that the employee will not receive any compensation or other incentive for waiving this Plan's benefits.

If the employee or spouse is enrolled in this Plan and enrolls in Medicare (any Part) due to age, this Plan pays first and Medicare pays second, as long as the employee remains actively employed by the Employer.

If the employee, spouse, or dependent child is enrolled in this Plan and enrolls in Medicare (any Part) due to the disability, this Plan pays first and Medicare pays second, as long as the employee remains actively employed by the Employer.

If the employee, spouse, or dependent child is enrolled in this Plan and enrolls in Medicare because of end stage renal disease ("ESRD"), this Plan pays first for the first 30 months that Medicare benefits are available because of ESRD, and Medicare pays second for that 30-month period. However, after the end of the 30-month period, Medicare will pay first and this Plan will pay second.

However, if Medicare is primary, the Plan Administrator will give consideration to the benefits available under Medicare when determining this Plan's payments for a participant's covered expenses. If Medicare is primary and the spouse or dependent is enrolled in Part A, but not Part B, the Plan will not pay any claims that would have been covered by Part B, despite the fact that the spouse or dependent did not enroll in Part B.

5) Coordination of COBRA Benefits for Medicare Eligible Individuals

Generally, COBRA coverage will be available if a COBRA qualified beneficiary enrolled in Medicare (Part A, Part B, or both) prior to enrolling in COBRA coverage. See Section 10, below. In this case, Medicare will be primary, and the COBRA coverage will be secondary.

Generally, COBRA coverage will terminate if a COBRA qualified beneficiary enrolls in Medicare (Part A, Part B, or both) after enrolling in COBRA coverage. See Section 10, below.

However, for any COBRA coverage provided under the UHC contract, in the case of a COBRA qualified beneficiary who enrolls in Medicare Part A, but not Part B, prior to enrolling in COBRA coverage, such beneficiary's COBRA coverage will be primary for any Medicare Part B claims, and the Plan will pay benefits with no consideration of any Medicare Part B benefits that would have been available if such beneficiary had enrolled in Part B.

C. Fraud

No payments with respect to Plan benefits will be paid if the employee, the employee's dependent, or the provider of services for which payment is sought attempts to perpetrate a fraud upon the Plan or performs an act or omission that constitutes fraud, or if the employee, the employee's dependent, or the provider of services makes an intentional misrepresentation of material fact with respect to any claim. The Plan Administrator has the right to make the final determination of

whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made, and its decision shall be final, conclusive, and binding upon all persons. The Plan reserves the right to fully recover any amounts, with interest, improperly paid by the Plan by reason of fraud, attempted fraud, or misrepresentation of fact and to pursue all legal or equitable remedies. Any retroactive cancellation of group health coverage pursuant to this section and subject to the PPACA will comply with PPACA's limitation and requirements for rescission of coverage.

D. No Responsibility for Outcomes

The Plan does not provide health-related diagnoses, treatment, or services, although it pays for them if its requirements are met, subject to the limitations it imposes. Neither the Employer, any Plan fiduciary, nor any of its or their delegates, agents, or affiliates guarantees any medical results or outcomes or is responsible for them or makes any express or implied warranties concerning the outcome of any covered services or supplies.

Section 10: Continuation Coverage (COBRA)

Federal law requires the Plan to offer employees and their families the opportunity to elect a temporary extension of group health plan coverage under the Plan (called "COBRA coverage") in certain instances when health coverage under the Plan would otherwise end. This includes any medical package, dental package, vision package, or other benefit that provides medical care under the Plan.

Please note that life insurance and disability benefits are not group health plans and so are not subject to the COBRA coverage provisions. However, in certain circumstances, an existing life or disability insurance conversion privilege may be exercised within 31 days following the date of termination. If you wish to exercise this conversion option, please refer to your Certificate of Coverage for specific requirements, including important deadlines for requesting such coverage.

You do not have to show that you are insurable to elect COBRA coverage. However, you will have to pay the entire premium for your COBRA coverage, plus applicable administration fees.

This Section provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA coverage rights than what the COBRA statute requires, and this Section should be construed accordingly.

Note: You may have other options available to you and your family when you lose Plan coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan for which you are eligible (such as a spouse's plan), through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

A. Qualifying Events

If you are an employee and are covered by the Plan, you have the right to elect COBRA coverage if you lose health coverage under the Plan because of either of the following two "qualifying events":

1) Termination of your employment (for reasons other than gross misconduct); or

2) Reduction in the hours of your employment.

Your spouse who is covered by the Plan has the right to elect COBRA coverage if they lose health coverage under the Plan because of any of the following "qualifying events":

1) Your death;

2) Termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment;

3) Divorce or legal separation from you. Note that, if you eliminate health coverage for your spouse in anticipation of a divorce or legal separation which later occurs, then the actual date of divorce or legal separation is considered a qualifying event even though your ex-spouse lost health coverage earlier. If your ex-spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and can establish that health coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation; or

4) You become enrolled in Medicare benefits.

Note: *Federal law does not extend COBRA coverage to your domestic partner or their dependents; these individuals are not "qualified beneficiaries" under federal COBRA law, and so these individuals do not have their own independent election or other rights under COBRA.*

Your dependent child who is covered by the Plan has the right to elect COBRA coverage if they lose health coverage under the Plan because of any of the following "qualifying events":

1) Your death;

2) Termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment;

3) Your divorce or legal separation from your spouse;

4) You become enrolled in Medicare benefits; or

5) Your dependent ceases to be a "dependent child" under the Plan.

