HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

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Amendment and Restatement
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HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

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PREAMBLE

This amendment and restatement of the Hood College Health and Welfare Benefits Plan (the "Plan") is effective July 1, 2023.

The purpose of the Plan is to allow eligible employees of the Employer to choose benefits from among those benefits provided under the Plan.

The Plan includes provisions for a "cafeteria plan" meeting the requirements of §125 of the Internal Revenue Code of 1986, as amended, but some benefits offered under the Plan (or benefits offered to certain participants) may not be offered pursuant to the Plan's cafeteria plan feature.

ARTICLE 1
DEFINITIONS

The following terms have the meanings indicated unless the context clearly requires otherwise:

1.1 ADMINISTRATOR means the Plan Administrator referred to in Article 8.

1.2 BENEFIT ACCOUNT is defined in Section 4.1.

1.3 BENEFIT CREDITS means the benefit credits, if any, allocable to a Participant in any Plan Year, as determined by the Employer, and communicated to Participants from time to time.

1.4 BENEFITS means those benefits or coverage available for election by a Participant under Article 6.

1.5 CODE means the Internal Revenue Code of 1986, as amended, together with applicable regulations and other authoritative guidance issued thereunder.

1.6 COMPANY means Hood College and any successor entity.

1.7 COMPONENT PLAN means any plan or program referred to in Article 6 and any other plan or program designated by the Company as a Component Plan.

1.8 DEPENDENT includes, and is limited to an individual described in Section 1.8(a), subject to the rules and definitions in Section 1.8(b).

(a) Except as otherwise provided in Section 1.8(b), Dependent includes and is limited to:

(i) the spouse of a Plan Participant;

(ii) for purposes of any Component Plan offering medical benefits that are subject to PPACA (as determined by the Employer), dental benefits, or vision benefits, any child of the Participant who is under age 26; or

(iii) for purposes of any Component Plan that provides medical benefits that are subject to PPACA, dental benefits, or vision benefits, an unmarried child of a Participant who is a Code Section 152 dependent who receives over half of his or her support from the Participant and who is physically or mentally incapable of self-support, regardless of the child's age, provided the child became physically or mentally incapable of self-support before reaching age 26;

(iv) for purposes of any Component Plan that provides dependent life insurance coverage, an unmarried child of a Participant who is a Code Section 152 dependent who receives over half of his or her support from the Participant and who is:

(A) at least 14 days old but under age 18;

(B) age 18 or over but under age 26 and a full-time student (as defined in Code Section 152(f)(2), without regard to the five-month requirement of that definition);

(C) physically or mentally incapable of self-support, regardless of the child's age, provided the child became physically or mentally incapable of self-support before reaching age 18 (or age 26 if the child was enrolled as a full-time student when he or she became incapable of self-support);

(v) any child of a Participant who is a Code Section 152 dependent but would not otherwise qualify as a Dependent under this Section 1.8 solely because the child is not primarily dependent upon the Participant for support, so long as the child's principal place of abode is the same as that of the Participant for more than half of the applicable tax year of the Participant and the child does not provide more than half of his or her own support during the calendar year in which the applicable tax year of the Participant begins;

(vi) any child of a Participant who is a Code Section 152 dependent but would not otherwise qualify as a Dependent under this Section 1.8(a) solely because the child is not primarily dependent upon the Participant for support, so long as over half of the support of the child is treated as having been received from the Participant pursuant to a multiple support agreement as described in Code §152(d)(3); and

(vii) any child of a Participant who is a Code Section 152 dependent but would not otherwise qualify as a Dependent under this Section 1.8(a) solely because the child is not primarily dependent upon the Participant for support and/or does not share the same principal place of abode as the Participant for more than half of the Participant's tax year, so long as either (i) the Participant is entitled to claim the child as a dependent under Code §151 pursuant to an agreement with a spouse or former spouse described in Code §152(e)(3), or (ii) at least half of the child's support for the calendar year is treated as being provided by the Participant and the child's other parent (on a combined basis) for purposes of §152(e)(2).

(b) Additional Rules and Definitions. For purposes of this Section, "child" means a natural child, a legally adopted child (or a child placed for adoption) if the child is under

eighteen years of age at the time of the adoption (or placement for adoption), a stepchild (as determined for purposes of federal income tax law), an eligible foster child (as defined in Code §152(f)(1)(C)) or any other person whose welfare is the legal responsibility of the Participant pursuant to a written divorce settlement, written separation agreement, court order or order by an administrative process having the force and effect of state law. Notwithstanding the preceding, for purposes of Section 1.8(a)(ii) only, "child" has the same meaning as under the previous sentence, except to the extent that a different meaning is required for the Plan to comply with Code §9815 and §2716 of the Public Health Service Act and any applicable regulations or other guidance issued pursuant to Code §9815 or §2716 of the Public Health Service Act (as determined by the Employer).

