MASTERY SCHOOLS GROUP BENEFITS PLAN

Summary Plan Description
(Amended and Restated as of July 1, 2023)

A. INTRODUCTION

This document, with the various Certificate(s) of Coverage referenced herein, which describe the Benefits provided, constitutes a Summary Plan Description ("**SPD**") which summarizes and explains the important provisions of the Mastery Schools Group Benefits Plan (the "**Plan**") as amended and restated as of July 1, 2023. The Plan's purpose is to combine in one plan document provisions of the health and welfare benefit plans (the "Component Benefit Plans") sponsored by Mastery Schools and its affiliated employers, and to provide uniform administration of these health and welfare benefits. The Component Benefit Plans are listed in Appendix A to this SPD.

This Plan also contains a cafeteria plan component that is designed to comply with Section 125 of the Internal Revenue Code. It includes a premium conversion feature that allows you to use salary reductions to pay your share of the cost of participating in the Medical Benefit, Dental Benefit, Vision Benefit, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account. Although they are described in this document, the Dependent Care Flexible Spending Account and the Flexible Benefits Plan components are not subject to the requirements of ERISA.

Mastery Schools (the "**Employer**") is the Plan sponsor.

Complete details of the Plan are found in the official Plan document and the Certificate(s) of Coverage relating to the benefit options offered under the Plan. The Plan document, Certificate(s) of Coverage and any written administrative procedures pertaining to the Plan may be reviewed by Plan Participants and/or their legal representatives during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator.

Important: If there is a conflict of language between this SPD and the Plan Document, the Plan Document will control. Also, if there is a conflict of language between the applicable Certificate(s) of Coverage and either the Plan Document or this SPD, the provisions of the Certificate(s) of Coverage will control unless the Plan Document specifically provides otherwise, or unless otherwise required by law. Copies of the Certificate(s) of Coverage are available to Plan Participants upon request and are available online.

The Plan is not a contract of employment and does not guarantee continued employment. The benefits under the Plan are provided at the sole discretion of the Company. The Company makes no promises to continue Plan benefits in the future, and rights to future benefits will never vest. In addition, the Employer reserves the right, by action of the Employer's Fiduciary, in its sole discretion, to amend, modify or terminate the Plan, in whole or in part, at any time, as necessary to comply with requirements of applicable law.

It is recommended that you read this SPD carefully so you can understand the Plan's operation and the benefits it offers. Capitalized terms used in this SPD will have the same meaning provided in the "Definitions" section of the Plan. If you have any questions after reading this SPD or would like additional information, please contact the Plan Administrator at the address specified in Section B: *Basic Facts*.

B. BASIC FACTS

Plan Name: Mastery Schools Group Benefits Plan

Plan Number: 501

Plan Year: July 1st – June 30th

Plan Sponsor/Employer: Mastery Schools
5700 Wayne Avenue
Philadelphia, PA 19144
(215) 866-9000

Sponsor's Employer Identification Number: 23-3060542

Plan Administrator: Mastery Schools
5700 Wayne Avenue
Philadelphia, PA 19144
(215) 866-9000

Plan Fiduciary: Dr. Joel Boyd, Chief Executive Officer
Mastery Schools
5700 Wayne Avenue
Philadelphia, PA 19144
(215) 866-9000

Service of Legal Process: Mastery Schools
5700 Wayne Avenue
Philadelphia, PA 19144
(215) 866-9000

Plan Type: The Plan is an employee welfare benefit plan established under section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and the Department of Labor Regulations thereunder.

Type of Administration:

This plan has both fully insured benefits (provided by contracts with an Insurance Carrier) and a self-funded component. Benefits are provided under a group insurance contract entered between the Employer and the Insurance Carriers or through an Administrative Processing arrangement with an authorized Administrator. Claims for benefits are sent to the Insurance Carriers. The Insurance

Carriers listed in Appendix A (not the Employer) is responsible for paying benefits. Note that the Employer and the Insurance Carriers share responsibility for administering the plan.

C. OVERVIEW OF PLAN BENEFITS

1. Employer Paid and Employer Subsidized Benefits

(a) The Plan provides Eligible Employees certain "Employer Paid Benefits," the cost of which is fully paid by the Employer. The Employer Paid Benefits include the following:

Dental Benefits
Accidental Death and Dismemberment Benefits
Life Insurance Benefits
Short Term Disability Benefits
Long Term Disability Benefits
Employee Assistance Plan Benefits

(b) The Plan provides Eligible Employees certain "Employer Subsidized Benefits," the cost of which is partially paid by the Employer and the remainder of which is paid for by the Employee. The Employer Subsidized Benefits include the following:

Medical Benefits

2. Optional Benefits

The Plan also provides an Eligible Employee the opportunity to elect certain "Optional Benefits" for himself or herself and his or her Eligible Dependents. The Optional Benefits include the following:

Vision Benefits
Supplemental Accidental Death and Dismemberment Benefits
Supplemental Life Insurance Benefits
Health Care Flexible Spending Account
Dependent Care Flexible Spending Account
Voluntary Benefits

During each open enrollment period prior to the beginning of the Plan Year, you will receive information regarding the required Participant contributions for the Optional Benefits.

3. The Pre-Tax Advantage

If you elect coverage for which your contributions will be paid on a "pre-tax" basis, your gross earnings will be reduced by the amount you are required to pay for the benefits you selected. You will be taxed for federal income tax purposes only on the remaining amount of your gross

earnings and not on the amounts used to pay for these benefits. The pre-tax contributions made for the benefits are not subject to Social Security taxes. Therefore, your Social Security benefits may be reduced if you elect these benefits, rather than taxable compensation. Generally, the reduction is a small one. However, the impact varies from case to case and cannot be predicted by the Employer. In return for this pre-tax advantage, the law provides that your election must be *irrevocable* for the year. You may make mid-year changes only in response to and consistent with certain events as described in Section L. Any amounts not expended for benefits during the year will be forfeited.

Under current federal law, coverage for Domestic Partners is considered a taxable benefit. Therefore, additional contribution made to cover a Domestic Partner must be made on an after-tax basis and taxable income will be assessed each pay period.

D. ELIGIBILITY AND PARTICIPATION

1. Important Definitions

"Hours of Service" means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following: (i) Vacation; (ii) Holiday; (iii) Illness or incapacity; (iv) Layoff; (v) Jury duty; (vi) Military duty or leave of absence.

"Administrative Period" means a two month period after the end of a Measurement Period and before the beginning of the Stability Period during which the Employer shall perform administrative tasks, such as calculating the hours for the Measurement Period, determining eligibility for coverage, providing enrollment materials to Eligible Employees, and conducting open enrollment. .

