MCLEOD HEALTH
FLEXIBLE BENEFITS PLAN,

SUMMARY PLAN DESCRIPTION,

AND IMPORTANT PLAN NOTICES

Amended and Restated
Effective January 1, 2021

This booklet, which incorporates by reference the applicable insurance policies, certificates of coverage, component plan benefit booklets, and benefit website serves as both the official plan document and the Summary Plan Description (SPD) for McLeod Health Flexible Benefits Plan (Plan).

McLeod Health (Employer) reserves the right to amend, suspend or terminate the Plan or any of the benefits thereunder at any time and for any reason. If any such amendment, modification, or termination results in a material reduction of benefits, the Employer will notify you and/or your beneficiary(ies) of the adoption of the amendment, modification, or termination.

Only the Employer, the Plan Administrator or the designated claims fiduciary is authorized to interpret the Plan and will do so only in writing. You should not rely on any representation—whether verbal or in writing—that any other individual may make concerning Plan provisions and your entitlement to benefits under the Plan.

McLeod Health
555 East Cheves Street
Florence, SC 29506

HR Service Center:
843-777-2595

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IMPORTANT Information

This booklet, which incorporates by reference the applicable insurance policies, certificates of coverage, component plan benefit booklets, and benefit website serves both as the official plan document and as the SPD for the Plan. The Employer intends for this Plan to serve as the single plan through which all of the Employer's welfare benefits that are governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA) are offered. The Employer also intends for this Plan to satisfy the requirements for a cafeteria plan as set forth in Section 125 of the Internal Revenue Code of 1986, as amended (Code). The following component plan benefits are offered under the Plan to eligible employees of McLeod Health:

Medical Benefits
Prescription Drug Benefits
Dental Benefits
Vision Benefits
Behavioral Health Benefits
Employee Assistance Program
McLeod Healthier You
Health Savings Account
Health Care Flexible Spending Account
Dependent Care Flexible Spending Account
Term Life (Basic, Supplemental, and Dependent)
Universal Group Life
Accidental Death & Dismemberment
Short-Term Disability (Basic and Supplemental)
Long-Term Disability (Basic and Supplemental)
Critical Illness
Accident
Identity Theft Protection

These component plan benefits are subject to change from time to time. You should refer to the McLeod Health benefit website at https://devbenefits.mcleodhealth.org (the "Benefit Website") for a current listing of the Plan's component plan benefits. Except as otherwise provided herein or in an Appendix hereto, in the event of a conflict between the benefits information in this booklet or the Benefit Website, and the applicable insurance policies, certificates of coverage or other component plan benefit booklets, such insurance policy, certificate of coverage or other component plan benefit booklet will prevail. Copies of the insurance policies, certificates of coverage and other component plan benefit booklets are available through the Plan Administrator.

This booklet includes information about the administration of the benefits under the Plan and your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA). Except as otherwise provided herein, this booklet, the Benefit Website, and the applicable insurance policies, certificates of coverage or other component plan benefit booklets replace all plan documents and SPDs previously issued with regard to the Plan.

To the extent a component plan benefit is not subject to ERISA (for example, the Health Savings Account benefit or Dependent Care Flexible Spending Account Plan benefit), its inclusion in this booklet or the Benefit Website is for informational purposes only and will not serve to subject such benefit to ERISA. Not all benefits discussed on the Benefit Website are subject to ERISA.

Plan Sponsor

The Plan Sponsor for the Plan is the Employer.

The Internal Revenue Service assigns every employer an Employer Identification Number (EIN). The Plan Sponsor's EIN is 51-0473500. If you need to write to a government agency about the Plan, use this number along with the Plan name, Plan identification number, and the Plan Sponsor's name.

Plan Administration, Funding, Expenses, Other Provisions

■ Plan Administrator

McLeod Health is the Plan Administrator with respect to the Plan. McLeod Health may designate a person, committee, or entity to fulfill its functions as Plan Administrator. You can contact the Plan Administrator at the following address: 555 East Cheves Street, Florence, SC 29506. The telephone number for the HR Service Center is 843-777-2595.

The Employer provides indemnification against liability, costs, and expenses incurred by any employee or member of a board of directors or trustees of the Employer acting as a Plan fiduciary other than those that may result from the gross negligence, willful misconduct, or deliberate breach of fiduciary duty of that person. This indemnification is in addition to any other rights of the fiduciary. Fidelity bonds cover Plan fiduciaries and other parties having authority to handle Plan funds to the extent required by ERISA Section 412 or other applicable law.

Employees, officers, directors, and agents of the Employer shall not be personally liable for any action taken in good faith in reliance on any tables, valuations, certificates, or reports furnished by any duly appointed advisor to the Plan, such as an actuary, accountant, legal counsel, and/or physician.

■ Discretionary Authority of Plan Administrator and Plan Fiduciaries

The Plan Administrator has the full and discretionary authority and power to administer and construe the Plan (and any component plans there under) except to the extent that such powers have been delegated, such as to an administrator for claims determinations. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

- Allocate fiduciary responsibilities and designate one or more persons to carry out those responsibilities
- Designate agents to carry out responsibilities other than fiduciary responsibilities
- Employ legal, actuarial, medical, accounting, clerical, and other assistance as it may deem appropriate in carrying out the terms of the Plan
- Perform or cause to be performed anything necessary, appropriate, or convenient in the administration of the Plan
- Except as otherwise provided below, to interpret and construe the provisions of the Plan, to decide all questions that arise including any dispute which may arise regarding the rights of participants and beneficiaries under the Plan, which determinations shall be final and conclusive on all persons claiming benefits under the Plan; provided, however, that if an insurance certificate or benefits booklet sets forth a specific claims procedure, such provisions shall apply for purposes of that component plan, consistent with the "Claims and Appeals Procedures" section below; and

- To make and enforce such rules and regulations as it may deem necessary or proper for the efficient administration of the Plan.

For component plans provided through insurance, the insurance company, not the Employer or the Plan Administrator, is responsible for paying the actual cost of eligible claims you and your dependents incur. The insurance company providing such benefits has the full and final discretionary authority to interpret the component plan terms, determine benefit eligibility and is responsible for ensuring that claims are paid according to the provisions of the component plan. Such determinations shall be final and conclusive on all persons claiming such benefits.

■ Type of Administration

The Plan Administrator has delegated authority under the Plan to the respective insurance company or third party administrator to administer benefit claims under the applicable component plan. The Plan Administrator may designate different administrators from time-to-time, at the Plan Administrator's discretion. The administrator for claims determinations for each benefit is identified on the Benefit Website. The Plan Administrator administers the Plan for the exclusive benefit of participants and beneficiaries.

■ Funding of Insured Benefits

The Employer pays premiums to the applicable insurance company for the insured component benefits under the Plan. For some insured benefits, you may be required to contribute all or a portion of the cost of these premiums through payroll deductions. The insurance companies, not the Employer or the Plan Administrator, are responsible for paying the actual cost of eligible claims you and your dependents incur under the insured component program. The Plan Administrator has delegated to these insurance companies the full authority to administrator and make final determinations concerning all claims for benefits and appeals of denied claims for benefits.

■ Plan Expenses

All fees and reasonable expenses incurred by the Plan, to the extent payable from the assets of the Plan as permitted by ERISA, shall be an expense of the Plan. Notwithstanding the foregoing, the Employer reserves the right to either pay the administrative costs directly or allocate and reallocate administrative costs between the Employer and participants in the Plan.

■ Clerical Errors

Any clerical or similar error in keeping pertinent records or a delay in making an entry will not invalidate coverage or otherwise validate in force or continue coverage otherwise validly terminated. An equitable adjustment will be made when the error or delay is discovered.

■ Misrepresentation or Fraud

If a Plan participant or a person eligible for coverage under the Plan makes any intentional misrepresentations or uses fraudulent means in applying for coverage, making a change in their existing coverage election, or filing a claim for benefits, his or her coverage may be subject to immediate termination of coverage, recoupment by the Plan of erroneously paid expenses based on the misrepresentation or fraud, and other remedies available to the Plan Administrator at law and in equity, including retroactive rescission of coverage. For purposes of this section, a participant's failure to inform the Plan Administrator of status changes that would affect coverage (such as participant's divorce) will be considered an intentional misrepresentation.

■ Limitations on Actions

Notwithstanding the provisions of any applicable insurance policies, certificates of coverage or other component plan benefit booklets, any claims or action filed in court against or with respect to the Plan, the Plan Administrator, or the Plan Sponsor must be started within the following timeframes:

- Claims for benefits (including eligibility) cannot be started before all internal administrative claims and appeals procedures have been exhausted.

- A participant, beneficiary or alternate payee (collectively referred to as "Claimant" in this section) seeking judicial review of an adverse benefit determination under the Plan, whether in whole or in part, must file any suit or legal action (including, without limitation, a civil action under Section 502(a) of ERISA) within 12 months of the date the final adverse benefit determination is issued. Notwithstanding the foregoing, any Claimant that fails to engage in or exhaust the claims and review procedures must file any suit or legal action within 12 months of the date of the alleged facts or conduct giving rise to the claim (including, without limitation, the date the Claimant alleges he or she became entitled to the Plan benefits requested in the suit or legal action). Nothing in this Plan should be construed to relieve a Claimant of the obligation to exhaust all claims and review procedures under the Plan before filing suit in state or federal court. A claimant who fails to file such suit or legal action within the 12-month limitations period will lose any rights to bring any such suit or legal action thereafter.

- All other claims with respect to any fully insured benefit must be filed within the same time period specified by the insurance company in the applicable insurance policies, certificates of coverage or other component plan benefit booklets.