Notwithstanding any provision of this Plan to the contrary, for purposes of the health care flexible spending account Component Plan, "Dependent" means a Participant's spouse (determined under federal law) or a Code Section 152 dependent of the Participant, or a child (as defined in Code §152(f)(1)) of the Participant who will be age 26 or younger on the last day of the applicable calendar year and, for purposes of the dependent care flexible spending account Component Plan, "Dependent" means a "Qualifying Individual", as defined in Section 6.1(m)(v).

For purposes of this Section, a child is a "Code Section 152 dependent" of a Participant for any period when the child is reasonably expected to be a dependent of the Participant under Code §152(a) (as modified by Code §105(b) for purposes of any Component Plan providing accident or health benefits).

For purposes of this Section, an individual is physically or mentally incapable of self-care if, because of a physical or mental defect, he or she is incapable of caring for his or her own hygiene or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

For purposes of this Plan, a person is an Employee's "spouse" if he or she is treated as a "spouse" for purposes of federal income tax law, as determined by the Administrator. Notwithstanding any provision of this Plan to the contrary, no person will be considered an employee's spouse for purposes of this Section 1.8 solely because of a claimed "common law" marriage.

In addition, a spouse or child (excluding, for purposes of medical coverage, a child described in Section 1.8(a)(ii)) will not qualify as an eligible Dependent if he or she is on active duty in the armed forces of any country. Finally, a person otherwise qualifying as an eligible dependent will not be covered for any coverage providing benefits to dependents unless the Participant has elected to pay and has paid the required additional contributions, if any, for dependent coverage.

Notwithstanding any other provision of this Plan, for purposes of any Component Plan (other than a health care flexible spending account) that provides health benefits (as determined by the Employer), if a Dependent of an Employee is also an Employee, he or she may not be covered as both a Dependent and a Participant at the same time.

If a child would otherwise qualify as a Dependent of more than one Participant, the child may be treated as the Dependent of only one Participant at any one time. This paragraph will not apply to the extent that it conflicts with any provision of the PPACA, as

determined by the Employer.

In determining whether a person qualifies as a Dependent of the Participant under this Section, the Administrator may require a Participant to provide adequate evidence (as determined by the Administrator) that the person meets the applicable requirements of this Section. The Administrator, in its discretion, may also conclusively rely on representations from a Participant with regard to any applicable requirement, unless it is unreasonable to do so under the circumstances. The Administrator may recover from a Participant any Plan payments made to or on behalf of an individual who is determined not to qualify as a Dependent of the Participant, using any recovery means available under applicable law (including, but not limited to, wage garnishment).

Notwithstanding the preceding or any other provision of this Plan to the contrary, for purposes of any dependent coverage offered as an insured benefit under any Component Plan, if the insurance contract uses a different definition of dependent than the definition of Dependent that would otherwise apply under this Section, that definition will prevail and any person who would qualify as a dependent under that insurance contract will be treated as a Dependent under this Plan for purposes of that Component Plan.

1.9 EFFECTIVE DATE means July 1, 2023.

1.10 ELECTION FORM means the form provided by or process designated by the Administrator by which an Employee or a Participant enrolls or re-enrolls in the Plan and elects Benefits in accordance with Article 3.

1.11 EMPLOYEE means

(a) a person who is a full-time or part-time employee of the Employer with an established full time equivalency of .50 or greater (as determined by the Employer) or. Solely for purposes of long term disability benefits, employee means a full-time employee of the Employer with an established full time equivalency of .75 or greater (as determined by the Employer); or

(b) effective for any period when the Employer is an applicable large employer for purposes of Code §4980H, any New Employee, other than a Seasonal Employee or an Employee described in Section 1.11(a), who on his or her date of hire or on July 1, 2015, if later, is reasonably expected by the Employer to work at least 130 Hours of Service per month for the Employer; or

(c) effective for any period when the Employer is an applicable large employer for purposes of Code §4980H, any Section 4980H Employee (as determined by the Employer pursuant to applicable law and Section 2.1(b)).