"Measurement Period" means a 12 month period over which hours are calculated to determine whether a Variable Hour Employee has averaged at least 30 hours per week.

"Initial Measurement Period" means the 12 month period beginning on the first day of the month following the Employee's date of hire.

"Standard Measurement Period" means the 12 Month period that begins each May 1st and ends the following April 30th.

"Stability Period" shall mean the 12 month period that follows, and is associated with, a particular Measurement Period for the following:

(a) For those Variable Hour Employees that worked 30 or more hours per week in an initial Measurement Period, the Employer must offer an opportunity for enrollment in the Medical Benefit.

(b) For those Variable Hour Employees that did not work thirty (30) or more hours per week in a Measurement Period, the Employer does not have a requirement to offer an opportunity for enrollment in the Medical Benefit.

(c) An Employee's full-time or part-time status (determined based on hours credited during the Measurement Period) generally is locked in for the full Stability Period, regardless of the Employee's actual hours during the Stability Period (provided that the Employee continues to be an Employee during the Stability Period).

"Special Unpaid Leave of Absence" means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) Leave protected by the Family and Medical Leave Act, (ii) Parental Leave offered by the Employer, (iii) Other Medical Leave offered by the Employer, (iv) leave protected by the Uniformed Services Employment and Reemployment Rights Act; and (v) Jury Duty (as reasonably defined by the Employer).

2. Eligible Employees

To determine whether you and your dependent are eligible to participate in a component benefit program, please read the eligibility information contained within the attachments for the applicable component benefit programs. A summary of this information is set forth below.

Who Is Eligible	Plan	When Participation Begins
Full-time Employees working 30 or more hours per week	Medical Dental Vision Employee Assistance Plan Health Care Flexible Spending Account Dependent Care Flexible Spending Account Voluntary Benefits ---------- Life Insurance Supplemental Life Insurance Accidental Death and Dismemberment Supplemental Accidental Death and Dismemberment Short Term Disability Long Term Disability	First day of the month following date of hire ---------- 1st day of the month following 90 days of employment
Part-time Employees working less than 30 hours per week.	Vision Voluntary ---------- Supplemental Life Insurance Supplement Accidental Death and Dismemberment	1st day of the month following date of hire ---------- First day of the month following 90 days of employment
Variable Hour Employees working 30 or more per week during Measurement Period	Medical Health Care Flexible Spending Account Dependent Care Flexible Spending Account	First day of the month-following 13 months of employment

Part time Employees working 20 or more hours per week	Voluntary Benefits Health Care Flexible Spending Account Dependent Care Flexible Spending Account	1st day of the month following date of hire

Whether you are entitled to participate in a specific Benefit shall be determined in accordance with the rules and regulations of such Benefit. Any restrictions, limitations, and additional requirements relating to your entitlement to a Benefit that are not set forth in the Plan are described in the Certificate(s) of Coverage for the specific Benefit.

3. Eligible Dependents

In regard to the Medical, Dental, Vision, Supplemental Accidental Death and Dismemberment and Supplemental Life Insurance Benefits, your "Eligible Dependents" are defined as (i) your lawful Spouse determined under Federal law, (ii) your Domestic Partner and (iii) your Domestic Partner's or your child who is 26 years old or younger (in which case coverage will extend to the last day of the month in which such child attains age 26). For purposes of this definition, the term "child" shall mean the Participant's biological child, stepchild, legally adopted child or foster child.

An eligible Domestic Partner is a dependent that is a legally recognized Domestic Partnership of two eligible individuals as provided under applicable state law.

Individuals covered under a Qualified Medical Child Support Order issued against you are also eligible for group health benefits as described under the Order (see Section F.9).

4. Termination of Participation

Generally, your coverage for Benefits under the Plan will end on either your date of termination or the end of the month following your date of termination for any reason including death or, if earlier, when you cease to be an Eligible Employee. Coverage also ceases upon your election subject to the rules in Section L or if you fail to make required contributions.

Coverage you have elected for your Eligible Dependents under any benefit ceases when your coverage ceases or, if earlier, when such individual ceases to be your Eligible Dependent. If you are required to make contributions for certain coverage that you have elected for yourself and your Eligible Dependent(s), then such coverage will cease if you fail to make the required contributions. Further, all health and welfare benefit coverage provided under this Plan will cease on the date the Plan is terminated.

Although coverage may otherwise cease, you may elect COBRA continuation coverage for group health benefits as provided in Section F.1. You may also be able to convert some of the group insurance coverage to personal coverage. Please consult the applicable Certificate(s) of Coverage.

5. Rehires and Leaves of Absence

If you are an Eligible Employee who has terminated employment with the Employer and who is later rehired within a period 26 weeks, you will be offered enrollment into the same Medical Benefit before your termination date but must satisfy the eligibility period described in Section D.2 upon rehire in order to be eligible to participate in all other Employer Paid Benefits, Employer Subsidized Benefits and Optional Benefits. If you are an Eligible Employee who has terminated employment with the Employer and who is later rehired after a period 26 weeks, you must satisfy the eligibility period described in Section D.2 upon rehire in order to be eligible to participate in all other Employer Paid Benefits, Employer Subsidized Benefits and Optional Benefits.

If you are an Employee who is eligible and approved for a FMLA Leave, you will continue to receive all Employer Paid, Employer Subsidized and Optional Benefits during the period of such leave up to a maximum of 26 weeks. You will still be responsible to continue to pay your portion of the premiums within a grace period date provided by the Employer. If payments are not received timely, all Benefits can be terminated. If you choose not to continue benefits while on an approved FMLA Leave, then upon your return to work, you will be reinstated in all Benefits immediately following your return to work. Additionally, if the Leave lasts longer than 26 weeks, you will be permitted to continue coverage under COBRA. Then, upon return to active employment, you will be reinstated immediately.

If you are an Employee who is eligible and approved for a Sabbatical Leave, you will continue to be considered an active Employee but your coverage under all Benefits under the Plan will terminate during the period of such leave up to a maximum of 1 year. You will be permitted to continue Health Benefit coverage under COBRA. Then upon return to active employment, you will be reinstated immediately into the Plan.

If you are an Eligible Employee on a leave of absence for military service, you will be covered for benefits as determined in accordance with USERRA.

E. GROUP HEALTH BENEFITS

1. Medical/Prescription Coverage

The Employer provides a *self-insured* Medical Benefit under a contract between a designated provider (as listed in Appendix A) and the Employer. The coverage provides for medical coverage for Participants and their Eligible Dependents as described in the Certificate(s) of Coverage and insurance contracts between the Employer and the provider. The Eligible Employee may elect from among the coverage options and benefit levels set forth in the Certificate(s) of Coverage that is distributed to Participants. The Medical Benefit is more fully described in the Certificate(s) of Coverage and contracts.