B. Your Notice Obligations

If your spouse or dependent child loses health coverage under the Plan because of divorce, legal separation, or the child's losing dependent status under the Plan, then you or your spouse or dependent has the responsibility to notify the Plan Administrator of the divorce, legal separation, or the child's losing dependent status. You or your spouse or dependent must be made through Workday, our system of record, but if assistance is needed please contact the Benefits Department *If you or your spouse or dependent child fails to submit the Workday benefit event to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses health coverage will NOT be offered the option to elect COBRA coverage.* Furthermore, if you or your spouse or dependent child fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child's losing dependent status, then you, your spouse, and dependent children may be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is timely provided with written notice of a divorce, legal separation, or a child's losing dependent status that has caused a loss of health

coverage, then the Plan Administrator will notify the affected family member of the right to elect COBRA coverage (but only to the extent that the Plan Administrator has been notified in writing of the affected family member's current mailing address).

If these procedures are not followed or the notice is not provided in writing to the Plan Administrator during the notice period, you will lose the right to elect COBRA coverage.

The Plan Administrator will also notify you, your spouse, and dependent children of the right to elect COBRA coverage after it receives notice of the following events that result in a loss of health coverage: your termination of employment (other than for gross misconduct), reduction in hours, death, or enrollment in Medicare. A copy of the required notice is available from the Plan Administrator.

C. Election Procedures

You or your spouse and dependent children must elect COBRA coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect COBRA coverage. *If you or your spouse and dependent children do not elect COBRA coverage within this 60-day election period, you will lose your right to elect COBRA coverage.* A COBRA election mailed to the Plan Administrator is considered to be made on the date of mailing.

You or your spouse and dependent children may elect COBRA coverage for all qualifying family members. You, your spouse, and dependent children each have an **independent** right to elect COBRA coverage. So, your spouse or dependent child may elect COBRA coverage even if you do not (or are not deemed to) elect it. This applies to each of the health plan options offered separately.

You or your spouse and dependent children may elect COBRA coverage even if covered under another employer-sponsored group health plan or enrolled in Medicare. However, COBRA coverage will terminate automatically if, after the election, you or your spouse and dependent children become enrolled in Medicare benefits or become covered under other group health plan coverage.

D. Type of Coverage

Ordinarily, COBRA coverage that is offered will be the same coverage that existed on the day before the qualifying event. Therefore, an employee, spouse, or dependent child who is not covered under the Plan at that time generally is not entitled to COBRA coverage, except, for example, when there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage is modified for similarly-situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way.

Specifics on the election notice, timing, etc. will be outlined in the election notice that is sent you at the time of the qualifying event.

The Plan offers a choice of separate benefit packages, and you (or your spouse or dependent children) may elect COBRA coverage under those separate benefit

packages in which you have health coverage. For example, if you are covered under a medical package, a dental package, and a vision package, you could elect COBRA coverage under the medical package and decline coverage under either or both of the dental and vision packages.

E. COBRA Premiums You Must Pay

Persons electing COBRA coverage can be required to pay 102% of the cost for the applicable coverage. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay up to 150% of the cost for the applicable coverage for the 19th through the 29th month of COBRA coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

Continued coverage will be subject to the same benefits and rate changes as the Plan.

The premium payments for the "initial premium months" must be paid for you and for any spouse or dependent child by the 45th day after electing COBRA coverage. The initial premium months are the months that end on or before the 45th day after the election of COBRA coverage is made. The Plan will not reinstate COBRA coverage until BOTH the full payment required as well as the election form(s) are received by the Plan Administrator.

Once COBRA coverage is elected, the right to continue COBRA coverage is subject to timely payment of the required COBRA premiums. Monthly premiums are due on the first of the month for which the premium is paid, subject to a 30-day grace period. A premium payment that is mailed is considered to be made on the date it is sent. If you do not make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the first of the month, with no possibility of reinstatement. It is **your** responsibility to ensure timely premium payment is received by the Plan Administrator.

F. Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of COBRA Coverage before the End of the Maximum Coverage Period."

1) 18 Months. If you, your spouse, or your dependent child lose health coverage due to your termination of employment (other than for gross misconduct) or reduction in hours, then the maximum coverage period for each of you is 18 months from the date of termination or reduction in hours. There are three (3) exceptions:

    a) If you or a family member electing COBRA coverage is disabled at any time during the first 60 days after the date of termination or reduction in hours, and the disability lasts through the standard 18-month term of coverage, then the COBRA coverage period for all qualified beneficiaries under the qualifying event is up to an additional 11 months (for a maximum of 29 months) from

the date of termination or reduction of hours if timely notice of the disability is provided to the Plan, as described in 2) below.

b) If a second qualifying event that gives rise to a 36-month maximum coverage period for your spouse or dependent child (for example, you die or become divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for your spouse or dependent child) becomes 36 months from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of COBRA coverage will occur.

   For example, if you terminate coverage January 1 and elect COBRA continuation for your spouse, but get divorced in June of the same year, your spouse may continue coverage for 36 months from the January 1 COBRA coverage start date, provided the Plan is notified of the divorce (the second qualifying event) within 60 days of the divorce.

c) If the qualifying event is your termination of employment or reduction in hours, and the qualifying event occurs within 18 months after you become enrolled in Medicare, then the maximum coverage period (for your spouse and dependent child) ends 36 months from the date you became enrolled in Medicare. For example, if you enrolled in Medicare 8 months prior to your termination of employment or reduction in hours, the maximum coverage allowed for your covered dependents under COBRA is 28 months after your termination of employment or reduction in hours.