Any claim or action not started within the above timeframes will be void and forfeited.

■ Acceptance and Cooperation

Any individuals seeking or accepting benefits under the Plan are considered to have accepted its terms. All individuals claiming any interest in or benefits from the Plan agree to perform any act and to execute any documents that may be necessary or desirable to carry out the Plan or any of its provisions.

■ Governing Law

The Plan is to be interpreted under federal law, including ERISA, and under the laws of the State of South Carolina, to the extent state law is not preempted.

■ Third Party Beneficiaries; Assignment

The Plan is not intended to benefit any person other than covered individuals. Other than direct payment to health care providers, and except as may otherwise be required in applicable insurance policies, certificates of coverage or other component plan benefit booklets or documents (but only to the extent permitted by applicable law), a covered individual cannot assign or alienate (voluntarily or involuntarily) the covered individual's rights under or interest in the Plan. Any such attempt to assign or alienate these rights or interests is void. In no event shall any assignment of benefits be construed to confer status as a participant or a beneficiary, or to confer standing to sue whether in a direct or representative capacity.

■ Coordination of Benefits (COB)

Subject to the terms of the insurance policies, certificates of coverage or other component plan benefit booklets, if you or an eligible child are covered by any other group plan (for example, if your child has coverage through this plan and your spouse's employer's plan), benefits from this Plan and the other plan will be "coordinated."

That means the benefits you receive from this plan, when combined with benefits from all other group plans, will not add up to more than 100% of the eligible expense for the covered service.

Plan Limitations

Nothing contained in the benefit documents or this booklet creates any employment contract or in any way alters the Employer's policy and practice of employment at will contained in the Employer's employment application, handbook and/or policy manuals.

Plan Continuance and Amendment or Termination

The Plan Sponsor reserves the right at its discretion to amend or terminate the Plan, the Benefit Website, or any provision, benefit coverage or contribution under any component plan, at any time, for any reason, prospectively or retroactively. Contributions, premium rates, deductibles, out-of-pocket maximums, benefit levels, covered benefits, and other plan features may be affected. Such changes may affect any or all participants, including active and inactive retired employees. Notwithstanding the foregoing, no verbal statement made by anyone involved in administering this plan, or any other employee of the Employer or a Plan vendor, can waive any of the terms or conditions of this Plan or prevent the Employer enforcing any provision of this Plan. Waivers are valid only if they are contained in a written instrument signed by an authorized individual on behalf of the Employer. Any such written waiver will be valid only as to the specific plan, term or condition set forth in the written instrument. Unless specifically stated otherwise, a written waiver will be valid only for the specific claim involved at the time and will not be a continuing waiver of the term or condition in the future.

If the Plan is terminated for any reason, you will be notified. You will receive information about converting your health care and group insurance benefits to individual policies wherever conversion privileges apply.

Without limiting any other Plan provisions for the discontinuance of coverage, including but not limited to the provisions of any component plan as provided in the applicable insurance policy, certificate of coverage or other component plan benefit booklet, your coverage will terminate when the Plan Sponsor terminates the Plan, or when you are no longer eligible to receive benefits under the Plan, whichever occurs first. Neither you, your dependents, your beneficiaries, nor any other person have or will have a vested or non-forfeitable right to receive benefits under the Plan.

Plan Records

The records of the Plan are kept on the basis of a "Plan Year." The Plan Year shall mean the twelve-month period which begins on January 1 and ends on December 31. The Plan Administrator keeps records on all of its proceedings and determines which records are necessary or advisable for Plan administration. The Plan Administrator may also use records of the Employer.

Reimbursement, Subrogation and Recovery of Overpayment

As a condition for receiving benefits under the Plan, you, your spouse or any dependent child (each, a "covered person") agree to and grant the Plan the rights of reimbursement, subrogation and recovery of overpayment. To the extent that a benefit booklet or insurance certificate also contains provisions regarding reimbursement,

subrogation and/or recovery of overpayment, this section and the applicable provisions of such booklet or certificate both apply so as to grant the Plan the greatest possible rights.

With respect to the right of reimbursement, if a covered person becomes injured or ill because of the actions or inactions of a third party, the Plan shall have the right to recover related Plan expenses out of any payments made by (or on behalf of) the third party (whether by lawsuit, settlement, or otherwise) to a covered person (or his or her assignee). The Plan's right of recovery applies to the extent the Plan has paid expenses related to the injury or illness, regardless of whether any related settlement or other third-party payment states that the payment (all or part of it) is for health care expenses. By accepting Plan benefits to pay for treatments, devices or other products or services related to such injury or illness, a covered person agrees to place such third-party payments in the covered person's separate identifiable account (in an amount equal to related expenses paid by the Plan or, if less, the full third-party payment amount) and that the Plan has an equitable lien on such funds, without regard to whether the covered person has been made whole or fully compensated for the injury or illness. The covered person also agrees to serve as a constructive trustee over the funds until the time they are paid to the Plan. The covered person further agrees to cooperate with the Plan's recovery efforts and do nothing to prejudice the Plan's recovery rights. The Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) incurred in obtaining the funds.

Should it be necessary for the Plan to institute proceedings against the covered person for failure to reimburse the Plan or to otherwise honor the Plan's equitable interest in obtaining amounts described in this Section, the covered person shall be liable for the costs of collection relating to such failure, including reasonable attorney's fees. The Plan shall have the right to offset future benefits to which a claimant (or a covered person through whom the claimant derives his or her claim) may be entitled, until the amount otherwise due the Plan under this Section, plus interest, has been received by the Plan.

The Plan's rights under this Section shall be enforceable regardless of whether the third party admits liability for the injury or illness to a covered person and shall remain enforceable against the heirs and estate of any covered person.

If for some reason a benefit is paid that is larger than the amount allowed under the plan, the Plan Administrator has the right to recover the excess amount from the person or agency that received it. A person receiving benefits must complete any papers requested by the Plan Administrator that are needed to ensure this right of recovery.

If an overpayment is made to a covered person, the Plan Administrator may withhold future benefit payments from the plan until the overpayment has been collected or, instead, the covered person may be required to reimburse the plan in full for the overpayment.

Unclaimed Benefits

In the event that any self-insured benefit payment under the plan remains unclaimed for one year, or if any check issued to you, your spouse or dependent, or a provider remains uncashed for one year, then such benefit or other entitlement will be forfeited. If the claimant subsequently files a valid claim for the forfeited benefit payment or other entitlement, then such amount will be paid to the claimant, without interest.

Agent of Service for Legal Process

Any legal process against the Plan in the event of an unresolved dispute over benefit plan provisions should be served on the Plan Administrator.

Claims and Appeals Procedures

Claims for Benefits.

If you feel an error has occurred in your records or in processing your claim for benefits, you should know that claims and appeals procedures are available to every participant and beneficiary in the applicable insurance policy, certificate of coverage, booklet or other component benefit plan document. **Your claim(s) for benefits will be processed according to the procedures set out in the applicable insurance policy, certificate of coverage, benefit booklet or other component plan document. In the event no such claims and appeals procedures are included in the applicable insurance policy, certificate of coverage, booklet or other component benefit plan document, or such claims and appeals procedures do not comply with applicable law, the below procedures will apply.**

The Plan Administrator has delegated to the insurance companies of the applicable component plan benefits the full authority, in each case as claims administrator, to administer and make final determinations concerning all claims for benefits and appeals of denied claims for benefits. With respect to any component plan that is a group health care plan subject to the Patient Protection and Affordable Care Act (Affordable Care Act), you also have the right under the Plan to request an external review in accordance with the provisions of the component plan booklet, insurance policy or certificate of coverage or, if no such provisions exist, as set forth below.

To the extent that a component plan provides for voluntary levels of appeal, the Plan agrees (i) to waive the right to assert that you failed to exhaust your administrative remedies by not submitting the dispute to the voluntary level of appeal; (ii) that the statute of limitation will be tolled during the time that such voluntary level of appeal is pending; and (iii) that you may elect to submit the benefit dispute to the voluntary level of appeal only after you have exhausted the appeals permitted under Department of Labor regulations.

If the Plan Administrator learns of conflicting benefit claims made by two or more claimants, the benefit may be withheld until the conflict is resolved by one of the following: (a) agreement between the claimants; (b) a final judicial determination of entitlement to benefits; or (c) any other procedure reasonably calculated to protect the Plan from paying the same benefit more than once. If there is both a conflict between claimants and a dispute between one of those claimants and the Plan regarding benefit payment, the Plan Administrator may allow the processing of the request for benefits under normal appeal procedures before resolving the conflict between claimants.

Claims Regarding Plan Eligibility.

Claims for eligibility will normally be approved or denied by the Plan Administrator within 90 days after they are received. If your claim is denied, the written notice you receive will tell you why it was denied and will refer to the Plan provisions upon which the decision was based. The notice will also tell you about any additional information which may be necessary for your claim to be approved.

You may appeal the denial of your claim by writing the Plan Administrator and stating that you wish to appeal. The Plan Administrator will consider your written appeal provided it is received no more than 30 days after you have received notice of the denial of your claim. You may submit written comments, documents, records, and other information relating to your claim.

If you appeal, the Plan Administrator will review your appeal and any additional information you furnish. Normally the Plan Administrator will decide your appeal within 60 days after it is received. In unusual circumstances, it may be necessary to delay the final decision of your appeal for an extra 60 days. You will be notified of any delay within 60 days after your appeal is received. After your appeal is decided, the Plan Administrator will tell you both how it was decided and what Plan provisions the Plan Administrator relied upon.