The Employer and the Participant each pay a portion of the premium for the Medical Benefit. You make these contributions on a pre-tax basis under the Flexible Benefits Plan by agreeing to reduce your pay for the Plan Year by the amount of your required contribution. Your pay will be reduced on a pro-rata basis for your contribution.

2. Dental Coverage

The Employer provides a *self-funded* stand-alone Dental Benefit for Eligible Employees and their Eligible Dependents as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and a designated provider (as listed in Appendix A). The Dental Benefit is more fully described in that Certificate(s) of Coverage and contract.

The Employer will pay the entire premium for the Dental Benefit.

3. Vision Coverage

The Employer provides a *fully insured* stand-alone Vision Benefit for Eligible Employees and their Eligible Dependents as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and a designated provider (as listed in Appendix A). The Vision Benefit is more fully described in that Certificate(s) of Coverage and contract.

The Participant is responsible for the entire portion of the premium for the Vision Benefit. You make these contributions on a pre-tax basis under the Flexible Benefits Plan by agreeing to reduce your pay for the Plan Year by the amount of your required contribution. Your pay will be reduced on a pro-rata basis for your contribution.

4. Health Care Flexible Spending Account

You may elect to reduce your compensation on a pre-tax basis and have such amounts credited to a Health Care Flexible Spending Account under the Flexible Benefits Plan. Your contributions are made on a pre-tax basis, so you avoid federal income and Social Security taxes on the amount you set aside. The amount you contribute can then be used to reimburse you for otherwise unreimbursed qualified health care expenses that you, your Spouse (as defined under federal law) and your Dependents (who qualify as dependents under Internal Revenue Code section 106) incur during the Plan Year (July 1st – June 30th) and while you are a participant with respect to such Health Care Flexible Spending Account.

You decide how much to contribute to your account based on how much you expect to spend on qualified health care expenses during the Plan Year up to a maximum amount set each by the IRS. If you don't expect to have any qualified health care expenses in the Plan Year, you may not want to contribute anything because amounts not used for eligible expenses during the Plan Year are forfeited with the exception of a permitted Carry Over. The Plan permits you to Carry Over an amount (up to a maximum of 20% of the annual maximum set by the IRS and disclosure by the Plan Administrator) from the Plan Year to be used to reimburse expenses incurred in the following Plan Year. This amount is in addition to your maximum annual contribution described above. You may use your Health Care Flexible Spending Account to pay health-related expenses for yourself, your Spouse and your Dependents regardless of the insurance coverage you have, whether through the Employer or another source. As long as the expense is not reimbursed through any other source, you may submit the expense for reimbursement. The following are examples of eligible expenses:

- Health care plan deductibles, co-payments, and other out-of-pocket expenses which are not excludable. ("Exclusions" below.)
- Medical expenses which generally are not covered until deductibles are met, such as doctors' office visits and prescription drugs.
- Medical/dental expenses not covered under your health care plan but considered to be health care expenses under section 213(d) of the Internal Revenue Code: e.g., vision exams and prescription eye wear; hearing exams and hearing aids; orthodontia, etc.
- Certain over the counter medicines purchased for medical care such as antacids, allergy medicines, pain relievers, cold medicines, menstrual products and personal protective equipment (PPE).

Exclusions: There are certain expenses which may not be reimbursed by your Account. These include:

- Expenses reimbursed through any other policy or plan, including any health insurance plan for your Spouse or dependent child, Medicare, or any other Federal or state program;
- Expenses specifically prohibited by the IRS, including medical insurance premiums paid by your Spouse at his/her company or by you;
- Expenses incurred before you became eligible to participate;
- Expenses which are incurred in another calendar year;
- Expenses for which you claim a deduction or credit for federal income tax purposes;
- Expenses for cosmetic surgery or similar procedures unless necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury from an accident or trauma, or disfiguring disease; and
- Items that are merely beneficial to your general health, such as dietary supplements and vitamins.

Your pre-elected contributions will be deducted in equal amounts throughout the year from your pay as long as you are eligible to participate. The amounts are then deposited in your Account. No single installment may exceed your gross pay for the pay period. Newly hired employees will normally have contributions deducted in equal installments during the remainder of the year unless otherwise noted.

Information regarding the procedures for reimbursement and the documentation required will be provided to you. Claims for expenses not considered eligible under IRS rules will be disallowed. You will be reimbursed for eligible expenses up to the amount you elected for the year regardless of the amount of your contributions as of such date. If you have any questions regarding the procedures for reimbursement, please contact your Plan Administrator.

In order for an expense to be reimbursable for a particular Plan Year, the expense must be for services that were rendered in that Plan Year. It is important to remember that what determines whether an expense is reimbursable is when you incur the expense and not when you receive the

bill for those services. Claims for eligible expenses incurred during a Plan Year must be submitted within 90 days following the end of such Plan Year.

Once you have made your Health Care Flexible Spending Account election, you may not change the amount of your Health Care Flexible Spending Account contributions until the next Plan Year unless a revocation or change is permitted as provided under Section L.

Any amount remaining in your Health Care Flexible Spending Account after all eligible claims for that Plan Year have been reimbursed (in excess of the Carry Over) will be forfeited. You cannot receive any of your deposits back if you do not use the full amount you have contributed.

Any amount remaining in your Dependent Care Flexible Spending Account after all eligible claims for that Plan Year and applicable Grace Period have been reimbursed will be forfeited. You cannot receive any of your deposits back if you do not use the full amount you have contributed.

For these reasons, it is important to estimate your anticipated expenses carefully before you commit a portion of your pay to the Plan.

If you terminate employment with the Employer for any reason, your Health Care Flexible Spending Account can only be used to pay expenses incurred prior to your termination unless you have a right to, and elect, continuation coverage. All claims, however, must be submitted by the end of the Plan year following your termination date.

If you die, your surviving Spouse or Dependents may continue to use any balance in your Health Care Flexible Spending Account to obtain reimbursements for covered expenses that were incurred prior to your death. These claims must be submitted by the end of the Plan Year following your date of death.

If coverage under the Health Care Flexible Spending Account would cease, you, your Spouse and/or dependents may also have a right to elect continuation coverage. See "Your Rights under COBRA" in Section F.1.

F. LEGAL RIGHTS WITH RESPECT TO GROUP HEALTH BENEFITS

1. Your Rights under COBRA

You have a right to choose continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") for yourself and your covered Spouse, Domestic Partner and dependent children if you lose group health plan coverage (medical, dental, vision and health care flexible spending account) under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). (A child who is born to, or placed for adoption with, a Participant during a period of COBRA coverage is also considered a covered dependent child.)