2) 29 Months. The disability extension (above) is only available if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability (under Title II – Old Age, Survivors and Disability Insurance, or Title XVI – Supplemental Security Income of the Social Security Act) before the end of the initial 18-months of COBRA coverage and within 60 days after the latest of:

   a) The date of the Social Security Administration's disability determination; or
   b) The date of your termination of employment or reduction of hours; or
   c) The date on which the qualifying beneficiary loses (or would lose) health coverage under the Plan as a result of your termination or reduction of hours.

   In providing this notice, you must use the "Notice of Disability" form, and you must follow the notice procedures for the form. If these procedures are not followed or if written notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months of your termination or reduction of hours, **then there will be no disability extension of COBRA coverage.**

3) 36 Months. If your spouse or dependent child loses health coverage because of your death, divorce, or legal separation, or because the child loses dependent status under the Plan, then the maximum coverage period for your spouse or dependent child is 36 months from the date of the qualifying event.

G. Special Enrollment During COBRA Period

1) Children Born to or Adopted by You during COBRA Period. A child born to, adopted by, or placed for adoption with you during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if you are a qualified beneficiary, you have elected COBRA coverage for yourself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for your other family members. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

2) Open Enrollment Rights and HIPAA Special Enrollment Rights. Qualified beneficiaries who have elected COBRA coverage will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA coverage. HIPAA, a federal law, gives a person already on COBRA coverage certain rights to add coverage for dependents if the person acquires a new dependent (through marriage, birth, adoption, or placement for adoption) or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described under "Children Born to or Adopted by You During COBRA Period," dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries. Their coverage will end at the same time that your COBRA coverage ends. If you become enrolled in or cease to be enrolled in Medicaid, or if your spouse or dependent child does so, or if you, your spouse, or your dependent child loses coverage under a state child health plan or qualifies for premium assistance under Medicaid or under a state child health plan, you may change your election with respect to health benefits.

3) Alternate Recipients Under QMCSOs. Your child who is receiving health benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during your employment with the Employer is entitled to the same rights under COBRA as a dependent child of yours, regardless of whether that child would otherwise be considered your dependent.

H. COBRA Termination Before End of Maximum Coverage Period

COBRA coverage of you, your spouse, and/or your dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following occurs:

1) The Employer no longer provides group health coverage to any of its employees.

2) The premium for the qualified beneficiary's COBRA coverage is not timely paid.

3) After electing COBRA coverage, you, your spouse, or your dependent child becomes covered under another group health plan (as an employee or

otherwise). This rule applies only to the qualified beneficiary who becomes covered by another group health plan.

4) After electing COBRA coverage, you, your covered spouse, or your dependent child becomes enrolled in Medicare. This will apply only to the person who becomes enrolled in Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.

5) You, your spouse, or your dependent child became entitled to a 29-month maximum coverage period due to the disability of a qualified beneficiary, but then there is a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled (however, COBRA coverage will not end until the month that begins more than 30 days after determination).

6) The occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage.

Section 11. Special Continuation Coverage Rights – California Employees Only

A. Coverage Period Extension – Cal-COBRA

If you are enrolled in a medical HMO or insured medical coverage in California **(Kaiser)** at the time of your initial COBRA qualifying event, you and your eligible dependents may be eligible to extend COBRA coverage from 18 or 29 months to a total of 36 months measured from the date of the original qualifying event. The HMO or insurance company may charge up to 110% of the cost (disabled individuals may be charged up to 150% of the cost). Refer to your Certificate and/or contact Kaiser to find out whether you are eligible for this continuation benefit and how to obtain it.

Cal-COBRA terminates the earliest of:

a) The date the maximum period of coverage expires;
b) The date coverage ceases because a premium payment is not made in time;
c) The date the Employer no longer provides any group health plan;
d) The date the qualified beneficiary moves out of Insurance Company's service area; or
e) When the qualified beneficiary commits fraud or deception in the use of benefits.

Cal-COBRA only applies to medical benefits – it does NOT apply to dental or vision benefits. Cal-COBRA does not apply to a medical package that is self-insured by the Employer. Cal-COBRA does not apply to employees covered in the Kaiser Northwest package.

Section 12: HIPAA

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

A. Special Enrollment Rights

HIPAA requires the Plan to provide special mid-year enrollment opportunities to certain employees and/or their dependents in these circumstances:

1) Loss of other health coverage; or
2) Acquisition of a new dependent.

If you are covered under another group health plan and involuntary lose that coverage (due to expiration of COBRA or loss of eligibility under the other group plan), you or your dependents may enroll in the Plan under the special mid-year enrollment rights. You must request enrollment in writing within 31 days after the loss of other coverage or the 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.

If you as an employee acquire a new dependent, by marriage, birth, adoption, or placement for adoption, you have a right to enroll yourself and the new dependent in the Plan. You must request enrollment in writing within 31 days of the marriage, birth, adoption, or placement for adoption. Coverage will become effective retroactive to the date of marriage, birth, adoption, or placement for adoption.