Medical Claims.

Urgent Care Claims
In the event of a claim that involves urgent care, you will be notified whether your claim has been approved or denied within 72 hours after the Plan receives your claim. If your claim is incomplete, the Plan will notify you within 24 hours of receiving the claim that additional information is needed, as well as the deadline for providing this information (the deadline for providing the additional information will not be less than 48 hours after you are notified). In this instance, you will be notified of the claim determination within 48 hours after the Plan receives the additional information or, if later, within 48 hours after the deadline for submitting the additional information.
Notification may be provided orally or in writing. If you are notified orally, you will also receive a formal written notice within three days after the oral notice.

Ongoing Care Claims
Special rules apply where the Plan has approved an ongoing course of treatment—either for a specific period of time or for a specific number of treatments. A reduction in or end to the course of treatment *before* the previously approved time period or number of treatments end will be considered a claim denial (unless the Plan is amended or ends). The Plan will notify you in advance of any reduction in or end to a course of treatment(s) so you can appeal the decision and obtain a determination on review before the benefit is reduced or terminated.

Pre-Service Claims
A pre-service claim is any request for approval of a benefit (other than urgent care and ongoing care) that the Plan requires be approved in advance of getting that care (for example, hospital pre-certification). The Plan will notify you whether a pre-service claim has been approved or denied within 15 days of receiving your claim. If you do not follow the correct procedures for filing a pre-service claim, you'll be notified within five days of the receipt of the claim of the proper procedures you need to follow.

The original 15-day period to respond to your claim may be extended for another 15 days if you are notified that the extension is necessary due to matters beyond the control of the Plan. This notification will be made before the end of the original 15-day period. The notice will explain the reason for the extension and when the Plan expects to rule on your claim. If the extension is needed because you failed to provide the information needed to decide the claim, the notice will tell you what additional information you need to furnish. In this event, you will have 45 days from the date you receive the notice to provide the additional information.

Post-Service Claims
Post-service claims are all other claims that are not pre-service claims or claims for urgent care or ongoing care. The Plan will notify you whether a post-service claim has been approved or denied within 30 days of receiving your claim. This period may be extended for another 15 days if you are notified (before the end of the original 30-day period) that the extension is necessary due to matters beyond the control of the Plan. The notice will explain the reason for the extension and when the Plan expects to rule on your claim. If the extension is needed because you failed to provide the information needed to decide the claim, the notice will tell you what additional information you need to furnish. In this event, you will have 45 days from the date you receive the notice to provide the additional information.

Notification of Medical Claims Decision
The notice of the Plan's claims decision will be given in writing or electronically. In the event that your claim is denied, the notification will include:

- The specific reasons for the denial,
- The specific Plan provisions on which the decision is based,
- A description of any additional material or information necessary for the claim to be complete, as well as an explanation of why such material or information is necessary,
- A description of the Plan's review procedures and the time limits applicable to such procedures, including your right to bring a civil action in court following a claims denial on review,

- A description of any internal rules, guidelines, protocols or other similar criteria that were relied upon in the decision, *or* a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request (free of charge),
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, *or* a statement that such explanation will be provided upon request (free of charge),
- For a claims denial involving an urgent care claim, a description of the expedited review process applicable to such claims.

If you have any questions about a denied claim, you should contact the claims administrator.

Appealing a Denied Medical Claim

After you receive notice that a claim has been denied, you (or your authorized representative) will have 180 days after receiving notice to appeal the decision in writing to the claims administrator. You may submit written comments, documents, records and other information relevant to the claim. In addition, you will be provided (upon request and free of charge) reasonable access to and copies of all documents, records and other information relevant to the claim. The medical or vocational experts whose advice was obtained by the plan in connection with the initial claim denial will be notified.

Urgent Care Claims

In the case of an urgent care claim, you can call or write the claims administrator and all necessary information regarding the review will be provided to you as quickly as possible. You will be notified of the decision on your appeal within a reasonable period that is appropriate for your medical condition, but no later than 72 hours after the Plan receives your request for review.

Pre-Service Claims

In the case of a pre-service claim (other than urgent care), you will be notified of the decision on your appeal within a reasonable period that is appropriate for your medical condition, but no later than 30 days after the Plan receives your request for review.

Post-Service Claims

You will be notified of the decision on your appeal within 60 days after the Plan receives your request for review. Your appeal will be reviewed by a Plan fiduciary who had no role in the initial claim denial and who is not a subordinate of the individual who made the initial claim denial. The review will be an independent one without giving the original denial any special consideration. If a medical judgment is involved, the person reviewing your appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who had no role in the initial claim denial and who is not a subordinate of any individual involved in the initial claim denial.

Notice of the Plan's decision on the appeal will be given electronically or in writing. In the event that the appeal is denied, the notification will include:

- The specific reasons for the denial,
- The specific Plan provisions on which the decision was based,
- Your right to request access to or copies of all information relevant to your claim,
- Your right to bring a civil action in court,
- A description of any internal rules, guidelines, protocols or other similar criteria that were used in the decision-making, *or* a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request (free of charge), and
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, *or* a statement that such explanation will be provided upon request (free of charge).

If the claims administrator fails to follow the required claims appeals procedures, you have the right to bring a civil action in court.

Disability Claims

Notwithstanding anything in this Plan to the contrary, the following procedures apply with respect to claims for disability benefits after April 1, 2018. These procedures are limited to claims where benefits are based on disability and the Plan Administrator is determining whether you satisfy the Plan's definition of disability (e.g., where the plan is not relying on an independent determination, such as qualifying for Social Security disability benefits or where a participant's eligibility for disability benefits is determined under the Employer's long term disability program).

These procedures are intended to meet ERISA requirements set forth in DOL Regulation §2560.503-1 and will be interpreted in accordance with such regulations. The procedures are designed to ensure that claimants are not unduly inhibited from making claims; that claimants may appoint an authorized representative in accordance with Plan rules; determinations will be made in accordance with the Plan documents; that Plan provisions are applied consistently; and that decisions are made by impartial and independent decision makers.

The Plan may offer additional voluntary appeal and/or mandatory arbitration procedures other than those described here. If applicable, the Plan will not assert that a claimant has failed to exhaust administrative remedies for failure to use the voluntary procedures, any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending; and the voluntary process is available only after exhaustion of the appeals process described in this section. If mandatory arbitration is offered by the Plan, the arbitration must be conducted instead of the appeal process described in this section, and the claimant is not precluded from challenging the decision under ERISA §501(a) or other applicable law.

The "claimant" refers to you, your authorized representative, or anyone else entitled to benefits under the Plan (such as a beneficiary).

For purposes of these procedures, a document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

How do I submit a claim for Plan benefits?

You may file a claim for benefits by submitting a written request for benefits to the Plan Administrator. You should contact the Plan Administrator to see if there is an applicable distribution form that must be used. If no specific form is required or available, then your written request for a distribution or a written assertion that your benefits under the Plan have been determined incorrectly, will be considered a claim for benefits.

The claim for benefits must include sufficient evidence to enable the Plan Administrator to determine whether you have met the Plan's definition of disability.

Decisions on the claim will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days. If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

Initial Claims

A claim must be resolved, at the initial level, within 45 days of receipt by the Plan. A Plan may, however, extend this decision-making period for an additional 30 days for reasons beyond the control of the Plan. The Plan will notify the claimant of the extension prior to the end of the 45-day period. If, after extending the time period for the first 30-day period, the Plan Administrator determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension period, the Plan may extend decision making for a second 30-day period.

Appropriate notice must be provided to the claimant before the end of the first 45 days and again before the end of each succeeding 30-day period. This notice will explain the circumstances requiring the extension and the date the Plan Administrator expects to render a decision to the claimant. It will explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues.

The claimant will have 45 days from the date of receipt of the Plan Administrator's notice to provide the information required.

What if my benefits are denied?

If the Plan Administrator determines that all or part of the claim should be denied (an "adverse benefit determination"), it will provide a notice of its decision in written or electronic form explaining the claimant's appeal rights. An "adverse benefit determination" also includes a rescission, which is a retroactive cancellation or termination of entitlement to disability benefits. The notice will be provided in a culturally and linguistically appropriate manner and will state:

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

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

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

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

(e) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

- the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or

- a disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.

(f) If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(g) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make a determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

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

Review of Adverse Benefit Determinations

When a claimant receives a notice of an adverse benefit determination, the claimant may request a review of the decision. The request must be in writing and must be filed within 180 days following receipt of the notice. In the case of an adverse benefit determination regarding a rescission of coverage, the claimant must request a review within 90 days of the notice. The claimant or his authorized representative may submit written comments, documents, records, and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be considered by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the initial adverse benefit determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was neither involved in or subordinate to the person who made the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Plan considers, relies upon or creates any new or additonal evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to the claimant, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow the claimant time to respond.

Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, the claimant must be provided a copy of the rationale at no cost to the claimant. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the claimant time to respond.

The claimant will be notified of the determination on review of the claim no later than 45 days after the Plan’s receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, the claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify the claimant of the determination on review no later than 90 days after receipt of the request for review.

Notice of Adverse Benefit Determination on Review

The Plan Administrator shall provide written or electronic notification to the claimant or his authorized representative in a culturally and linguistically appropriate manner. If the initial adverse benefit determination is upheld on review, the notice will include:

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

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

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

(d) A statement of claimant's right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to claimant's right to bring such an action, a statement to that effect which includes the calendar date on which such limitation expires on the claim.