If you are the Spouse or Domestic Partner of a Participant you have the right to choose COBRA continuation coverage for yourself and your covered dependent children if you lose group health plan coverage under the Plan for any of the following four reasons, known as "qualifying events":

- The death of the Participant;
- A termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- Divorce or legal separation from your Spouse or dissolution of a Domestic Partnership; or
- Entitlement of the Participant to Medicare.

A covered "dependent child" of a Participant has the right to continue coverage under COBRA if Health Coverage under the Plan ends because of any of the following five qualifying events:

- Death of the Participant;
- Termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment with the Employer;
- Divorce or legal separation of the Participant and Spouse, or dissolution of a Domestic Partnership; or
- Entitlement of the Participant to benefits under Medicare; or
- Ineligibility for coverage as a dependent child under this Plan.

You or a family member or legal representative must inform the Human Resources Department within 60 days of the date of a divorce, legal separation, or loss of dependent child status under this Plan. If the Human Resources Department is not notified within 60 days, you will lose the right to continue coverage. **You must provide notice in writing to the Mastery Schools Human Resources Department.** The notice must state the nature of the event, the date of the event, the covered individuals who are affected, and the identity of the person providing the notice and his or her relationship to the affected individual(s). The Plan Administrator may require copies of documents evidencing the event, such as the court order evidencing divorce or legal separation.

When the Human Resources Department is notified on a timely basis that a qualifying event has occurred, you will be notified that you have the right to choose COBRA continuation coverage. You have 60 days from the later of the date you are notified about COBRA or the date of loss of your coverage to inform the Human Resources Department that you want to continue your coverage by completing and submitting the required forms. If you do not choose COBRA continuation coverage, your group health coverage under this Plan will END.

Generally, if you choose to continue your coverage, you may be charged up to 102% of the full cost to the Plan for your coverage. You will be required to pay your first premium payment within 45 days from the date you choose to continue your coverage. If you lose health coverage under the Plan due to a reduction in the hours of the Participant's employment or the termination of the Participant's employment, you may continue your coverage for 18 months. However, the 18-month coverage period for covered Spouses and dependent children may be extended to 36 months if another event (death, divorce or legal separation, Medicare entitlement, or ineligibility for Dependent coverage) occurs during the initial 18-month period. For all other qualifying events, you may continue your coverage for 36 months. You or a family member or legal representative must inform the Human Resources Department in writing if you believe that you, your covered Spouse or covered dependent children are entitled to extend the period of continuation coverage. The notice must meet the requirements set forth above.

If you are eligible for 18 months of COBRA continuation coverage, coverage may be extended for up to an additional 11 months if you (or a covered Spouse or child is) are determined to be disabled under the rules for Social Security benefits within 60 days of the date of your termination of employment or reduction in hours of employment. You may be charged up to 150% of the cost of the coverage for the 19th through the 29th month of coverage. To extend coverage, you must notify the Human Resources Department in writing at the mailing address or email address set forth above of a determination of disability within 60 days after the later of the date the determination is made, or the date coverage would be lost as a result of the qualifying event and before the end of the first 18 months of COBRA coverage. The notice must state the identity of the covered individual determined to be disabled, the date the disability was determined to have commenced, and the identity of the person providing the notice and his or her relationship to the disabled individual. The notice must be accompanied by a copy of the Social Security disability determination.

Your COBRA continuation coverage may end earlier for any of the following reasons:

- The Employer no longer provides group health benefits coverage to any of its Employees;
- The premium for your continuation coverage is not timely paid;
- You become covered under another group health plan that does not contain any exclusion or limitation with respect to a pre-existing condition that you have and that would apply to deny you coverage;
- You become entitled to Medicare; or
- Coverage is extended for up to 29 months due to a disability and there has been a final determination that the disabled individual is no longer disabled. You must notify the Human Resources Department within 30 days of the date of any final determination that disability has ended.

2. Your Rights under WHCRA

The Plan, as required by the Women's Health Cancer Rights Act of 1998 ("WHCRA"), provides the following benefits for a Plan Participant or beneficiary who is receiving health care benefits in connection with a mastectomy:

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

Coverage for these benefits or services will be provided in consultation with the Participant's or beneficiary's attending physician.

Coverage for the mastectomy-related services or benefits required under the WHCRA are subject to the same deductibles and coinsurance or co-payment provisions that apply with respect to other medical or surgical benefits provided by your health care medical contract. Contact the Plan Administrator for more information.

3. Your Rights under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights relating to group health benefits. These provisions apply to your medical/prescription, dental and vision coverage and, with respect to the privacy rules, also your medical and health care reimbursement benefits (referred to jointly as "medical coverage" below).

a. Special Enrollment Rights. HIPAA amended the Code, ERISA, and the Public Health Service Act to provide special enrollment rights to certain individuals who earlier declined group health coverage and later wish to elect enrollment for themselves, one or more Eligible Dependents, or both themselves and their Dependents. Group health plans and any insurer offering group health coverage must provide special enrollment periods to certain individuals eligible for group health coverage.

An Employee who is eligible, but not enrolled for medical coverage, under the terms of the Plan (or his or her Dependent if the Dependent is eligible but not enrolled for coverage) is permitted to enroll for medical coverage under the Plan if:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time the Plan's medical benefits were previously offered to the Employee or individual;
- The Employee stated in writing at the time he or she declined coverage that the reason for declining medical coverage under the Plan during enrollment

was due to coverage under another group health plan or health insurance coverage;

- The coverage of the Employee or Dependent who has lost the coverage was (i) under COBRA continuation coverage and the COBRA coverage was exhausted, or (ii) was not covered under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated; and

- The Employee requests enrollment within 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contribution (as described in (ii) above).

In addition to the circumstances above, HIPAA permits an eligible employee who declined to enroll in medical coverage under the Plan during open enrollment the opportunity to enroll in medical coverage if the employee requests enrollment due to certain circumstances under the Children Health Insurance Program (CHIP). See Section F.4 below.

b. Nondiscrimination Based on Health Factor. The Plan generally may not establish any rule for eligibility to enroll in the plan (including continued eligibility) that discriminates against an Employee or Dependent because of a Health Factor or charge higher premiums on account of a Health Factor. Health Factors include, with respect to an individual: (i) health status; (ii) medical condition (including both physical and mental illnesses); (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information; (vii) evidence of insurability (includes conditions arising out of acts of domestic violence and activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities); and (viii) disability.

c. Privacy Rules. HIPAA requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the privacy notice, which was last distributed to you upon enrollment. You can obtain a copy of the privacy notice from the Human Resources Department. Notices for the insured benefits are also available from the insurers.

This Plan, and the Employer, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions, or in connection with any other benefit or Employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain

disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact the Privacy Official within the Human Resources Department.