Additional Special Enrollment Rights under CHIPRA: Please be aware that you also have certain Medicaid- and CHIP-related special enrollment rights under federal law and the Plan. Those rights and the notice requirements are described in Section 14, under "Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)" later in this SPD.

B. Privacy of Health Information

The HIPAA Privacy Rule applies to "Protected Health Information", which is defined as any written, oral, or electronic health information that meets the following three requirements:

1) The information is created or received by a health care provider or the Plan.
2) The information includes specific identifiers that identify you or could be used to identify you.
3) The information relates to one of the following:
   a) Providing health care to you.
   b) Your past, present, or future physical or mental condition.
   c) The past, present, or future payment for your health care.

Protected Health Information also includes genetic information and information related to substance use disorder treatment records. The Notice of Privacy Practices

for the Plan contains a complete explanation of your rights under the HIPAA Privacy Rule (the Insurance Companies that insure the health plan benefits under the Plan also will provide you with their own notices of privacy practices). The notice describes how Protected Health Information may be used and disclosed, and how you can get access to that Protected Health Information. The following is a summary of those uses and disclosures of Protected Health Information and your rights with respect to Protected Health Information:

1) The Plan may use or disclose your Protected Health Information for purposes of conducting health care operations or paying your health care claims.

2) The Plan may use or disclose your Protected Health Information to tell you about treatment alternatives, or to provide you with information about other health-related benefits or services that may be of interest to you.

3) The Plan may disclose your Protected Health Information to the Employer, as sponsor of the Plan, to assist the Employer in the performance of plan administration functions; the Plan also may provide summary health information to the Employer, as Plan sponsor, so that the Employer may obtain premium bids or modify, amend, or terminate the Plan; summary health information does not directly identify you, but summarizes claims history, claims expenses, or types of claims experienced; finally, the Plan may disclose your enrollment and disenrollment information to the Employer as Plan sponsor.

4) The Plan may disclose your Protected Health Information when required to do so by any federal, state, or local law, and when permitted to do so under the circumstances set out in the Employer's Notice of Privacy Practices.

5) The Plan may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes; for example, the Plan may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries.

6) The Plan may disclose your Protected Health Information to health care providers to assist them in connection with their treatment or payment activities; in addition, the Plan may disclose your Protected Health Information to other entities subject to the HIPAA Privacy Rule to assist them with their payment activities or certain of their health care operations; for example, the Plan might disclose your Protected Health Information to a health care provider when needed by the provider to render treatment to you.

7) Other than as permitted or required by law, the Plan will not use or disclose your Protected Health Information without your written authorization; if you authorize the Plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time; if you revoke the authorization, the Plan no longer will use or disclose your Protected Health Information for the reasons covered by your written authorization; your revocation will not affect any uses or disclosures the Plan already has made prior to the date the Plan receives notice of the revocation.

In general, you have the following rights regarding the Protected Health Information retained by the Plan:

1) You have the right to request that the Plan restrict uses and disclosures of your Protected Health Information to carry out payment or health care operations and to satisfy any legal requirements.

2) You have the right to request that the Plan communicate with you in a certain way if you feel that the disclosure of your Protected Health Information could endanger you.

3) You have the right to inspect and obtain a copy of your Protected Health Information.

4) If you believe that the Protected Health Information the Plan has about you is inaccurate or incomplete, you have the right to request a correction.

5) You have a right to request a list of disclosures made by the Plan of your Protected Health Information, other than those disclosures for which an accounting is not required.

6) You have a right to request and receive a paper copy of the Notice of Privacy Practices for the Plan, even if you have received this notice previously or agreed to receive this notice electronically.

For more information regarding these rights and the privacy policies of the Plan, please review the Notice of Privacy Practices for the Plan. The Notice of Privacy Practices for the Plan is available from the Plan Administrator.

C. Right to Use Data

On behalf of the Employer, the Plan Administrator reserves the right to derive data for purposes of statistical analysis from the claims files held in connection with the Plan and the benefits offered under the Plan.

Section 13: Family and Medical Leave Act (FMLA)

A. Compliance

When required by law, the Plan will comply with the Family and Medical Leave Act (FMLA) requiring continuation rights for health coverage. If you are covered under health benefits and take an FMLA leave of absence, you may be able to continue the health coverage under the Plan for a certain period of time.

An eligible employee is an employee who has worked for the Employer:

1) For at least 12 months; and
2) For at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the FMLA leave; and
3) At a work site where the Employer employs at least 50 employees within a 75 mile radius.

For this purpose, "employs" has the meaning provided by the FMLA.

The FMLA allows eligible employees to take a leave for up to a total of 12 work weeks in a 12-month period for one or more of the following reasons:

1) The birth of your child and to care for the newborn child;
2) The placement of a child with you for adoption or foster care;
3) To care for a family member (child, spouse, or parent) with a serious health condition;
4) Your own serious health condition that makes you unable to perform the functions of your job; and
5) Any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered member in the Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

If eligible, you may also take leave for up to a total of 26 work weeks in a single 12-month period to care for a covered member of the Armed Forces with a serious injury or illness.

Please note that any time provided under the FMLA will run concurrently with any other continuation provisions of this Plan for sickness, injury, layoff, or approved leave of absence, if any. Further, if continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

B. Benefits

The Employer will continue your health coverage under the Plan during your FMLA leave just as if you were still employed. To the extent required under the FMLA, and the regulations thereunder, if there are any employee contributions for health benefits, 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 Plan 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 shall continue to be made on behalf of an employee on an FMLA leave.