An employee who, during his or her Initial Measurement Period, experiences a material change in position or employment status that results in the employee becoming reasonably expected to work at least 130 Hours of Service per month for the Employer will be treated as an Employee described in Section 1.11(b) for all purposes under the Plan beginning on the date of that change in employment status.

Notwithstanding the foregoing, Employee does not include an employee in the following categories unless he or she is an Employee described in Section 1.11(b) or (c): a leased

employee, a temporary employee, a Seasonal Employee, an adjunct professor, a graduate assistant, a coach, or a student employee.

Under no circumstances will Employee include (i) any employee of the Employer who is a member of a collective bargaining unit covered under a collective bargaining agreement unless the collective bargaining agreement provides for the employee's participation in the Plan, or (ii) any person who is not classified by the Employer as a common law employee of the Employer for the period during which the person is not so classified by the Employer notwithstanding the later reclassification by a court or any regulatory agency of the person as a common law employee of the Employer.

1.12 EMPLOYER means the Company and any other entity that, with the consent of the Board of the Company, adopts the Plan by action of its Board.

1.13 ERISA means the Employee Retirement Income Security Act of 1974, as amended, together with applicable regulations and other authoritative guidance issued pursuant to that Act.

1.14 HOUR OF SERVICE means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related employer); and each hour for which an employee is paid, or entitled to payment by the Employer (or a related employer) for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 C.F.R. §2530.200b–2(a)). For purposes of the preceding sentence, a related employer is any entity that must be treated as part of the same "applicable large employer" as the Employer for purposes of Code §4980H, as determined at the time that the applicable Hour of Service is performed or credited.

Notwithstanding the preceding paragraph, Hour of Service does not include (i) any hour to the extent that compensation for that hour constitutes income from sources outside the United States (within the meaning of Code §862(a)(3)), (ii) any hour for services performed as a "bona fide volunteer" (as defined in Code §457(e)(11)(B)(i) or as otherwise determined under applicable guidance (as determined by the Administrator), or (iii) any hour for services performed as part of a Federal Work-Study Program, as defined under 34 C.F.R. Part 675 or a substantially similar program of a State or local government.

1.15 INITIAL MEASUREMENT PERIOD means the 12-month period beginning on the date a New Employee first performs an Hour of Service as an employee of the Employer (as determined by the Employer) and ending on the day before the first anniversary of that date.

For purposes of this Section, an employee who has been rehired by the employer is treated as first performing an Hour of Service for the Employer on his or her most recent reemployment date only if more than 26 weeks have passed since the employee was last credited with an Hour of Service with the Employer (or with any affiliated organization that is required to be treated as the same employer for purposes of regulations issued under Code §4980H).

1.16 INITIAL STABILITY PERIOD means the 12-month period beginning on the first day of the month that begins on or after the Employee's first anniversary date.

1.17 INSURER means any insurance company to which premiums are paid and which provides benefits with respect to a Participant in accordance with Article 6.

1.18 MEASUREMENT PERIOD means an Initial Measurement Period or a Standard Measurement Period.

1.19 NEW EMPLOYEE means an individual who is a common-law employee of the Employer who commenced employment (or resumed employment after at least 26 weeks during which he or she was not credited with an Hour of Service) after the start of the current Standard Measurement Period. An individual ceases to be a New Employee on the last day of the first Standard Measurement Period that begins on or after he or she commences employment (or resumes employment after at least 26 weeks during which he or she was not credited with an Hour of Service), except that, for purposes of Section **Error! Reference source not found.**, an employee will be treated as a New Employee until the end of the last day before the start of the first Standard Stability Period that begins after the Standard Measurement Period described in this sentence.

1.20 OUTBREAK PERIOD has the same meaning as that term has under the Federal Notification issued by the Employee Benefits Security Administration and the Internal Revenue Service (the "Agencies") and published in the Federal Register on May 4, 2020 and any subsequent guidance issued by the Agencies, which extended certain time frames relating to special enrollment rights, COBRA continuation coverage and claims, appeals and external review procedures for employee benefit plans and currently means the period beginning on the later of March 1, 2020 or the "Applicable Event Date" and ending on the earliest of (1) 60 days after the announced end of the National Emergency Period that began on March 1, 2020 relating to the COVID-19 outbreak (2) any other date that is subsequently announced by the Agencies or (3) one year from the Applicable Event Date. For purposes of this Section 1.20, the Applicable Event Date is determined based on the following table:

Event	Event type	Applicable Event Date
(1)	Special enrollment event	First day of 30-day or 60-day special enrollment period
(2)	Initial COBRA election	First day of 60-day COBRA election period
(3)	Initial COBRA payment Monthly COBRA payment	First day of 45-day initial payment period First day of 30-day payment grace period
(4)	COBRA qualifying event notice	First day of 60-day period for providing notice
(5)	Initial claim	Date of claim
(6)	Internal or external appeal	Date of receipt of claim denial
(7)	Request for external review	Date of notice of adverse determination on appeal
(8)	Perfection of external appeal	Date of receipt of notice of need for information

1.21 PARTICIPANT means an Employee who becomes a Participant pursuant to Article 2. An individual ceases to be a Participant for purposes of a Component Plan on the date that coverage under that Component Plan terminates, as provided in Section 2.2(a)

1.22 PARTICIPANT ACCOUNT is defined in Section 4.1.

1.23 PARTICIPATION DATE is the first date on which an Employee may participate in the Plan (or a particular Component Plan, if applicable), as set forth in Section 2.1.

1.24 PLAN means, collectively, the Hood College Health and Welfare Benefits Plan, as described in this document and as amended from time to time, and the Component Plans.

1.25 PLAN YEAR means the twelve month period beginning each July 1 and ending each June 30 while this Plan is in effect.

1.26 PPACA means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 and any subsequent legislation, together with applicable regulations and other authoritative guidance issued pursuant to that Act.

1.27 SALARY REDUCTION CONTRIBUTIONS means contributions made under the Plan based on an election (including a deemed election) by a Participant pursuant to Section 5.2 to have amounts withheld from the Participant's compensation on a pre-tax or after-tax basis to pay for benefits or coverage provided under a Component Plan or to contribute to a health savings account.

1.28 SEASONAL EMPLOYEE means a worker who performs labor or services on a seasonal basis for no more than six months each year (as determined by the Employer), except to the extent that the Employer determines a different definition must apply for purposes of Code §4980H under applicable guidance.

1.29 SECTION 4980H EMPLOYEE means any individual employed by the Employer, other than a person described in the final paragraph of Section 1.11, who is not otherwise classified by the Employer as an Employee under Section 1.11 but is determined to be a full-time employee for the applicable Initial Stability Period or Standard Stability Period for purposes of Code §4980H and Section 2.1(b). Except as otherwise provided under Section 2.1(b), an employee is a Section 4980H Employee only for each Stability Period for which he or she is determined to be a full-time employee based on the applicable Measurement Period.

1.30 STABILITY PERIOD means an Initial Stability Period or a Standard Stability Period.

1.31 STANDARD MEASUREMENT PERIOD means the 12-month period beginning each April 3 and ending on the following April 2.

1.32 STANDARD STABILITY PERIOD means the next Plan Year following the applicable Standard Measurement Period.

1.33 STATUS CHANGE means, and is limited to:

(a) an event that changes an Employee's legal marital status, including marriage, death of spouse, divorce or legal annulment;

(b) an event that changes an Employee's number of Dependents, including the birth, adoption, placement for adoption (as defined in regulations under Code §9801) or death of a Dependent;

(c) an event that changes the employment status of an Employee or the Employee's Dependent including the termination or commencement of employment by the

Employee or the Employee's Dependent, the change in worksite of the Employee or the Employee's Dependent, the reduction or increase in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or commencement or return from an unpaid leave of absence) of the Employee or the Employee's Dependent and any change in the employment status of an Employee or the Employee's Dependent that results in that person becoming (or ceasing to be) eligible under a plan sponsored by that person's employer;

(d) an event that causes the Employee's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstance;

(e) the change in location of the residence of the Employee or the Employee's Dependent;

(f) for purposes of a Component Plan offering dependent care assistance benefits, an event that changes the number of Qualifying Individuals, as defined in Section 6.1(m)(v);

(g) for any election that is not accomplished on a pre-tax basis, any other event that, in the Administrator's sole discretion, qualifies as a Status Change.

ARTICLE 2
ELIGIBILITY AND PARTICIPATION

2.1 PARTICIPATION.

(a) Except as provided in Section 2.1(b), each Employee other than a Section 4980H Employee is eligible to participate in the Plan beginning on the later of the Effective Date or his or her "Participation Date," which will be the first day of the month coincident with or next following the date the Employee becomes an Employee. However, individual Component Plans may impose different or additional eligibility and participation requirements as provided in each Component Plan.