4. Your Rights under CHIP

You and your Dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the Plan Year under two circumstances:

- You or your Dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

5. Your Rights under the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA")

Group health plans and health insurance issuers 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 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 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

6. Your Rights Under Michelle's Law

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the Plan. Coverage will be continued until: (1) one year from the start of the medically necessary leave of absence, or (2) date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

7. Your Rights Under the Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the ERISA, the Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

8. Your Rights Under the Genetic Information Non-Discrimination Act ("GINA")

GINA broadly prohibits covered employers from discriminating against an Employee, individual, or member because of the Employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual. GINA also prohibits employers from requesting, requiring, or purchasing an Employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record and may be disclosed to third parties only in very limited situations.

9. Qualified Medical Child Support Orders ("QMCSOs")

The Plan is required to provide health benefits in accordance with the applicable provisions of any "qualified medical child support order" ("QMCSO") as required under ERISA. In general, the term qualified medical child support order means a "medical child support order" which requires the Plan to provide a child of a Participant with health coverage under the Plan where the child would not otherwise be covered; for example, if the child would lose coverage as a result of a parent's divorce. A medical child support order is a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction. It also includes a National Medical Support Notice that meets the requirements of the regulations of the Department of Labor set forth at 29 CFR § 2590.609-2. Under a QMCSO, the Plan can be ordered to enroll the child in any available health care expense coverage option and deduct the applicable cost from the Participant's wages. Accordingly, the Plan Administrator has the right to make any necessary changes to the Participant's medical coverage elections in order to provide the child(ren) with the coverage required by the QMCSO, and to authorize on the Participant's behalf the payment of any additional premium costs from the Participant's wages. The Plan Administrator has established procedures for qualifying medical support orders. Participants and beneficiaries may obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

10. Special Rules Regarding Military Leaves

An Employee on leave will be entitled to coverage no less favorable than as required under the Uniformed Services Employment and Reemployment Right Act ("USERRA") provided, however, that coverage pursuant to the terms of USERRA and COBRA coverage will run concurrently.

G. DISABILITY

1. Short Term Disability Insurance

The Employer provides *fully insured* short term disability coverage for Eligible Employees. The Short Term Disability Benefit provides short term disability insurance to eligible Participants through a designated provider (as listed in Appendix A), as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and the provider. The Short Term Disability Benefit is more fully described in that Certificate(s) of Coverage and contract. The Employer pays your entire cost of the coverage.

While receiving Short Term Disability Benefits, Employees may be eligible to continue Benefits, as pursuant to your Rights under FMLA.

2. Long Term Disability Insurance

The Employer provides *fully insured* long term disability coverage for Eligible Employees. The Long Term Disability Benefit provides long term disability insurance to eligible Participants through a designated provider (as listed in Appendix A), as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and the provider. The Long Term Disability Benefit is more fully described in that Certificate(s) of Coverage and contract. The Employer pays your entire cost of the coverage.

While receiving Long Term Disability Benefits, Employees may be eligible to continue Benefits, as pursuant to your Rights under COBRA (See, "Your Rights under COBRA" in Section F.1 above).

H. LIFE INSURANCE COVERAGE

1. Employer Provided Insurance

You will be covered under a *fully insured* group term life insurance policy if you are Eligible Employee. The Life Insurance Benefit provides life insurance (in an amount that varies depending on your status with the Employer) for you through a designated provider (as listed in Appendix A), as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and the provider. The Life Insurance Benefit is more fully described in that Certificate(s) of Coverage and contract. The Employer pays your entire cost of the coverage.

2. Supplemental Life Insurance

You will be offered enrollment in a *fully insured* supplemental life insurance policy if you are Eligible Employee. The Supplemental Life Insurance Benefit provides life insurance for you, in addition to the Life Insurance Benefit provided by the Employer. Additionally, you may elect coverage for your Eligible Dependents. This benefit is provided for you through a designated provider (as listed in Appendix A), as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and the provider. The Life Insurance Benefit is more fully described in that Certificate(s) of Coverage and contract. The Participant is responsible for the entire cost of the coverage.

3. Accidental Death and Dismemberment

You will be covered under a *fully insured* group accidental death and dismemberment insurance policy if you are an Eligible Employee. The Accidental Death and Dismemberment Benefit provides you with accidental death and dismemberment insurance through a designated provider (as listed in Appendix A), as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and the provider. The Accidental Death and Dismemberment Benefit is more fully described in that Certificate(s) of Coverage and contract. The Employer pays your entire cost of the coverage.

4. Supplemental Accidental Death and Dismemberment

You will be offered enrollment in a *fully insured* supplemental accidental death and dismemberment insurance policy if you are Eligible Employee. The Supplemental Accidental Death and Dismemberment Benefit provides accidental death and dismemberment insurance for you, in addition to the Accidental Death and Dismemberment Benefit provided by the Employer. Additionally, you may elect coverage for your Eligible Dependents. This benefit is provided for you through a designated provider (as listed in Appendix A), as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and the provider. The Life Insurance Benefit is more fully described in that Certificate(s) of Coverage and contract. The Participant is responsible for the entire cost of the coverage.

I. EMPLOYEE ASSISTANCE PLAN

You will be covered under a *fully insured* Employee Assistance Plan with your enrollment in the Life Insurance Benefit. The Employer pays your entire cost of the coverage. The Employee Assistance Plan provides counseling and referral services for you through a designated provider (as listed in Appendix A), as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and the provider. The Employee Assistance Plan is more fully described in that Certificate(s) of Coverage and contract.

J. VOLUNTARY BENEFITS

You will be offered the opportunity to enroll in a *fully insured* voluntary Accidental Injury or Hospital Plan if you are Eligible Employee. This benefit is provided for you through a designated provider (as listed in Appendix A), as described in the Certificate(s) of Coverage and in the insurance contract between the Employer and the provider. The Life Insurance Benefit is more fully described in that Certificate(s) of Coverage and contract. The Participant is responsible for the entire cost of the coverage and make these premium on a post-tax basis.

K. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

You may use your Dependent Care Flexible Spending Account to pay dependent care expenses for children under age 13, or certain other Dependents, incurred so that you can work, provided you can claim a deduction for these individuals on your federal income tax return. The Plan can be used to cover expenses for babysitters and eligible day care centers (to be eligible, a day care center must meet all applicable state and local regulations, provide care for more than six non-resident people, and receive a fee for such services, whether or not for profit).

Dependent care expenses are covered only if (i) the Dependent (your child, grandchild, sibling or stepsibling or their descendant) lives with you (for more than one-half of the year), is under age 13 and provides less than one-half of his or her support; or (ii) the individual is your Spouse who is physically or mentally incapable of self-care and lives with you (for more than one-half of the year); or (iii) the Dependent, regardless of age, is physically or mentally incapable of self-care, lives with you (for more than one-half of the year) and has gross income less than the exemption amount and you provide over one-half of his or her support. If services are provided outside your home, an incapacitated Spouse or Dependent that is age 13 or over must regularly spend at least eight hours a day in your household.