If the Plan offers voluntary appeal procedures, a description of those procedures and the claimant's right to obtain sufficient information about those procedures upon request to enable the claimant to make an informed decision about whether to submit to such voluntary appeal. These procedures will include a description of the claimant's right to representation, the process for selecting the decision maker and the circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on the claimant as part of the voluntary appeal. A claimant's decision whether to use the voluntary appeal process will have no effect on the claimant's rights to any other Plan benefits.

(e) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
- a disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.

(f) If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(g) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

Your Rights Under ERISA

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

■ Your Right to Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. 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.

■ Your Right to Continue Group Health Plan Coverage

Under ERISA, you are entitled to:

- 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 the Appendix entitled “COBRA Continuation Coverage” and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

■ Your Right to Prudent Actions by Plan Fiduciaries

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

■ How to Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits, which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these

costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

■ Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-275-7922 or go to www.dol.gov/ebsa.

Summary Plan Information

Official Plan Name:	**McLeod Health Flexible Benefits Plan**
Plan Sponsor	McLeod Heath 555 East Cheves Street Florence, SC 29506 EIN: 51-0473500
Plan Administrator	McLeod Heath 555 East Cheves Street Florence, SC 29506 HR Service Center: 843-777-2595 EIN: 51-0473500
Agent for Service of Legal Process	McLeod Heath Attention: VP of HR Operations 555 East Cheves Street Florence, SC 29506
Plan Number:	**506**
Type of Plan:	Welfare benefit plan, with the following component plan benefits: Medical Benefits Prescription Drug Benefits Dental Benefits Vision Benefits Behavioral Health Benefits Employee Assistance Program *McLeod Healthier You* Health Savings Account Health Care Flexible Spending Account Dependent Care Flexible Spending Account Term Life (Basic, Supplemental, and Dependent) Universal Group Life Accidental Death & Dismemberment Short-Term Disability (Basic and Supplemental) Long-Term Disability (Basic and Supplemental) Critical Illness Accident Identity Theft Protection ***These component plan benefits are subject to change from time to time. You should refer to the Benefit Website, the applicable insurance policies, certificates of coverage, or other component plan benefit booklets for a complete description of the Plan's current component plan benefits, as well as the contact information for the component benefit plan providers. To the extent a component plan benefit is not subject to ERISA (for example, the Health Savings Account benefit, or Dependent Care Flexible Spending Account Plan benefit), its inclusion in this booklet is for informational purposes only and will not serve to subject such benefit to ERISA.***

APPENDIX – Eligibility for Coverage, Commencement and Termination of Coverage

■ Employee Eligibility

In General

- The rules governing employee eligibility and commencement of coverage for the Flexible Spending Account component plan benefits are set forth in the **APPENDIX – Flexible Spending Accounts.**

- For all other component plan benefits, the insurance policies, certificates of coverage or other component plan benefit booklets describe who is eligible to participate, as well as the requirements for enrollment, waiting periods, if any, and when coverage commences. An overview of these rules is contained on the Benefit Website.

- In order to participate in any of the component plans under the Plan, you must timely complete and submit the applicable enrollment materials (either electronically or in paper, as require by the Plan Administrator in accordance with applicable law) and satisfy any other enrollment requirements for the component benefit.

- The Plan Administrator or its designee, or an administrator of claims has the right to request information needed to determine or confirm an individual's eligibility for benefits under this Plan.

■ Ineligible Employees

The following employees are not eligible to participate in the component plans described in this booklet:

- **Union Employees.** Persons who are subject to a collective bargaining agreement.

- **Related Employer Employees.** Persons employed by any employer who is related to the Employer pursuant to Sections 414(b), 414(c), 414(m) or 414(o) of the Code.

- **Leased, Payroll Service or Agency.** A leased, payroll service or agency employee means an individual (a) for whom the direct payor of compensation with respect to the performance of services for the Employer or an affiliated employer is any outside entity, including but not limited to a payroll service or temporary employment agency, rather than by the Employer's internal payroll system; or (b) who is paid directly by the Employer, but not through an internal corporate payroll system (e.g., through purchase order accounts); or (c) designated by the Employer as an independent contractor, either through the terms of an agreement with such individual or otherwise. The determination whether an individual is a "payroll service or agency employee" shall be made by the Employer, in its sole discretion, based solely upon these criteria, without regard to whether the individual is considered a common law employee of the Employer or an affiliated employer for any other purpose. Any independent contractor or any other ineligible individual who is reclassified by a court,

administrative agency or other party as an eligible employee will not be considered an eligible employee for periods before the Employer implements the reclassification decision, even if the decision applies retroactively for other purposes.

■ Dependent Eligibility

- The insurance policies, certificates of coverage or other component plan benefit booklets describe the classes of dependents eligible to participate (including with respect to retiree benefits), as well as the requirements for enrollment, waiting periods, if any, and when coverage commences.

- In order to participate in such plan(s), dependents must be timely enrolled. The Plan Administrator or its designee, or an administrator of claims has the right to request information needed to determine or confirm an individual's eligibility for coverage and/or benefits under this Plan at enrollment or any time thereafter.

■ Termination of Coverage

- The component plan benefits, the insurance policies, certificates of coverage or other component plan benefit booklets describe when coverage terminates under the respective component benefit plan. An overview of these rules is contained on the Benefit Website. For all other component plan benefits, coverage ends on the last day of employment. Coverage also ends if you no longer meet the eligibility requirements for coverage under the Plan, you retire, you stop making contributions for coverage or the Plan or covered plan benefit is terminated. Where applicable, however, you may be eligible to continue your coverage under COBRA, FMLA, or USERRA, or to convert to individual coverage.

- Your covered dependent's benefits terminate on the date that person no longer meets the definition of dependent, you stop making contributions for dependent coverage, you disenroll your Dependent as provided under the Plan (for example, due to a change in status), the Plan or covered plan benefit is terminated, or such later date provided under the applicable insurance policies, certificates of coverage or other component plan benefit booklets. The dependent may be eligible for continuation of coverage under COBRA or other continuation or conversion coverage, as applicable.

- If you or your dependent(s) engage in fraudulent conduct or intentionally furnish the Employer, a Claims Administrator or other service provider with fraudulent or misleading material information relating to claims or application for benefits, your coverage and that of your dependents may be adversely affected, up to and including termination of your benefits, effective on the date you engaged in fraudulent conduct or intentionally furnished fraudulent or misleading material information, whichever is applicable. You shall be responsible to pay the Employer or the applicable carrier, and the Employer and applicable carrier may seek to recoup for the cost of previously received services, less any copayments made or fees paid for such services. If you permit the use of your or any other person's identification card by any other person; use another person's card; or use an invalid card to obtain services, your coverage shall terminate immediately. Any person or dependent involved in the misuse of an identification card will be liable to and must reimburse the Employer or the applicable carrier for the cost of services received through such misuse.

APPENDIX – Change in Status

While you are a member of the Plan, you usually will only be allowed to make changes to your elections during the annual Open Enrollment Period, unless you have a "Change in Status." The events that constitute a Change in Status are discussed on the Benefit Website and include any other event that the Employer, in its sole discretion, determines is a Change in Status consistent with IRS rules and regulations and guidelines, such as entitlement to Medicare or Medicaid or pursuant to court orders.

A Change in Status may allow you to enroll, disenroll, or change your benefit elections. However, the change in your election must be consistent with the Change in Status. That is, the change must be on account of and correspond with a Change in Status that affects eligibility for coverage under this Plan, or another employer's plan.

Employer Approval and Determination of the Change in Status

It is important to remember that having a Change in Status does not automatically mean that you may change your election. The IRS has strict guidelines about when mid-year election changes may be made. The Employer, in its sole discretion, will determine if you have had a Change in Status and if a requested election change is "consistent" with the Change in Status and consistent with IRS rules, regulations and guidelines. The Employer reserves the right to deny any change request that the Employer, in its sole discretion, determines is not permitted or appropriate under IRS rules and regulations.

If the Employer determines that you have had a Change in Status, but the election change you have requested is not "consistent" with the Change in Status, you will not be allowed to change your before-tax election until the next annual Open Enrollment Period, or special enrollment event, even though you have had a Change in Status.

If you anticipate that for some reason you may want to adjust your contribution amount or cancel your membership in the Plan during the next Plan Year, you should contact the Plan Administrator before making your election to determine if your situation will qualify as a Change in Status.

Again, you may only change your election to make adjustments to your membership that are on account of and consistent with a Change in Status.

The Benefit Website provides more information about the time frame and procedures for changing elections. If the change is not made according to the Plan rules, you will not be allowed to make the change until your next annual Open Enrollment Period.

In the cases of Life Event elections that require Evidence of Insurability (EOI), the change is effective as of the date of the EOI approval.

APPENDIX – Leaves of Absence

Except as provided in the underlying insurance and benefit booklets, this section describes how your coverage will be continued during certain leaves of absence. ***Thus, to know whether you will be eligible to continue coverage during a leave of absence, you must review the terms of the applicable insurance policies, certificates of coverage or component plan benefit booklets.*** If you have any questions, contact the Plan Administrator.

■ Paid Leave of Absence

In addition to other options that may be available, if you take an approved paid leave of absence, and coverage under one or more component benefits is continued, such as under the Family and Medical Leave Act (FMLA), your scheduled payroll deductions will automatically continue during your leave**.** If your paycheck does not cover the amount of any regularly scheduled contribution during your leave, you will be treated as being on an unpaid leave.

If the full amount of any required scheduled contribution is not made within thirty days after it was due, your coverage under the applicable component benefit options under the Plan may be terminated for the remaining period of your leave of absence, retroactive to the last day for which a required contribution was made.