A newly acquired dependent is eligible for health coverage while your health coverage is continued during an FMLA leave.

If the Employer offers new health benefits or changes its benefits while you are on an FMLA leave, you are eligible for the new or changed benefits.

Continued health coverage ends on the earliest date that you:

1) Terminate employment;
2) Do not make any required participant contributions; or
3) Exhaust your approved period of FMLA leave and do not return to work from your FMLA leave.

If your employment does not terminate during your FMLA leave, but you do not return to work once your FMLA leave ends, you can choose to continue health coverage under the COBRA continuation rules. See Section 10 (COBRA) for more details.

Section 14: Other Federal Laws that Impact Benefits

Grandfathered Health Plans under the Patient Protection and Affordable Care Act (PPACA) – Applies to Medical Benefits

The Employer believes the United Healthcare and Kaiser Permanente medical portion of this Plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, 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 PPACA 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 PPACA, 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. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Other changes provided for under the PPACA do not impact the Plan because the Plan already contains these benefits. These include:

1) Direct access to OB/GYN care without a referral or authorization requirement.
2) The ability to designate a pediatrician as a primary care (PCP) if your Plan benefits require a PCP designation.
3) Prior authorization is not required before you receive services in the emergency department of a hospital.

   If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Preventing Surprise Medical Bills

To the extent required by the Consolidated Appropriations Act, 2021 (the "Consolidated Appropriations Act" or "CAA"), including, without limitation, the No Surprises Act (at Division BB, Title I of the CAA) and Transparency provisions (at Division BB, Title II of the CAA), each applicable health plan will cover (i) out-of-network "emergency services," (ii) out-of-network non-emergency services performed by out-of-network providers at certain in-network facilities, and (iii) out-of-network air ambulance services (if the health plan covers in-network air ambulance services) at the levels required by, and subject to all applicable requirements of, the Consolidated Appropriations Act (e.g., via Sections 716 and 717 of ERISA) and the rules of the Plan. Refer to your Certificate of Coverage or contact the Plan Administrator or Contract Administrator for more information.

Continuity of Care upon the Expiration of Provider Network Contract

To the extent required by the Consolidated Appropriations Act, each applicable health plan will provide continued transitional care to a "continuing care patient" within the meaning of, and subject to the requirements of, the Consolidated Appropriations Act (e.g., via Section 718 of ERISA) and the rules of the Plan.

Mental Health/Substance Use Disorder Parity

The Plan, to the extent its health plans provide mental health or substance use disorder ("MH/SUD") benefits, may not, under federal law, impose less favorable benefit limitations on those MH/SUD benefits than on medical/surgical benefits, as required under (and in accordance with) the Mental Health Parity and Addiction Equity Act of 2008, as amended (MHPAEA).

Please refer to your Certificate of Coverage for details and/or contact the Contract Administrator for more information.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) expands special enrollment rights under the Plan.

You or your dependent may be eligible to enroll during a special enrollment period. A special enrollment period is not available to you and your dependents if coverage under a prior plan was terminated for cause or because premiums were not paid on a timely basis.

A special enrollment period applies for you and/or your dependent who did not enroll during the Initial enrollment period or open enrollment period; and

1) a) You and/or your dependent had existing health coverage under Medicaid or Children's Health Insurance Program (CHIP) at the time you had an opportunity to enroll during the initial enrollment period or open enrollment period; and

   b) Coverage under a prior plan ended because you and/or your dependent loses eligibility under Medicaid or Children's Health Insurance Program (CHIP).

   Coverage will begin only if the Plan Administrator receives the completed enrollment form within 60 days of the date the Medicaid or CHIP coverage ended.

2) You previously declined coverage under the Plan, but you and/or your dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if the Plan Administrator receives the completed enrollment form within 60 days of the date of determination of subsidy eligibility.

Genetic Information Nondiscrimination Act (GINA)

GINA prohibits discrimination in health coverage and employment on the basis of genetic information. The Plan will not request or require genetic information of a participant or use it for decisions regarding coverage or rates.

The law also prohibits the Employer from using genetic information for hiring, firing, or promotion decisions and for any decisions regarding terms of employment.

GINA defines "genetic information" as information about:

1) An individual's genetic tests (including genetic tests done as part of a research study);
2) Genetic tests of the individual's family members (defined as dependents and up to and including 4th degree relatives);
3) Genetic tests of any fetus of an individual or family member who is a pregnant woman, and genetic tests of any embryo legally held by an individual or family member utilizing assisted reproductive technology;
4) The manifestation of a disease or disorder in family members (family history);
5) Any request for, or receipt of, genetic services or participation in clinical research that includes genetic services (genetic testing, counseling, or education) by an individual or family member.

Genetic information does not include information about the sex or age of any individual.

GINA defines "genetic test" as an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes.

The results of routine tests that do not measure DNA, RNA, or chromosomal changes, such as complete blood counts, cholesterol tests, and liver-function tests, are not protected under GINA. Also, under GINA, genetic tests do not include analyses of proteins or metabolites that are directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

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 generally does not prohibit the mother's or newborn's attending provider after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not is excess of the above period. Additional requirements may apply under state law—refer to your Certificate of Coverage for information.