Each Employee will become a Participant on his or her "Participation Date", provided that the Employee completes and submits an Election Form on or before that date, or is deemed to be enrolled in the Plan pursuant to Section 3.3(b) and provided further that the Employee is an active Employee on both the Participation Date and the date the Election Form is submitted, as determined by the Employer. If an Employee does not become a Participant on his or her "Participation Date", the Employee will become a Participant on the first day of a Plan Year following his or her completion and submission of an Election Form during an annual enrollment period under Section 3.4 or, if applicable, the date of coverage resulting from an election pursuant to Section 3.5; provided, however, that, except for Component Plans providing medical coverage, any Employee who does not become a Participant on the earliest possible date under the Plan, and his or her Dependents, may be required by the Employer, at his or her own expense, to submit such proof of good health as the Employer, in its discretion, may require before the Participant or Dependent, as applicable, commences participation in the Plan. The Dependents of a Participant are eligible for benefits under the Plan through and only through the Participant.

This paragraph applies only for purposes of Component Plans providing health benefits that are subject to the Health Insurance Portability and Accountability Act of 1996. For purposes of satisfying the Plan's continuous employment requirement (as described in this

Section 2.1), if an Employee is absent from work because of a health condition, any service performed immediately before that absence (and not interrupted by any other type of absence) will apply toward the continuous employment requirement and will be added to any service completed (and not interrupted by any other type of absence) after the absence due to health condition ends. Also, for purposes of the Plan's requirement that an Employee be an active Employee on his or her Participation Date to become a Participant, an Employee who has commenced employment but who is absent from work on his or her Participation Date because of a health condition, will be treated as an active Employee on that date.

Notwithstanding any other provision of this Plan, no person may participate in the Plan's Code §125 cafeteria plan feature at any time when he or she does not qualify as an employee of the employer (as determined by the Employer in accordance with Code §125(d)(1)(A) and other applicable guidance).

(b) Participation by Section 4980H Employees. A Section 4980H Employee is eligible to participate in the Plan's medical/prescription drug benefits, beginning on the later of (i) the Effective Date or (ii) the first day of the applicable Stability Period following a determination that the Employee is a Section 4980H Employee based on Hours of Service credited during the Measurement Period that corresponds to that Stability Period.

An employee is a Section 4980H Employee for a Stability Period only if the Employer determines that he or she was credited with an average of at least 130 Hours of Service per month during the applicable Measurement Period. Notwithstanding the preceding sentence, for any period after the last day of a New Employee's Initial Stability Period and before the start of the first Standard Stability Period that applies to that employee (i.e., the first Standard Stability Period that begins after the employee has completed his or her first Standard Measurement Period), a New Employee who is a Section 4980H Employee during his or her Initial Stability Period will continue to be a Section 4980H Employee.

For purposes of computing average Hours of Service for an employee during any Measurement Period, any portion of that Measurement Period that qualifies as "special unpaid leave" will be disregarded. For purposes of this paragraph, "special unpaid leave" means unpaid leave for jury duty, unpaid leave that is subject to the Family and Medical Leave Act of 1993, or unpaid leave that is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994.

Solely for purposes of computing average Hours of Service for a continuing employee during any Measurement Period that includes any portion of an "employment break period", a preliminary average will first be determined by disregarding the employment break period. The Employee will then be credited with additional Hours of Service equal to the lesser of (i) 501 Hours of Service or (ii) the number of Hours of Service that would be needed for the employee's average for the entire Measurement Period (disregarding special unpaid leave as defined in the preceding paragraph) to be equal to the preliminary average. The employee's final average, which will be used to determine if the employee is a Section 4980H Employee, will then be determined by dividing the total Hours of Service credited by the length of the Measurement Period (disregarding special unpaid leave).

A Section 4980H Employee's Participation Date is the later of the Effective Date or the date he or she becomes a Section 4980H Employee (including becoming a Section 4980H Employee again for an individual who has ceased to be a Section 4980H Employee at any

time).

For employees paid on a weekly, biweekly. or semi-monthly basis, the determination of Hours of Service credited for a Measurement Period is made over the period that begins with the first day of the pay period that includes the first day of the Measurement Period and ends with the last day of the last pay period that ends on or before the last day of that Measurement Period.

(c) Hours of Service Rules. Notwithstanding any provision of this Plan to the contrary, the rules described in this Section 2.1(c) will apply for purposes of calculating an individual's Hours of Service for purposes of Section 2.1(b).