Unless otherwise provided in a component plan document or under applicable law, your coverage under the Plan will generally cease (subject to any COBRA continuation rights or similar) as a result of a leave of absence, whether paid or unpaid, that extends for more than 6 months.

■ Unpaid Leave of Absence

If you take an approved unpaid leave of absence, including leave under the FMLA or another job-protected leave, you may elect either to terminate your coverage and to stop making required contributions during your leave, or to continue your coverage <u>if permitted</u> under the terms of the applicable component benefit.

During your unpaid leave, you must continue to pay any required contributions on an after-tax basis or catch up on your missed premiums upon your return from leave, as determined in the sole discretion of the Employer, subject to the requirements of the federal Family and Medical Leave Act ("FMLA") or the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA"), as may be applicable. If the full amount of any regularly scheduled contribution is not made within thirty days after it was due, your coverage under the applicable component benefit options under the Plan may be terminated for the remaining period of your leave of absence, retroactive to the last day for which a required contribution was made, and you will not be eligible for reimbursement of any claims incurred while your coverage was terminated.

Unless otherwise provided in a component plan document or under applicable law, your coverage under the Plan will generally cease (subject to any COBRA continuation rights or similar) as a result of a leave of absence, whether paid or unpaid, that extends for more than 6 months.

■ Family and Medical Leave Act

Notwithstanding any other provision of this Plan, if you take an approved leave of absence under the FMLA, coverage under the group health plans under this Plan will continue to be made available during such leave period to you and your covered dependents under the same terms and conditions that coverage was made available immediately prior to the commencement of the leave. If you do not wish to continue some or all of these benefits during the FMLA leave, you must inform the Employer before the start of the leave. Continuation of coverage also may be available for other component benefits under the Plan. Contact the Plan Administrator for more information.

If you elect to continue your coverage during such a leave period, you must continue to pay any required employee-portion of the cost of the level of coverage elected. Upon returning from an approved FMLA leave, coverage under the Plan will immediately resume regardless of whether you elected to continue coverage during the FMLA leave.

Employer Contributions. While you are on an FMLA leave, the Employer will continue to make the same contributions toward the cost of coverage continued under the Plan that it would have made had you not taken such leave of absence. The Employer will continue to do so until the earlier of the date that (a) you fail to return to work on the expiration of the FMLA leave, or (b) you voluntarily give notice of your intent to terminate employment. For these purposes, you are considered to "terminate employment" when you give oral or written notice of your intent not to return to work due to reasons within your control.

If you voluntarily terminate your employment due to reasons within your control at or before the end of the FMLA leave, the Employer shall have the right to be reimbursed by you for any and all contributions the Employer has made on behalf of you and your covered dependents during the leave. In this regard, the Employer shall have the right to obtain reimbursement from any funds that the Employer might otherwise owe you following your voluntary termination, including (but not limited to) (a) any regular or overtime wages, commissions, salary, or bonuses; (b) accrued vacation pay or sick leave pay; or (c) other sources. In addition, the Employer shall have the right to pursue reimbursement in a court of law. Regardless of whether or not you return from an FMLA leave, the Employer shall be entitled to recover from you any required employee contributions the Employer has made on behalf of you and your covered dependents during the unpaid leave to ensure continuity of coverage.

The Employer may not recover any of its regular contributions made on behalf of you and your covered dependents for the time you had been on an FMLA leave if your failure to return to employment at the expiration or exhaustion of such leave is due to (a) the continuation, recurrence, or onset of a serious health condition that would entitle you to the FMLA leave; or (b) other circumstances beyond your control (as set forth in the Employer's policies and procedures).

Covered Employee. If you choose ongoing coverage during FMLA leave, you must continue to make the same premium payments or contributions that you were making immediately before the leave took effect, as described above.

The obligation to provide ongoing coverage under this Plan for you and your covered dependents on an FMLA leave, if any, ceases if you are more than thirty (30) days late on making a required premium payment; provided, however, that the Employer may—at its

option—cover your missed payments so that coverage will be uninterrupted. In this event, the Employer's advances may be recovered in the event you voluntarily terminate your employment under circumstances within your control.

■ Military Leave

We will grant a leave of absence to any employee due to military service in the Armed Forces of the United States in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA), and applicable state law. In general, during such a leave of absence under USERRA, you may be eligible to elect to continue group health plan coverage for yourself and your enrolled dependents (if any) for up to 24 months.

More specifically, if you are absent from work for more than 31 days in order to fulfill a period of duty covered by USERRA, you will be treated as having experienced a "qualifying event," as that term is defined under the Plan's COBRA continuation coverage provisions, see below, as of the first day of your absence for such duty. This means that in addition to having the option to elect to continue coverage under COBRA, you will become eligible to elect continuation coverage under USERRA using procedures similar to those required by COBRA. The Plan Administrator or its designee will furnish you with a notice of the right to elect continuation coverage, which will include information about the premiums you will have to pay for such coverage. This notice will allow you the opportunity to elect such coverage for up to 24 months (so long as you continue to be on a leave of absence under USERRA) beginning on the date your USERRA leave commenced. Nothing in the Plan limits your right to continue your coverage under COBRA instead of under this section.

If qualified to continue coverage pursuant to USERRA, you may elect to continue coverage under the Plan by notifying the Plan Administrator and providing payment of any required contribution for the health coverage. The election procedures are same as for COBRA; refer to the COBRA section below for more information. However, only the covered employee who is called to serve in the uniformed services may make an election under USERRA to continue coverage. The employee's spouse and dependent children do not have independent election rights under USERRA. This means that if the employee does not elect continuation coverage under USERRA, his spouse, for example, still may elect continuation coverage under COBRA, but not USERRA. If you do not make your election within 60 days of being provided with the notice mentioned above, you will no longer be eligible to continue coverage under the Plan, except as required by USERRA.

The required contribution will include the amount we normally pay on your behalf if the period of continuation coverage is fewer than 31 days. If not, the required premium will be 102% of the full premium for the level of coverage elected. Premium payments must be made in the same time and manner as those required under COBRA.

If you elect to continue coverage under USERRA, the period of extended group health plan coverage shall run concurrently with the maximum continuation coverage period that may be available under COBRA. Continuation coverage under USERRA will end, however, upon the first to occur of the following: (i) the last day of the 24 month coverage continuation period, (ii) the last day of the period for which timely premium payment is made, (iii) you fail to return to work within the time frame required under USERRA following

the completion of your service, or (iv) you lose your rights under USERRA as a result of dishonorable discharge or other conduct under USERRA.

Regardless of whether you continue your health coverage, if you return to your position of employment in the time and manner required under USERRA, your health coverage for you and your enrolled dependents (if any) will be reinstated under the Plan as required under USERRA. No exclusions or waiting period may be imposed on you or your enrolled dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Contact the Plan Administrator for more information regarding the rights under USERRA to continue coverage, as well as reemployment and other rights you may have under USERRA.

APPENDIX – Cafeteria Plan

The Cafeteria Plan is intended to satisfy Section 125 of the Internal Revenue Code (Code) and, accordingly, shall be administered in accordance with Code Section 125 and applicable Treasury regulations thereunder. Employees who are eligible to participate in one or more of the following Covered Benefits (Covered Benefits) shall be eligible to participate in the Plan:

(a) Medical Benefit (including Prescription Drugs);
(b) Dental Benefit;
(c) Vision Benefit;
(d) Flexible Spending Accounts;
(e) The HSA Component, subject to the special rules discussed below;
(f) Supplemental Short-Term Disability Benefit;
(g) Supplemental Life Benefit; and
(h) Accidental Death & Dismemberment Benefit.

■ Election to Participate

Choice Between Cash and Benefits. During each Open Enrollment Period, or at such other time as may be permitted hereunder, you may elect to reduce your compensation in exchange for participation in one or more of the Covered Benefits listed above. The Open Enrollment materials will describe the cost of each Covered Benefit, which may be subject to one or more premium surcharges or discounts as described on the Benefit Website.

Enrollment Form / Salary Reduction. You must enter into a salary reduction agreement on such forms as may be required, and in accordance with procedures established and uniformly applied, by the Plan Administrator or its delegate. The terms of any such salary reduction agreement shall provide that you agree to accept a reduction in compensation for each pay period, by an amount equal to the cost of participation in the applicable Covered Benefit, in consideration of the Employer's agreement to apply an amount equal to such reduction to the applicable Benefit on your behalf. By entering into a salary reduction agreement, you also agree to be bound by the terms of the Cafeteria Plan and of the applicable Covered Benefit. The salary reduction agreement shall become effective as of the January 1 immediately following the Open Enrollment Period or, for new eligible employees, effective as of the date he or she first becomes eligible to participate in the Cafeteria Plan. The salary reduction agreement shall remain in effect thereafter until amended, revoked, or terminated in accordance with this Appendix.

Time of Election. Except as may otherwise be permitted under this Appendix, you must enter into a salary reduction agreement either during the Open Enrollment period or, if you are newly hired, by no later than the date on which you first become eligible to participate in the Cafeteria Plan and by no later than the enrollment date specified in this Plan or the applicable Booklet.

Failure to Return Enrollment Form. If you fail to timely return a properly completed salary reduction agreement to the Plan Administrator, or its delegate, you shall be deemed to have elected to receive your full compensation in cash, except as otherwise provided on the Benefit Website.

Election Changes. Except as provided below or on the Benefit Website with respect to the HSA benefits, you may revoke or change an election for Covered Benefit as provided in **APPENDIX – Change in Status**.