Your deposits for dependent care expenses are limited to a maximum of $5,000 a year (or $2,500, if you are married and you file a separate Federal income tax return). Reimbursement for dependent care is limited to employment-related expenses as defined by the Internal Revenue Code which are excludable from your income. The following limitations for Dependent Care Flexible Spending accounts apply:

(1) Both you and your Spouse (unless your Spouse is a full-time student or is disabled) must work in order for dependent care expenses to be excludable from your income for Federal income tax purposes.

(2) Dependent care expenses are not excludable to the extent they exceed the lesser of:

- Your earned income; or
- The earned income of your Spouse.

For example, if you earn more than your Spouse and your Spouse earns $3,000 per year working part-time, $3,000 is the maximum you can exclude for dependent care costs (assuming you have allocated at least that amount to your Account).

If your Spouse is either a full-time student or disabled, even if he or she does not earn income, you may exclude up to $200 a month if dependent care expenses apply to one Dependent or $400 a month if the expenses apply to two or more Dependents. However, months during which a student-Spouse is not attending classes may not be counted.

(3) Your Dependent Care Account may not be used to exclude payments to anyone who can be claimed as a Dependent on your or your Spouse's tax return, or to your own child or stepchild under age 19. For example, you cannot exclude payments you make to your 17-year-old daughter for babysitting your three-year-old son.

(4) There are certain other expenses which may not be reimbursed. These include:

- Expenses reimbursed through any other policy or plan;
- Expenses incurred before you became eligible to participate;
- Expenses which are incurred in another Plan Year;
- Expenses for which you claim a deduction or credit for federal income tax purposes; and
- Expenses that the IRS would not permit to be claimed as a deduction or credit for federal income tax purposes.

Note: For many people, making contributions to their Dependent Care Flexible Spending Account will be more tax-effective to cover dependent care expenses than taking a dependent care tax credit. Others may find that it is more tax-effective to take a dependent care tax credit on their Federal income tax return at the end of the year. Employees who use the Dependent Care Flexible Spending Account (or who take a tax credit) will be required to provide the name and taxpayer ID number of each provider on their tax return. For specific advice about your personal situation, you should consult your own tax advisor.

Your pre-elected contributions will be deducted in equal amounts throughout the year from your pay as long as you are eligible to participate. The amounts are then deposited in your Account. No single installment may exceed your gross pay for the pay period. Newly hired Employees will normally have contributions deducted in equal installments during the remainder of the year unless otherwise noted.

Information regarding the procedures for reimbursement and the documentation required will be provided to you. Claims for expenses not considered eligible under IRS rules will be disallowed. You will be reimbursed up to the balance in your Account and any excess amount will be carried over to the next reimbursement period.

The amount you elect for a Plan Year is used to reimburse expenses incurred in that Plan Year (July 1st – June 30th) and applicable Grace Period (September 15th) and while you are a

Participant with respect to the Dependent Care Flexible Spending Account. A Participant who has a balance in his or her Account at the end of the Plan Year and applicable Grace Period may continue to receive reimbursement for eligible expenses incurred by the end of the Plan Year and Grace Period. Any amounts not used to reimburse eligible expenses incurred before the end of the Plan Year are forfeited.

In order for an expense to be reimbursable for a particular Plan Year, the expense must be for services that were rendered in that Plan Year or applicable Grace Period. It is important to remember that what determines whether an expense is reimbursable is when you incur the expense and not when you receive the bill for those services. Claims for eligible expenses incurred during a Plan Year and Grace Period must be submitted within 90 days following the end of the Plan Year.

Any amount remaining in your Account after all eligible claims for that Plan Year have been reimbursed will be forfeited. You cannot receive any of your deposits back if you do not use the full amount you have contributed, and you cannot carry unused amounts forward into another Plan Year. For these reasons, it is important to estimate your anticipated expenses carefully before you commit a portion of your pay to the Plan.

L. PRE-TAX ELECTIONS

1. Mid-Year Changes to Elections

As provided above, you may elect to reduce your compensation on a pre-tax basis to pay your required contributions for elected benefits through the cafeteria plan. The cafeteria plan includes a premium conversion feature that allows you to use salary reductions to pay your share of the cost of participating in the medical, dental and vision coverage for yourself and your Eligible Dependents, and for elected amounts to be allocated to your Health Care Flexible Spending Account/Dependent Care Flexible Spending Account. In return for the pre-tax advantage, your election is generally binding for the year. You may change your election during the year only if you meet the circumstances set forth below. You are permitted to make election changes under the following circumstances provided you notify the Plan Administrator within 30 days of the event and timely submit your election change form.

a. Change in Status. The events that constitute a "change in status" include the following:

- Events that change your legal marital status, including marriage, death of Spouse, divorce, legal separation, and annulment.

- Events that change your number of Dependents, including birth, death, adoption, and placement for adoption. (Note: Gaining or losing a Dependent who is not a tax Dependent such as a parent will not be considered an allowable event for an election change.)

- Events that change your employment status, or the employment status of your Spouse or Dependents, that affect your eligibility for benefits, including a termination or commencement of employment, reduction or increase in hours, a strike or lockout, a commencement of, or return from, an unpaid leave of absence or a change in work site.

- You have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will be reasonably expected to average less than 30 hour of service per week after the change, (even if that reduction does not result in you being ineligible for the group health plan) and your termination from the medical benefit corresponds with intended enrollment for you and your dependents in another plan that provides minimum essential coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

- Events that cause your Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstances.

- A change in your place of residence, the place of residence of your Spouse or Dependent that affect eligibility for benefits under the plan.

<u>*General Consistency Rules*</u>: You may only make an election change pursuant to a change in status if your requested election change is consistent with that change in status. The Plan Administrator has sole discretion to determine whether a requested change is consistent with the change in status. Your election change will be consistent with the change in status <u>only</u> if the change is on account of and corresponds with a change in status *that affects eligibility for coverage under the Plan*. A change in status that affects eligibility under the Plan includes a change in status that results in an increase or decrease in the number of an Employee's family members or Dependents who may benefit from coverage under the Plan. *Please note, it is possible to experience a "change in status" event, but not have the change affect your eligibility to participate in the Plan's benefits or change benefit elections. In such case, you will not be able to make a change in your elections.*

<u>*Exception for COBRA Qualifying Events:*</u> If you, your Spouse or Dependent become eligible for continuation coverage under the Plan due to a COBRA qualifying event, you may elect to increase your contributions in order to pay for the continuation of coverage.

b. Judgment, Decree or Order. If there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a Qualified Medical Child Support Order, *see* <u>Section F.9</u>, that requires a change in accident or health coverage

for your child or foster child who qualifies as your Dependent, you or the Plan Administrator may make an election change to add or drop coverage consistent with the terms and scope of the order.

c. Entitlement to Medicare or Medicaid. If you or your Spouse or Dependent becomes entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines), you may make a corresponding prospective election change to cancel or reduce coverage under the Plan. Similarly, if you or your Spouse or Dependent loses eligibility for Medicare or Medicaid, you may make a corresponding prospective election change to commence or increase coverage under the Plan.

d. Significant Cost or Coverage Changes. This applies to benefits other than the Health Care Flexible Spending Account.