Women's Health and Cancer Rights Act of 1998

The federal Women's Health and Cancer Rights Act of 1998 required coverage of treatment related to mastectomy. If you are eligible for mastectomy benefits under your health coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

1) Reconstruction of the breast on which mastectomy has been performed;
2) Surgery and reconstruction on the other breast to produce a symmetrical appearance;
3) Prostheses;
4) Treatment of physical complication of all stages of mastectomy, including lymphedemas.

Coverage for reconstruction 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. Coverage is subject to applicable deductibles, copayments, and coinsurance payments.

Uniformed Services Employment And Reemployment Rights Act Of 1994 (USERRA)

Federal law requires that, if your coverage would otherwise end because you enter into active military duty, you may elect to continue coverage (including dependents coverage) in accordance with the USERRA.

A. Continuation

If active employment ends because you enter active military duty, coverage may be continued until the earliest of:

1) For you and your dependents:

   a) The date the Plan is terminated; or

   b) The end of the contribution period for which contributions are paid if you fail to make timely payment of a required contribution; or

   c) The date 24 months after the date you enter active military duty; or

   d) The date after the day on which you fail to return to active employment or apply for reemployment with the Employer.

2) For your dependents:

   a) The date dependent coverage would otherwise cease under the Plan; or

   b) Any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in this Plan for sickness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

B. Cost of Continuation Coverage

For military leaves of less than 31 days, you will pay for your health coverage as if you were still an active employee. For military leaves of 31 days or more, the Employer may charge you and your dependents up to 102% of the total cost of coverage.

C. Reinstatement

The reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of USERRA.

This is a general summary of the USERRA and how it affects your Plan. Contact the Employer for details on this continuation provision.

Section 15: Miscellaneous Provisions

Headings. The Section headings contained within this document are included only for convenience of reference and should not be construed to limit or define the contents contained therein.

Exclusive Benefit. The Plan has been established and shall be maintained for the exclusive benefit of participants, dependents, or beneficiaries. Benefits shall be paid only in accordance with the Plan's terms. Reasonable expenses of administering the Plan may be paid only in accordance with the Plan's terms.

Timely Payment of Claims. All benefit claims under the Plan (and any adjustments to claims or recoupments of discounts sought by providers) must be complete and filed with the Plan or its Contract Administrators within one (1) year of the date the services were rendered or supplies provided, unless a different deadline is provided in your Certificate of Coverage. No payments under the Plan or otherwise are owed for any claims completed or filed outside of this timeframe.

Participating Provider Networks and Directories. For health benefits, a participant may obtain the participating provider directories from the Contract Administrator for a particular benefit, free of charge.

No Guarantee of Tax Consequences. The Employer makes no commitment or guarantee 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 or that any other federal or state tax treatment will apply to or be available to any participant. It shall be the obligation of each participant to determine whether amounts paid to or for the benefit of a participant under this Plan are excludable from their gross income for federal and state income tax purposes and to notify the Employer if the participant has reason to believe that any such payment is not so excludable.

Limitation on Liability. The Employer does not guarantee benefits payable under any Insurance Contract described or referred to in the Plan, and any benefits thereunder shall be the exclusive responsibility of the Insurance Company that is required to provide such benefits under the Insurance Contract. If any participant receives one (1) or more payments or reimbursements under this Plan that are not payments of qualified benefits, such participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security and Medicare taxes from such payments or reimbursements, including, but not limited to, any liability for taxes, penalties, and interest.

Non-Alienation and Assignment. No benefit, right, or interest of any participant, dependent, or beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment, or legal, equitable, or other process or be liable for, or subject to, the debts, liabilities, or other obligations of such person, except as otherwise required by law, for example by the designation of any authorized representative in the claims procedure process.

Notwithstanding the foregoing, the Plan may, in the discretion of the Plan Administrator, make direct payments to providers of covered supplies or services.

In addition, a participant, dependent, or beneficiary under the Plan may not assign their rights to bring a lawsuit under the Plan to any providers or other persons who may provide or render any treatment or services to such person.

Gender and Number. Except as otherwise indicated by context, whenever used in the Plan, a pronoun in any gender will include any/all genders; and terms used in the singular may also include the plural and vice versa.

Mistake of Fact. In the event of any mistake of fact as to an employee's eligibility or participation, or with regard to the payment of benefits, the Plan Administrator shall, in its discretion, cause to be allocated to or adjusted or withheld from future benefits payable to or on the account of the participant, dependent, or beneficiary any such amount the Plan Administrator deems necessary to correct such mistake of fact.

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

Mental or Physical Incompetence. All persons entitled to receive or to claim benefits under this Plan shall be presumed to be mentally and physically competent and of age unless the Plan Administrator is otherwise notified, in writing, of such mental or physical incompetence or that such person is a minor. Any such notice received by the Plan Administrator shall be in written form, in such manner deemed acceptable by the Plan Administrator.

Post-Mortem Payments. In the event of a participant's death, any benefits payable under the Plan to such participant after death shall be paid to their surviving spouse, if any, or otherwise to their estate. If there is any doubt as to the right of a beneficiary to receive such amounts, the Plan Administrator may retain such amounts, without liability for any interest, until the right of the beneficiary is determined.

Inability to Locate Payee. If the Plan Administrator is unable to ascertain the whereabouts or identity of a participant or other person to whom payment is due under the Plan after reasonable efforts have been made to locate such participant or other person, such payment and all subsequent payments, if any, otherwise due the participant or other person shall be forfeited, provided such forfeiture occurs within a reasonable period of time, as determined by the Plan Administrator, following the date such payment first became payable.