■ Special Enrollment Events

You may change your election in order to exercise your "special enrollment rights" under each applicable Covered Benefit. The change permitted under this Section may have retroactive effect in order to add an eligible dependent as of the date of such eligible dependent's birth, adoption, or placement for adoption. Except as provided below, you must properly initiate the election change allowed under this subsection within thirty-one (31) days before or after the date on which the event that permits such election change occurs or during such other time frame as may be provided on the Benefit Website.

If you are not enrolled in the medical Covered Benefit, you shall be permitted to make an election change if all of the following apply:

- you or your eligible dependent is covered under a Medicaid Plan or under CHIP;
- coverage of you or eligible dependent under the Medicaid Plan or CHIP is terminated as a result of loss of eligibility for such coverage; and
- you properly make the election change by a date that is no later than sixty (60) days after the date of termination of coverage under the Medicaid Plan or CHIP, as applicable.

You also shall be permitted to make an election change if all of the following apply:

- you or your eligible dependent becomes eligible for assistance, with respect to coverage under the medical Covered Benefit, under a Medicaid Plan or CHIP (including under any waiver or demonstration project conducted under or in relation to such a plan); and
- you request coverage under the medical Covered Benefit by a date that is not later than sixty (60) days after the date you or your eligible dependent is determined to be eligible for such assistance.

■ Failure to Make Required Contributions

Reduction in, or Cessation of, Salary. If your compensation ceases or is reduced to an amount that is not sufficient to cover the cost of Covered Benefits elected hereunder, if you wish to continue such Covered Benefits, you must continue to pay your share of the cost to the Plan Administrator on an after-tax basis. Alternatively, you may, before the period of absence, in order to cover the required contributions during such absence (or during the period of lower salary), authorize extra salary reduction from his or her salary. Failure to continue required payments shall result in cancellation of coverage.

Similarly, if your salary does not stop but drops below the amount of salary reduction that you have authorized, you must either pay the difference to the Plan Administrator on an after-tax basis or authorize extra salary reduction.

Special Enrollment Rights under HIPAA. If your compensation ceases or is reduced to an amount that is not sufficient to cover the cost of Covered Benefits elected hereunder, if you wish to continue such Covered Benefits, you must continue to pay your share of the cost to the Plan Administrator on an after-tax basis. Alternatively, you may, before the period of absence, in order to cover the required contributions during such absence (or during the period of lower salary), authorize extra salary reduction from your salary. Failure to continue required payments shall result in cancellation of coverage.

■ Benefits Provided on an After-Tax Basis or Automatically

The Plan Administrator, or its delegate, may, in their sole discretion, provide any Covered Benefits to you on an after-tax basis or without charge; if so, such Covered Benefits shall not be considered to be made available through, and shall not considered to be a part of, the Cafeteria Plan. Notwithstanding the foregoing, the enrollment periods described in this Plan, including all prohibitions on changing elections unless a Change in Status applies, shall apply to any Covered Benefit described under this Section.

■ HSA Component

Notwithstanding anything to the contrary in this Section, the following governs the HSA Component

- The Benefit Website describes who is eligible for the HSA.

- If you are eligible, you can elect to participate in the HSA Component by electing to pay contributions on a pre-tax salary reduction basis to the HSA established and maintained outside the Plan by a trustee/custodian selected by the Company. The Company will forward such HSA contributions for deposit to the trustee/custodian (this funding feature constitutes the HSA benefits offered under the Plan). Subject to the dollar limitations of Section 223(b) of the Code, your HSA shall be credited with amounts you elect to contribute on a pre-tax basis, and your pre-tax contributions will cease within a Plan Year in the event the contributions to the your HSA for a Plan Year reach the dollar maximum provided in Section 223(b) of the Code.

- The annual contribution for your HSA benefits is equal to the annual benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. You should refer to the Benefit Website for more information.

- You may prospectively make, change, or revoke his elections with regard to contributions to an HSA pursuant to the election procedures required by the Plan Administrator. An election, change, or revocation made with respect to HSA contributions during a calendar month shall be effective as soon as administratively feasible, according to the rules of the Plan Administrator.

- The tax treatment of the HSA (including contributions and distributions) is governed by Section 223 of the Code.

- The HSA Component under the Cafeteria Plan consists solely of the ability to make contributions to the HSA on a pre-tax basis. The terms and conditions of your HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian and are not a part of this Plan.

- The HSA Component is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of 'qualified eligible medical expenses' as set forth in Section 223(d)(2) of the Code. The Employer has no authority or control over the funds deposited in an HSA. Even though this Plan may allow pre-tax contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

- The Plan Administrator will maintain records to keep track of HSA contributions an Employee makes via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in the HSA. In the event of contributions in excess of the dollar limitations of Section 223(b), the Plan Administrator has the discretion to make corrections in accordance with applicable IRS guidance.

APPENDIX – Flexible Spending Accounts

■ Purpose

The Flexible Spending Accounts Benefit, also referred to as the FSA Benefit, is intended to satisfy, and shall be administered in accordance with, Code Sections 105 and 129, including applicable Treasury regulations thereunder, and, to the extent applicable, with Code Section 125 and Treasury regulations thereunder. Subject to the eligibility requirements of the Plan, you shall be eligible to be reimbursed, on a tax-free basis, for the following:

- certain health care expenses that have not been, or are not eligible to be, reimbursed under other applicable sections of this Plan; and
- certain dependent care expenses.

■ Employee Eligibility

All employees who are eligible for the Medical Covered Benefit are eligible to participate in the FSA Benefit.

■ Deadline / Forfeiture of FSA Balances

Deadline for Claims. All claims for reimbursement under this Appendix must be submitted by no later than the March 31 following the end of the calendar year for which such claim was incurred. Expenses shall be considered as incurred on the date such care is provided. If you have not submitted a claim for reimbursement from your Health Care Spending Account and/or Dependent Care Spending Account (as applicable) by this deadline, the entire balance attributable to the applicable calendar year of either, or both, the Health Care Spending Account and/or the Dependent Care Spending Account (as applicable) shall be forever forfeited, except as provided below in the case of limited rollovers.

Health Care Spending Account Rollovers. If you have an unused balance in your Health Care Spending Account as of the end of a Plan Year, such unused balance (up to a maximum amount specified on the Benefit Website) may be carried over to the next Plan Year and made available to reimburse claims in such later Plan Year. This unused rollover amount shall not be included in your benefit election for the year to which the unused amount is rolled over. Any amounts in excess of maximum rollover amount shall be forfeited as provided above.

In the event of a rollover to a Plan Year for which you elect the High Deductible Health Plan Medical Benefits, your standard Health Care Spending Account benefit will be converted to a Limited Purpose Health Care Spending Account under the Plan. The Limited Purpose Health Care Spending Account is a Health Care Spending Account that pays or reimburses benefits only for (i) "permitted coverage", as defined in Internal Revenue Code §223(c)(1)(B) or (ii) preventive care benefits, as defined in applicable Treasury guidance. It is designed this way to ensure you can take full advantage of your High Deductible Health Plan and HSA coverage election.

■ Health Care Spending Account

The Health Care Spending Account provides reimbursement for Eligible Health Care Expenses incurred during the applicable Plan Year.

Election Procedures. You must elect the annual dollar amount, if any, you will contribute to your Health Care Spending Account, except that the amount of such pre-tax contributions may not be less than four dollars ($4) per pay period or exceed the annual dollar limitation set forth in Code Section 125 from time to time, as may be adjusted by the Internal Revenue Service. The Benefit Website contains additional information about the applicable Plan Year maximum.

Reimbursement Procedures. You must submit your claim for reimbursement on such forms, and in such manner, as may be established by the Plan Administrator, or its delegate, from time to time. At a minimum, however, you must submit the following to the Plan Administrator, or its delegate, to substantiate your claim:

- a bill showing (i) the medical procedure (or what was purchased), (ii) when the procedure was performed or when the product was purchased, (iii) the amount that was charged, and (iv) proof of the amount that you paid; and

- a signed statement that the expense (i) has not been reimbursed and (ii) is not reimbursable under any other health plan coverage.

The Plan Administrator, or its delegate, may establish procedures that permit you to use an electronic debit card for the purpose of paying for Eligible Health Care Expenses, provided, however, that such procedures, if established, comply with Internal Revenue Service Revenue Ruling 2003-43, including any successor ruling and any other applicable guidance issued by the Internal Revenue Service. By way of example, and not by way of limitation, the established procedures must require you to substantiate any charges that fail to be independently verified as properly reimbursable hereunder.

Notwithstanding anything herein to the contrary, you may be reimbursed for Eligible Health Care Expenses up to the total annual amount you elected to contribute during the applicable Open Enrollment Period even if you have not yet made such pre-tax contributions, provided you are actively employed. Claims incurred after you cease to be eligible may not be reimbursed from your Health Care Spending Account, unless COBRA continuation coverage is available and elected.

Eligible Health Care Expenses. Eligible Health Care Expenses means:

- amounts you pay for medical care, as defined under Code Section 213(d), for you or an eligible dependent; and

- amounts paid that have not been, and will not be, reimbursed under any other health plan.

Eligible Health Care Expenses shall include unreimbursed amounts paid for prescription and over-the-counter medicines and such other amounts permitted by the Code, IRS rules, regulations or guidelines to be reimbursed by a Health Care Spending Account.

Eligible Health Care Expenses shall not include amounts paid for:

- non-prescribed dietary supplements which are merely beneficial to general good health;
- long-term care notwithstanding anything in Code Section 213(d) to the contrary; or
- medical insurance premiums.