- *Automatic Changes:* If there is an increase or decrease in the cost of a benefit, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective change to your premium election, to cover the change in cost.

- *Significant Cost Changes:* If the cost charged to Employees significantly increases or decreases during the Plan Year, as determined by the Plan Administrator, you may be allowed to make a new election for the option with the decreased cost or with respect to the higher cost option to revoke your election, but you must elect similar coverage if available under the Plan. If there is an increase in the cost of Dependent care coverage, a change is permitted only if the dependent care provider is not a relative of the Employee.

- *Significant Curtailment without Loss of Coverage*: If coverage for you, your Spouse or Dependent is significantly curtailed under a benefit option during the Plan Year (without a total loss of coverage), you may revoke your election and make a new prospective election for similar coverage that is offered under the Plan. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided under the benefit option that constitutes reduced coverage generally. Thus, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

- *Significant Curtailment with Loss of Coverage*: If your coverage under a medical care provider ceases or is significantly curtailed during a Plan Year, you may revoke your election of that option and elect a new option prospectively which provides similar coverage (or, if there is no similar option, you may drop the coverage).

- *Addition or Improvement of a Benefit Option*: If the Plan adds a new benefit type, or a new option under an existing benefit during the Plan Year, or if coverage under an existing benefit or option is significantly improved

during the Plan Year, then: (i) Eligible Employees who are not Participants may prospectively elect the new benefit; and (ii) current Participants may revoke their existing elections of similar benefits and prospectively elect the new benefit or option.

- *Change in Coverage under Another Employer Plan*: You may make a prospective election change that is on account of, and corresponds to, a change made under another employer plan if such other plan is a cafeteria plan that permits election changes or has a Plan Year that is different from that of the Plan.

- *Loss of Coverage under Other Group Health Insurance*: You may make a prospective election change to add coverage for a Spouse or Dependent if you or your Spouse or Dependent loses coverage under a group health plan sponsored by a governmental or educational institution.

e. Special Family Medical Leave Act Requirements. An Employee who takes leave under the Family Medical Leave Act of 1993 (FMLA) may either continue participation or revoke his election of any benefit. See Section L.3 below for more details.

f. HIPAA Special Enrollment Rights. If you gain the right to enroll in medical coverage or to add coverage for a family member under the special enrollment rights of HIPAA, see Section F.3, you may revoke an election for medical coverage during the Plan Year and make a new election.

g. Family Member Exchange Enrollment. If one or more of your family members enroll in a qualified health plan (QHP) through an Exchange during an Exchange special or open enrollment period, you may revoke prospectively an election of family coverage under a group health plan. This cancellation of coverage under the group health plan must correspond to the intended enrollment of the related individual or individuals in a QHP through an Exchange. This coverage must be effective beginning no later than the day immediately following the last day of the original group health plan coverage that was revoked.

h. Enrollment in a Qualified Health Plan. You may revoke your medical coverage IF:

You are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace, or you wish to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

You intend to enroll in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

2. New Hire Election and Annual Open Election Period

New Hire Election. If you are an Eligible Employee, you will be automatically covered under any Employer Paid Benefits. You will be provided access to an online enrollment system as soon as administratively feasible after you are hired. You must complete the online enrollment before the end of your Individual Election Period in order to elect Employer Subsidized Benefits and Optional Benefits for the remainder of the current Plan Year.

Annual Open Election Period. You may change your elections during the open election period prior to the beginning of each Plan Year. If you make no election, your coverage under the Plan will continue as previously elected with the exception of the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account where an election is required.

3. Special Rules Regarding FMLA Leaves

You are required to pay for benefits continued during an unpaid FMLA leave on a "pay-as-you-go" basis or provided the Plan Administrator so permits by advance withholding or catch-up payments upon return. Payments made during an unpaid FMLA leave on a "pay-as-you-go" basis must be made on the same schedule and in the same manner as payments would be made if you were not on FMLA leave but will be made on a post-tax basis.

If you revoke your elections for medical, dental and vision coverage during FMLA leave and then return to work in the same Plan Year as an Eligible Employee, you may reinstate your election(s) which were in effect immediately before the FMLA leave with respect to these benefits.

M. CLAIMS AND APPEALS UNDER THE PLAN

1. Overview

Except as provided below, claims for benefits under each Plan that is either insured or self-funded will be reviewed in accordance with procedures contained in the policies, contracts, summary plan descriptions or other written materials for such Plan benefits. All other general claims or requests should be directed to the Claims Administrator. If a claim under the Plan is denied in whole or in part, the Claims Administrator will notify you or your beneficiary in writing of such denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific

reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. The decisions of the Claims Administrator are final, conclusive and binding.

2. Claims Procedure for Benefits Based on Determination of Disability

The following claims procedure shall apply specifically to claims made under the Plan for benefits based on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for such plans, the claims procedure in the other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulations.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification regarding the claim denial. This claim denial will include the reasons for the denial, reference to the Plan provision supporting the denial, and a description of the Plan's appeals procedures. The discussion of the claim denial will also include:

- If applicable, an explanation for disagreeing with or not following the views of health care professionals or vocational experts, or with a disability benefit determination made by the Social Security Administration;

- The internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim (or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist); and

- 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 for benefits; and, if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances (or a statement that such explanation will be provided free of charge upon request).

You will receive a benefit denial notice within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information,

if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

You have 180 days to appeal an adverse benefit determination. Upon request and free of charge you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. You will be notified of the Claims Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request.

The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

3. Claims for Group Health Plans

The following claims procedures shall apply specifically to claims made under any group health plan under this Plan. To the extent that these procedures are inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for the group health plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials shall supersede these procedures as long as such other claims procedures comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, as applicable to the Plan.

a. Benefit Determinations

(i) *Post-Service Claims*

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the group health plan on which the denial is based, and provide the claim appeal procedures.

(ii) ***Pre-Service Claims***

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

(iii) ***Urgent Care Claims***

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.

- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

- If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or

- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

(iv) *Concurrent Care Claims*

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

(v) *Claim Denial Notices*

If your claim for benefits is denied in whole or in part, you or your beneficiary will receive notification regarding the claim denial within the applicable time period described above. This denial notice will include the reasons for the denial, reference to the Plan provision supporting the denial, a description of the Plan's appeals procedures and other relevant information regarding the claim decision.

(vi) *How to Appeal a Claim Decision*

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider's name.
- The reason(s) you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

(vii) ***Appeal Process***

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

4. Appeals Determinations

a. *Pre-Service and Post-Service Claim Appeals*

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

b. *Urgent Care Claim Appeals*

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.

- The Claims Administrator will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

c. ***External Review***

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

5. Prohibition on Assignment.

Your rights under the Plan to be covered by the Plan's benefits, and to receive benefits and benefit payments under the Plan, is personal to you, and is not assignable in whole or in part to any person, hospital, provider or other entity; nor may the benefit of any such coverage be transferred, either before or after services covered under such benefit are rendered to you. Any direct payments made under one of the Plan's health benefits to either an in-network or out-of-network provider shall not constitute a waiver of these terms that prohibit assignment of coverage and rights under such benefit, and any direction to pay any person, hospital, provider or entity shall not be treated as or constitute an assignment of any right under the particular Plan health benefit, or of any legal or equitable right to institute any court proceedings.

6. Statute of Limitation and Venue for Plan Claims.

Please note that no legal action may be commenced or maintained to recover benefits under component benefits of the Plan more than 24 months after the final review/appeal decision by the Plan Administrator or claim administrator (as defined under the Certificate(s) of Coverage has been rendered (or deemed rendered). <u>All legal action commenced under the Plan must be brought in the federal court of proper jurisdiction in the Commonwealth of Pennsylvania</u>.

N. LOSS OF BENEFITS

Except as otherwise provided herein, you will lose coverage either upon your termination of employment, or the end of the month following your termination. Your benefit coverage will also cease if you cease to be an Eligible Employee. Coverage will also be lost if you fail to pay any required contribution and you will lose amounts credited to your Health Care Flexible Spending Account/Dependent Care Flexible Spending Accounts if not used to pay qualifying expenses incurred during the Plan Year. As stated in the "Introduction," the Employer has reserved

the right to amend or terminate the Plan and thus you will lose the right to future benefits if a benefit is eliminated or reduced, or the Plan is terminated.

O. YOUR ERISA RIGHTS

Plan Participants, Eligible Employees, and all other Employees of the Employer are entitled to certain rights and protections under ERISA and the Code which apply generally to Participants in Employee benefit plans. These laws provide that Participants, Eligible Employees, and all other Employees are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents 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.

Obtain copies of all Plan 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 upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health 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 documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people, called "fiduciaries," who are responsible for the operation of Employee benefit plans. They have

a duty to operate the Plan prudently and in the interest of Plan Participants and beneficiaries. No one, including your Employer or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered, and receive, free of charge, copies of the documents relating to the decision, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, you may file suit in a federal court if you request materials from the Plan in writing and do not receive them within thirty (30) days. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them (unless the materials were not sent because of reasons beyond the Plan Administrator's control). If your claim for benefits is denied, in whole or in part, or ignored, you may file suit in a state or federal court (after you exhaust the claims and appeals procedures in Section M). If Plan fiduciaries misuse the Plan's money, or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court. If you are successful, the court may order the person you have sued to pay court costs and legal fees. If you lose, the court may order you to pay; for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hot line of the Employee Benefits Security Administration.

P. FUNCTION OF THE PLAN ADMINISTRATOR

The Plan Administrator (or its designees) shall have the authority to interpret the Plan, decide all questions of eligibility of persons to participate in the Plan, make findings of fact, correct any defect, and construe any uncertain or disputed term or provision in the Plan and this SPD, unless this function is the responsibility of an insurance company. The determinations made in the exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, you, your estate, your beneficiaries, and the Employer. To the extent an insurer or other provider or a contract administrator exercises discretionary authority or discretionary responsibility over claims for benefits, it shall have the authority and discretion to construe any

uncertain or disputed term or provision in its contracts, booklets, and certificates, or to determine the amount to be paid pursuant to a claim for benefits.

Additionally, the Plan Administrator has the authority and responsibility to (i) adopt such regulations, rules, procedures, and forms consistent with the Plan that are deemed necessary or desirable for the administration of the Plan; and (ii) employ individuals and firms to provide legal and actuarial advice and counsel, as necessary, to assure that the provisions of the Plan are properly interpreted and administered.

Q. SUBROGATION

As a condition of receiving medical, dental, vision, disability or any other benefits under the Plan, all covered persons, including all covered dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person, organization or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to the "make whole" doctrine, the "common fund" doctrine or other similar common-law subrogation rules or legal theories.

APPENDIX A
COMPONENT BENEFIT PLANS
CERTIFICATE(S) OF COVERAGE AND ADMINISTRATIVE SERVICE CONTRACTS

Medical Benefit	Self-funded	Aetna P.O. Box 981106 El Paso, TX 79998-1106 800-962-6842
Prescription Drugs	Self-funded	PrudentRX Aetna Inc P.O. Box 981106 El Paso, TX 79998-1106 800-962-6842
Dental Benefit	Self-funded	Guardian P.O. Box 2459 Spokane, WA 99210-2459 800-541-7846
Vision Benefit	Fully Insured	VSP Vision Plan P.O. Box 385018 Birmingham, AL 35238 800-877-7195
Accidental Death and Dismemberment Benefit **Supplemental Accidental Death and Dismemberment Benefit** **Life Insurance Benefit** **Supplemental Life Insurance Benefit** **Short Term Disability Benefit** **Long Term Disability Benefit** **Employee Assistance Plan**	Fully Insured	Reliance Standard Life Insurance Company Life/Accidental Death and Dismemberment P.O. Box 7307 Philadelphia, PA 19101-7307 800-351-7500 Disability www.matrixabsence.com 877-202-0055 Employee Assistance Plan http://rsli.acieap.com/code RSLI859 855-775-4357
Employee Assistance Plan	Fully Insured	Talk Space partners-support@talkspace.com
Health Care Flexible Spending Account **Dependent Care Flexible Spending Account**	Employee Funds	Benefit Resource, Inc. 245 Kenneth Drive Rochester, NY 14623-4277 800-473-9595
Voluntary Benefits	Fully Insured	Reliance Standard P.O. Box 7307 Philadelphia, PA 19101-7307 800-351-7500

Telemedicine	Fully Insured	Teladoc PA 4100 Spring Valley, Suite 515 Dallas, TX 75244 800-835-2362