Employer's Right to Use Social Security Number for Administration of Benefits. The Employer will require that participants provide Social Security numbers at the time of enrollment so that the Employer can comply with various reporting requirements.

The Employer retains the right to use Social Security numbers for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security numbers for benefit administration purposes, the Employer generally takes the position that ERISA preempts such state laws.

Password and Security
Your account information and the username and password for any Employer/Plan Sponsor or Plan vendor portal are considered personal and confidential.
You have a role in ensuring that your account information remains confidential. To protect the security of your account, it is critical that you establish a unique username and password and protect your insurance member identification cards and communications. Your passwords

should contain at least eight characters and combine letters, numerals, and symbols. Avoid using the same user ID and password for your financial accounts as you do for other sites. Do not share your passwords or member identification numbers or cards with anyone or leave them in places where they can easily be found. You should change your passwords regularly. In addition, when you are logged on to your account, be sure to log out before leaving your computer unattended.

No Vested Rights. To the maximum extent permitted by law, no person shall acquire any right, title, or interest in or to any Employer assets or to any portion of an Insurance Contract otherwise than by the actual payment or distribution of such portion under the provisions of the Plan or acquire any right, title, or interest in or to any benefit referred to or provided for in the Plan otherwise than by actual payment of such benefit.

Compliance with Federal Laws. The Plan is intended to comply with applicable requirements of all applicable federal laws, including (without limitation), the Patient Protection and Affordable Care Act, the Uniformed Services Employment and Re-employment Rights Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Mental Health Parity and Addition Equity Act, the Genetic Information Nondiscrimination Act, the Women's Health and Cancer Rights Act, the Newborns' and Mothers' Health Protection Act, the Health Insurance Portability and Accountability Act ("HIPAA"), the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), and the Consolidated Appropriations Act. Further, the Plan will honor the requirements of a valid Qualified Medical Child Support Order ("QMCSO"). If any of the above-referenced laws do not apply to the Plan, the Plan shall not be required to comply with it.

Not an Employment Contract. None of the Plan or benefits discussed in this document are to be considered contracts for employment between an employee and the Employer. The Plan does not guarantee an employee the right of continued employment nor does it limit the Employer's right to discharge any employee.

Applicable Law and Forum Selection. The Plan and all rights under the Plan shall be governed by and construed according to the laws of Texas, except to the extent preempted by federal law. Furthermore, no civil action (either at law or in equity) shall be commenced by a claimant seeking judicial review of an adverse determination of a claim or an appeal later than one (1) year after the final adverse determination of a claim on appeal. Moreover, no civil action against the Plan shall be filed outside a Texas federal court.

A. Legal Status of Plan

The Plan is intended to constitute an employee welfare benefit plan, as defined under ERISA Section 3(1). The Plan document, the Certificates of Coverage, and the Insurance Contracts shall constitute a single plan under ERISA for purposes of satisfying the reporting requirements of Title I of ERISA.

B. Applicability of Plan

The provisions of this amended and restated Plan shall apply only with respect to covered benefits provided on and after January 1, 2025, and the terms of the applicable prior plans shall apply with respect to covered benefits provided on or before December 31, 2024.

Section 16: HIPAA Privacy of Protected Health Information ("PHI")

The component plans of this Plan that are a "group health plan" shall administer the provisions of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), in accordance with this Section. The component plans of this Plan that are not subject to HIPAA shall not be subject to this Section.

A. HIPAA Privacy Rule

The Plan shall comply with the following provisions in accordance with the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E (the "Privacy Rule") under HIPAA. Capitalized terms used in this Section and not defined in the Plan shall have the meaning set forth in the Privacy Rule.

1) General Rule. The Plan shall use, disclose, store, retain and, if applicable, destroy a person's PHI in accordance with the Privacy Rule. For this purpose, the Plan is deemed a Hybrid Entity under the Privacy Rule, and the provisions of this Section shall be administered and interpreted to apply only to that portion of the Plan that constitutes a Covered Entity under the Privacy Rule.

2) Use or Disclosure for Payment and Health Care Operations. The Plan may use or disclose a person's PHI without the consent or authorization of the person for purposes of Payment, Health Care Operations, and any other purpose for which use or disclosure is permitted or required under the Privacy Rule.

3) Disclosure to Employer as Plan Sponsor. The Plan may not disclose a person's PHI to the Employer and any subsidiaries, except as permitted in this Section. The Plan may disclose a person's PHI to the Employer as provided in subsection (k) below. In addition, the Plan may disclose a person's PHI to the Employer solely in its capacity as Plan Sponsor in order for it to carry out Plan Administration Functions. The Plan may only disclose such information to members of the Employer's workforce (as designated in subsection (4) of this Section) involved in Plan Administration Functions, and only those designated members of the workforce shall have access to such information. The amount of PHI that the Plan discloses to the Employer for such purpose shall not exceed the Minimum Necessary amount of PHI to accomplish the intended purpose of the disclosure. No such disclosure shall occur unless and until the Plan receives a certification from the Employer stating the following provisions of subsections (a) through (k) below:

   a) The Employer shall use or further disclose PHI only as permitted or required by the Plan or as required by law.

   b) The Employer shall require that any agents or subcontractors to whom it provides PHI agree to the same restrictions and conditions that apply to it with respect to such information.