■ Dependent Care Spending Account

The Dependent Care Spending Account provides reimbursement for Eligible Dependent Care Expenses incurred during the applicable Plan Year.

Eligibility. In addition to having to satisfy the eligibility requirements for participation in the FSA Benefit, if you have a spouse, that spouse must work, be a full-time student, or be incapable of caring for him or herself in order for you to be eligible to contribute to a Dependent Care Spending Account.

Election Procedures. You must elect the annual dollar amount, if any, you will contribute to your Health Care Spending Account, except that the amount of such pre-tax contributions may not be less than four dollars ($4) per pay period or exceed the annual dollar limitation, set forth in Code Section 129 from time to time, as may be adjusted by the Internal Revenue Service. The annual dollar limitation is the lesser of:

1) $5,000 or $2,500, if you are married, but file your federal income tax return separately from your spouse; or

2) the lesser of your earned income or your spouse's earned income.

Notwithstanding the foregoing, if your spouse has no earned income because he or she is a full-time student or is incapable of caring for himself or herself, the limitation shall be $250 per month, or if there is more than one Qualifying Individual for the calendar year, the amount shall be $500 per month (but no more than the annual limits described above).

If both you and your spouse are eligible for the FSA Benefits, the annual dollar limit above shall not be doubled as such, but, rather, the dollar limit shall apply as if you and your spouse are one eligible employee.

Reimbursement Procedures. You must submit your claim for reimbursement on such forms, and in such manner, as may be established by the Plan Administrator, or its delegate, from time to time. At a minimum, however, you must submit the following to the Plan Administrator, or its delegate, to substantiate your claim:

- either (i) the name, address, and taxpayer identification number of the person performing the dependent care services or (ii) if the person providing dependent care services is an organization described in Code Section 501(c)(3) and is exempt from tax under Code Section 501(a), the name and address of such person;

- a bill from the dependent care provider showing when the care was rendered, which must include the amount charged for such services; and

- the name of the eligible dependent for whom the care was rendered.

Notwithstanding anything herein to the contrary, you may be reimbursed only for the pre-tax contributions you have made through the date you submit a claim for reimbursement. Claims incurred after you cease to be eligible may not be reimbursed from your Dependent Care Spending Account.

Eligible Dependent Care Expenses. Eligible Dependent Care Expenses shall have the meaning provided below. It is intended for this section to be interpreted in accordance with Code Sections 21 and 129 and applicable Treasury regulations, including Treasury Regulation Section 1.44A-1.

"Eligible Dependent Care Expenses" means:

- amounts you pay for the care of a Qualifying Individual, where such care is necessary to enable you or your spouse to remain gainfully employed; and

- amounts you pay for either household services or for the care of a Qualifying Individual, subject to the rules set forth below.

Household Services. Amounts paid for household services shall not be considered an Eligible Dependent Care Expense unless the amounts paid are attributable, in part, to the care of the Qualifying Individual. By way of example, and not by limitation, amounts paid for the performance in and about your home of ordinary and usual services necessary to the maintenance of the household may be considered as paid for household services, if they are attributable, in part, to the care of the Qualifying Individual.

Care Outside of the Household. Amounts paid for care of a Qualifying Individual outside of your household shall not be considered an Eligible Dependent Care Expense unless:

- the Qualifying Individual regularly spends at least eight (8) hours each day in the your household if that Qualifying Individual is age thirteen (13) or older; or

- the Qualifying Individual has not attained the age of thirteen (13).

Dependent Care Center. Amounts paid for care of a Qualifying Individual in a day care center shall not be considered an Eligible Dependent Care Expense unless it is a facility that:

- provides care for more than six (6) individuals, excluding individuals who reside at the facility;

- receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and

- complies with all applicable laws and regulations of a state or unit of local government.

Amounts Not Eligible for Reimbursement. Notwithstanding anything herein to the contrary, any amounts paid to your child, who is under age nineteen (19), or to anyone else that either you, or your spouse, could claim as an exemption on their federal income tax return shall not be considered an Eligible Dependent Care Expense. In addition, amounts paid for overnight camp shall never be considered as an Eligible Dependent Care Expense.

Qualifying Child means an individual who satisfies all of the conditions in (1), (2), (3), and (4) below (unless otherwise provided under the applicable Covered Benefit).

(1) An individual satisfies this condition (1) if such individual is your child, brother, sister, stepbrother, or stepsister or a descendent of such a relative. For purposes of this Section, an individual is a "child" if he or she is a son, daughter, stepson, stepdaughter, or an eligible foster child of the daughter.

- For purposes of this section, a individual you legally adopt or who is lawfully placed for legal adoption by you, shall be treated as a child by blood.

- For purposes of this section, the term eligible foster child means an individual who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

(2) An individual satisfies this condition (2) if he or she has the same principal place of abode as you for more than one-half (1/2) of the Plan Year.

(3) An individual satisfies this condition (3) if he or she either has not attained the age of 19 as of the last day of the Plan Year or, if he or she is a student, such individual has not attained the age of twenty-four (24) as of the last day of the Plan Year. For purposes of this Section, a "student" means an individual who during each of five (5) calendar months during the Plan Year is:

- a full-time student at an educational organization described in Code Section 170(b)(1)(A)(ii); or

- pursuing a full-time course of institutional on-farm training under the supervision of an accredited agent of an educational organization described in Code Section 170(b)(1)(A)(ii) or of a state or political subdivision of a state.

Notwithstanding the foregoing, an individual who is permanently and totally disabled, as defined in Code Section 22(e)(3), at any time during the Plan Year, this condition (3) shall be considered to have been satisfied.

(4) An individual satisfies this condition (4) only if he or she has not provided over one-half (1/2) of his or her own support for the Plan Year. For purposes of this section, "support" shall not include amounts received by a child, who is also a student, of yours as scholarships for study at an educational organization described in Code Section 170(b)(1)(A)(ii).

Qualifying Individual means any one of the following:

(1) a Qualifying Child who is under the age of thirteen (13);

(2) an eligible dependent who is not your legal spouse and who is under the age of thirteen (13);

(3) a Qualifying Relative, a Qualifying Child, or an eligible dependent:

- who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than one-half of the Plan Year, and

- whose gross income for the Plan Year is less than the exemption amount of Code Section 151(d); or

(4) your legal spouse, if your spouse is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than one-half of the Plan Year.

For purposes of this section, an individual shall not be treated as having the same principal place of abode as you if, at any time during the Plan Year, their relationship is in violation of local law.

Qualifying Relative means an individual who satisfies all of the conditions of (1), (2), and (3) below.

(1) An individual satisfies this condition (1) if such individual is:

- Your child or a descendent of a child;

- Your brother, sister, stepbrother, stepsister, or a son or daughter of your brother or sister;

- Your father, mother, stepfather, stepmother, or either an ancestor or a brother or sister of your father or mother;

- Your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or

- An individual, other than your spouse, who bears the same principal place of abode as you and is a member of your household. An individual shall not be treated as a member of your household if their relationship is in violation of local law.

(2) An individual receives over one-half of his or her support from you during the Plan Year. For purposes of this section, "support" shall not include:

- amounts received from your spouse which is includable as federal taxable income (except that, in the case of remarriage of a parent, support of a child received from the parent's spouse shall be treated as received from the parent); and

- amounts received by your child, who is also a student, as scholarships for study at an educational organization described in Code Section 170(b)(1)(A)(ii).

(3) An individual satisfies this subsection (3) if he or she is not your Qualifying Child or that of any other person during the Plan Year.

APPENDIX – Special Rules – Coronavirus (COVID-19) Relief

The rules in this Appendix implement the COVID-19 relief provided under the Consolidated Appropriations Act, 2021, IRS Notice 2020-29, IRS Notice 2021-15, and related guidance. This rules contained in this Appendix supersede any inconsistent provisions of the Plan, the Employer's Section 125 cafeteria plan and/or the underlying component benefit plans, and this Appendix serves as a Summary of Material Modifications to those documents. When applicable, the special rules expire as of the dates provided below. If you have any questions, contact the Plan Administrator.

■ Election Changes

Effective for plan year(s) ending in 2020 and 2021, subject to the limitations described below, you may:

- revoke or change an election for Covered Benefit as provided in **APPENDIX – Change in Status**, irrespective of the normal election change deadlines that apply;

- revoke or decrease a Health Flexible Spending Account or Dependent Care Flexible Spending Account prospectively, however your election may not be less than the amount you have already contributed to the applicable Flexible Spending Account or have already been reimbursed, if greater.

To make such change, you must complete the election change form(s) required by the Plan Administrator. Changes are effective as soon as administratively practicable after the change is processed.

■ FSA Carryover

Instead of forfeiting unused amounts in your Health Flexible Spending Account and/or Dependent Care Flexible Spending Account (as applicable), unused amounts from 2020 up to the maximum amount allowed by law may be carried over to 2021 and unused amounts from 2021 up to the maximum amount allowed by law may be carried over to 2022, provided that you remain in a benefit-eligible position in the year to which the amounts would be carried over.

■ Dependent Care Flexible Spending Account: Dependents

Under the Dependent Care Flexible Spending Account, the dependent age is temporarily modified to substitute "under age 14" for "under age 13" for purposes of determining the dependent care assistance expenses that may be paid or reimbursed. This change only applies to you if (1) you are enrolled in the Plan with an enrollment period ending on or before January 31, 2020, and (2) you have one or more dependents who attained age 13 in that plan year or the subsequent plan year if amounts are carried over to that subsequent plan year.