   c) Except as permitted by subsection (k), the Employer shall not use or disclose PHI for employment-related actions or decisions or in connection with other employee benefits or employee benefit plans.

   d) The Employer shall report to the Plan any uses and disclosures of PHI of which it becomes aware that are inconsistent with uses and disclosures provided for under this Section.

   e) The Employer shall provide for adequate separation between the Plan and the Employer, as Plan Sponsor, as required under 45 CFR Section 164.504(f)(2)(iii). The Employer shall limit access to PHI to those members of its workforce (or classes

thereof) entitled to use or disclose such information under this Section and will require that these members of the workforce only may use or disclose such information for Plan Administration Functions. If the persons to whom information is disclosed violate this Section, or applicable law, the Plan shall cease disclosing such information to such persons and shall otherwise resolve any such instances of noncompliance. Those members of the Employer's workforce (or classes thereof) that perform functions on behalf of the Plan and that may have access to PHI are designated in subsection (4) of this Section.

f) The Employer shall make available any information it holds under the certification in order for the Plan to comply with the access requirements under 45 CFR Section 164.524.

g) The Employer shall make available any information it holds under the certification in order for the Plan to comply with the amendment requirements under 45 CFR Section 164.526 and shall incorporate any amendments to PHI it holds, as required in 45 CFR Section 164.526.

h) The Employer agrees to document and provide a description of any disclosures of PHI, and information related to such disclosures, as would be required for the Plan to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

i) The Employer agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services, for purposes of the Secretary determining the Plan's compliance with the Privacy Rule.

j) The Employer shall, if feasible, return or destroy all PHI received from the Plan that the Employer maintains in any form, and retain no copies of such information, when it is no longer needed for the purpose for which the disclosure was made; except that, if such return or destruction is not feasible, the Employer shall limit further uses or disclosures of the information to those purposes that make the return or destruction of the information infeasible.

k) In the absence of the certification, the Plan may disclose to the Employer, as Plan Sponsor, only Summary Health Information and, with respect to a person, enrollment and disenrollment information. In addition and notwithstanding anything herein to the contrary, the Plan may disclose PHI to the Employer in accordance with a person's authorization or as otherwise permitted or required by the Privacy Rule.

4) Access to PHI. The following members of the Employer's workforce (or classes thereof) that perform functions on behalf of the Plan may have access to PHI:

a) Executive Vice President of Global Human Capital
b) Sr. Vice President of Human Capital Operations
c) Associate Vice President of Total Rewards
d) Benefits Department personnel

In addition, support staff assisting the above members of the Plan Sponsor's workforce, including, but not limited to, clerical, mailroom, fax delivery, and information technology staff, may have access to PHI. In addition, members of the Employer's workforce with management, supervisory, or oversight responsibility for such groups, departments, committees, teams, and support staff may have access to PHI.

Other persons or classes of persons may be furnished with access to PHI with respect to Plan Administration Functions that the Plan Sponsor performs for the Plan; provided that

the Plan Sponsor designates such persons or classes of persons in a writing furnished to the Plan.

5) Organized Health Care Arrangement. The Plan (including the coverage options offered under the Plan), and the other fully-insured and self-insured medical options offered or maintained by the Employer, shall be deemed part of an Organized Health Care Arrangement, to the fullest extent permitted under the Privacy Rule.

6) Interpretation. The Plan and this Section shall be interpreted and administered in accordance with the Privacy Rule, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Privacy Rule, statute, regulation, or guidance, such Privacy Rule, statute, regulation, or guidance shall govern.

B. HIPAA Security Rule

This Section is included in the Plan pursuant to the Standards for the Security of Electronic PHI, as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C (the "Security Standards"). The Plan shall comply with the following provisions. Capitalized terms used in this Section and not defined in the Plan shall have the meaning set forth in the Security Standards.

1) Implementation of Security Safeguards. The Employer shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan, consistent with the requirements of the Security Standards.

2) Support of Adequate Separation Requirement by Security Measures. The Employer shall ensure that the adequate separation requirement set forth in 45 CFR Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures, consistent with the requirements of the Security Standards.

3) Agents and Subcontractors. The Employer shall take reasonable steps to ensure that any agent, including a subcontractor, to whom it provides the Electronic PHI agrees to implement reasonable and appropriate security measures to protect such information.

4) Reporting Obligation. The Employer shall report to the Plan any Security Incident of which it becomes aware.

5) Interpretation. The Plan and this Section shall be interpreted and administered in accordance with the Security Standards, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Security Standards, statute, regulation, or guidance, such Security Standards, statute, regulation, or guidance shall govern. The Plan shall adopt written policies and procedures to implement the provisions of this Section.

C. Health Information Technology Act

The Employer shall comply with the breach notification provisions as set forth in the Health Information Technology Act of the American Recovery and Reinvestment Act of 2009.

D. Nondisclosure of Genetic Information for Underwriting Purposes

The Plan shall not use or disclose PHI that is Genetic Information (as set forth in 45 CFR Section 160.103) for underwriting purposes, as defined in 45 CFR Section 164.502(a)(5)(i).

* * * * * * * * *

In Witness Whereof, the Employer has caused this Plan Document, as amended and restated as set forth herein, to be executed by its duly authorized representative effective as of January 1, 2025.

Fisher Asset Management, LLC

By _____

[Title]: _____