■ Contribution Limits

The maximum amount that you may contribute to the Health Flexible Spending Account and/or the Dependent Care Flexible Spending Account each Plan Year is modified to

the amount communicated to you in writing by the Plan Administrator during your enrollment period. This amount is subject to change from year to year.

■ Eligible Health Care Expenses

Effective for expenses incurred after December 31, 2019, Eligible Health Care Expenses include unreimbursed amounts paid for prescription and over-the-counter medicines, menstrual care products, and such other amounts permitted by the Code, IRS rules, regulations or guidelines to be reimbursed by a Health Flexible Spending Account.

■ Extension of Time Frames

- As described in the U.S. Department of Labor ("DOL") Disaster Relief Notice 2020-01, 85 Fed. Reg. 26351, and Disaster Relief Notice 2021-01 (the "Relief Guidance"), the deadlines contained within the Plan's claims procedures and various other statutory deadlines, as noted below, are temporarily extended. The deadline has been extended until the earlier of: (1) one year from the date of the original deadline for delayed deadlines that would have occurred on or after March 1, 2020, or (2) until 60 days after the announcement of the end of the COVID-19 National Emergency (the "Relief Period"). The delayed deadlines provided under the Relief Guidance affects the following:

  Group Health Plan Relief

  - COBRA continuation coverage (notices, elections, premium payment obligations)
  - Special enrollment periods
  - Claims for benefits
  - Appeals of denied claims
  - External review of denied claims

  Disability and Other Benefit Relief

  - Claims for benefits
  - Appeals of denied claims

- This means that the normal deadlines for notices, elections, payments, claims, and appeals set forth in the Plan do not apply during the Relief Period. Instead, you have until the conclusion of the Relief Period to take these actions.

- The Plan Administrator will administer the Plan consistent with the Relief Guidance. If you have any questions about how these rules impact you, please contact the claims administrator or plan administrator for the applicable component benefit plan.

APPENDIX – SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS ONLY

APPENDIX -- QMCSO Procedures

A "QMCSO" is a QUALIFIED MEDICAL CHILD SUPPORT ORDER that applies only to group health plans.

ERISA requires that, as part of a divorce action, a court, domestic relations magistrate or administrator can enter an order (a Medical Child Support Order or MCSO) which grants a child the right to receive health benefits under one of his parent's group health plans, regardless of whether the parent is the custodial parent of the child. However, to be valid or "qualified" (QMCSO), the MCSO must meet certain statutory requirements which are identified below.

Upon receipt of a notice of a MCSO and request for coverage under the group health plan for one or more children of an employee or covered spouse, the following will occur:

- The Plan Administrator will send a letter acknowledging receipt of the MCSO. The letter will be sent to the Plan participant (the employee) and to each child affected by the MCSO.

  The Plan Administrator will review the MCSO to make certain that it:

  - was issued pursuant to a valid state domestic relations law;
  - specifically provides for a dependent (or dependents) to receive benefits under the group health coverage(s);
  - provides the name and last known mailing address of the employee (Plan participant) and each child covered by the MCSO;
  - provides a reasonable description of the coverage to be provided by the Plan(s) or the manner in which the coverage can be determined. The MCSO cannot require a Plan to provide any benefit or option that is not otherwise provided. If it does, it is not a qualified MCSO or "QMCSO";
  - specifies the time period to which the Order applies;
  - names each group health benefit to which the MCSO applies.

- The employee may be required to provide necessary identifying information about the child(ren), such as social security number(s), so that the Plan Administrator can comply with the requirements of the law.

- Upon completion of its review, the Plan Administrator will send a letter to the Plan participant (employee) and each affected child advising whether or not the MCSO has been determined to be a qualified MCSO – i.e., a QMSCO.

- If the MCSO is determined to be qualified, each child affected is entitled to all reporting and disclosure requirements to which other Plan participants are entitled under ERISA. Any child affected by the MCSO is also permitted to designate a representative to receive copies of any notices regarding this matter or any coverage or benefits matters. Any such designation should be sent to the Plan Administrator.

APPENDIX – SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS ONLY

APPENDIX -- COBRA Continuation Coverage

■ In General

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

■ What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

■ When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

■ How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

■ **Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

■ **Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

APPENDIX – SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS ONLY

APPENDIX – Required Notices

■ Rules Regarding Use and Disclosure of Protected Health Information Use and Disclosure of Protected Health Information

The Plan will use or disclose "Protected Health Information" (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations issued thereunder, as amended from time to time, including 45 CFR Parts 160 and 164, subparts A, D and E (HIPAA Privacy Rule) and 45 CFR Parts 160 and 164, subpart C (HIPAA Security Rule).

Use and Disclosure of PHI as Permitted by Authorization of the Participant or Beneficiary

As soon as practicable following the receipt of an authorization from a participant or his or her duly appointed personal representative, the Plan will disclose PHI in accordance with the authorization.

Disclosure to the Employer

Upon request of the Employer, the Plan will disclose summary health information and enrollment and disenrollment information to the Employer as permitted pursuant to Section 164.504 of the HIPAA Privacy Rule.

The Plan will disclose PHI other than summary health information and enrollment and disenrollment information for purposes related to "plan administration," "treatment," "payment" and "health care operations" as described above to the Employer only upon receipt of a certification from the Employer that the applicable Plan documents have been amended to incorporate the provisions set forth in the remaining sections of this Appendix.

To receive PHI as described in the preceding paragraph, the Employer shall certify to the Plan that it agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI or his or her duly appointed personal representative;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

- report to the Plan (i) any security incident as defined under the HIPAA Security Rule, and (ii) any Breach of Unsecured Protected Health Information; provided, however, that to avoid unnecessary burden on either party, the Employer shall report to the Plan any unsuccessful security incidents of which it becomes aware of only upon request of the Plan. The frequency, content and the format of the report of unsuccessful security incidents shall be mutually agreed upon by the parties. The term "unsuccessful security incidents" mean security incidents that do not result in unauthorized access, use, disclosure, modification or destruction of electronic PHI;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made. Where the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible.

Adequate Separation Between the Plan and the Employer Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- The Vice President of HR Operations;
- Staff designated by the Vice President of HR Operations.

The persons described in this section may only have access to and use and disclose PHI for the purposes described above.

If the persons described in this section do not comply with this plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

■ Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable component benefit. Refer to the insurance certificate or benefit booklet for information on the deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, contact the Plan Administrator.

■ Newborns' and Mothers' Health Protection Act of 1996

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).

■ Mental Health Parity and Health Insurance Coverage

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a recent amendment to the Mental Health Parity Act of 1996. These laws preclude medical plans from imposing financial requirements and treatment limitations on mental health or substance abuse benefits that are more restrictive than financial requirements and treatment limitations on medical and surgical benefits. MHPAEA also may prevent your large group health plan from placing annual or lifetime dollar limits on Mental Health and Substance Abuse benefits that are less favorable than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.

Although the law requires "parity", or equivalence, with regard to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does not require group health plans and their health insurance issuers to include these benefits in their medical plan.

Key changes made by MHPAEA include the following:

- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health and substance abuse benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits;
- Mental health and substance abuse benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;

- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, and the plan provides for out of network medical and surgical benefits, it must provide for out of network mental health and substance abuse benefits;
- Standards for medical necessity determinations and reasons for any denial of benefits relating to mental health and substance abuse benefits must be disclosed upon request.

■ The Genetic Information Nondiscrimination Act

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

■ Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within **60 days** after you or your dependents' coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

You also may have special enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). These rights occur when an employee or dependent child –

- loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program (acronym "CHIP," for children whose families do not qualify for Medicaid); or
- becomes eligible for premium assistance from Medicaid or CHIP allowing him or her to enroll in a group health plan.

However, you must request enrollment within **60 days** after the date of coverage loss or eligibility for Medicaid or CHIP premium assistance, whichever applies.

APPENDIX – SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS ONLY

To request special enrollment or obtain more information, contact the Plan Administrator.

■ Status Under Health Care Reform Law

1. Grandfathered Status

Your Plan is not considered grandfathered for purposes of the Affordable Care Act.

2. The Following Changes Also Apply To The Health Care Component Benefits Under The Plan:

- **The elimination of any overall *lifetime* maximum** on the dollar value of essential health benefits that may have previously applied.

- **The elimination of any overall *annual* maximum** on the dollar value of essential health benefits that may have previously applied.

  NOTE: Lifetime or annual maximums may continue to apply to specific services if they are not considered essential health benefits. For guidelines on which services are considered "essential health benefits" contact the Plan Administrator.

- **Coverage for adult dependents until 26,** regardless of whether the dependent is unmarried, married or is a student. The provision of the law does not require coverage for children of covered dependents.

- **Coverage for preventative benefits with no member cost-sharing.** When preventative services are received from a network or participating provider, program deductibles, copayments or coinsurance will no longer apply. For a service such as a colonoscopy, related services such as operating room and anesthesia charges will also be covered at no cost to the member. For guidelines on which preventative services are affected, please consult http://www.heathcare.gov/ and search under Preventative Care.

- **Revisions to the appeals process.** An updated appeal process that complies with the new health care reform regulations now applies. For example, if an appeal is denied internally, covered employees will now be able to request a further review by an independent external review entity.

■ Patient Protection Disclosure

To the extent the medical benefit component plans require or allow for the designation of primary care providers by participants or beneficiaries,

- participants have the right to designate any primary care provider who participates in the network and who is available to accept the participant and the participant's covered family members;

- if the component plans require or allow for the designation of a primary care provider for a child, participants may designate a pediatrician as the primary care provider; and
- a participant or beneficiary does not need prior authorization from the component benefit plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the applicable network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurance carrier.