Except as otherwise provided in this Section 2.1(c), for any period when an individual is not compensated by the Employer on an hourly basis, Hours of Service will be determined based on one of the following methods for each calendar year: (i) the individual will be credited with actual Hours of Service worked plus any other Hours of Service for which payment is made or due, (ii) the individual will be credited with exactly eight Hours of Service for each day for which he or she otherwise would be credited with at least one Hour of Service, regardless of how many Hours of Service would otherwise be credited or (iii) the individual will be credited with exactly 40 Hours of Service for each week for which he or she otherwise would be credited with at least one Hour of Service, regardless of how many Hours of Service would otherwise be credited. Notwithstanding the preceding sentence, the methods described in clause (ii) or clause (iii) of the preceding sentence will not be used for any calendar year or for any category of employee, if the result of using that method would be to substantially understate the individual's Hours of Service in a manner that would cause him or her not to be treated as a Section 4980H Employee.

The Administrator may change the method of calculating Hours of Service for non-hourly employees (or for one or more categories of non-hourly employees) for any calendar year to use a different method than the method that applied for a previous calendar year.

For individuals who are adjunct faculty employees of the Employer (or similar employees in other positions that raise analogous issues for purposes of computing Hours of Service, as determined by the Employer), the Administrator will calculate Hours of Service using a reasonable method that is consistent with Code Section 4980H (as determined by the Administrator in accordance with any applicable guidance). As one reasonable method, the Administrator may elect to credit such employees with 2.25 Hours of Service per week for each hour of scheduled classroom teaching (for teaching time, plus class preparation time and time for grading) plus one Hour of Service per week for each additional hour spent outside of the classroom for other required purposes (e.g., required office hours or required attendance at faculty meetings).

2.2 TERMINATION OF PARTICIPATION.

(a) Termination of Coverage for Participants. Except as otherwise provided under Section 2.2(c), a Participant's participation in the Plan terminates on the earliest of the following dates (or, if later, the date described in Section 2.2(a)(iii), if applicable):

(i) The day the Participant terminates employment.

(ii) The day the Participant ceases to qualify as an Employee.

(iii) For any coverage requiring Participant contributions, if those contributions are discontinued, the last day of the period for which such contributions are paid.

(iv) The day the Participant reports for active duty as a member of the armed forces of any country.

(v) The day all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.

(b) Termination of Coverage for Dependents. Except as otherwise provided under Section 2.2(c), a Dependent's participation in the Plan terminates on the earliest of the following dates (or, if later, the date described in Section 2.2(b)(iii), if applicable):

(i) The day the Participant terminates employment.

(ii) The day the Participant ceases to qualify as an Employee.

(iii) For any coverage requiring Participant contributions, if those contributions are discontinued, the last day of the period for which such contributions are paid.

(iv) The day the Dependent (other than a Dependent described in Section 1.8(a)(ii), for purposes of coverage for which Section 1.8(a)(ii) applies) reports for active duty as a member of the armed forces of any country.

(v) The day all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan, by exclusion of the applicable benefits, or all benefits, as to Dependents, or by discontinuation of contributions by the Employer.

(vi) The day the Dependent ceases to be a Dependent.

(c) Exceptions. If a Participant takes a leave of absence from employment with the Employer for "service in the uniformed services" as defined in §4303(13) of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), he or she (and any eligible covered Dependent, if applicable) may elect to continue to participate in the Plan's health benefits to the extent required by USERRA §4303(7). A Participant will be required to pay for such USERRA continuation coverage in an amount determined under USERRA §4317(a)(1)(B). USERRA Continuation coverage for such a Participant and his or her Dependents, will end on the earlier of: (1) to the extent permitted by USERRA, the date coverage would terminate under Section 2.2(a) or Section 2.2(b) for a reason other than the Participant's military leave; (2) the last day of the 24-month period that starts on the day the Participant's absence begins; or (3) the day the Participant reaches (and fails to satisfy) the applicable deadline under USERRA §4312(e) for timely applying for or returning to a position of employment with the Employer. Notwithstanding the preceding, USERRA continuation coverage under any group health plan that would otherwise terminate earlier than the last day of the month based on events described in items (2) or (3) of the preceding sentence may instead be terminated on the last day of the month in which that event occurs, if such group health coverage usually terminates only on the last day of a month following other termination events (as determined by the Employer).

If a Participant or a Dependent is eligible for and elects continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or any similar state law, he or she will remain a participant for purposes of any Component Plan under which continuation coverage is elected while that continuation coverage remains in effect, as determined by the Administrator pursuant to applicable law.

Benefits will be made available during certain periods of leave in accordance with the applicable requirements of the Family and Medical Leave Act of 1993 and any similar applicable state law.

If a Participant is on an approved leave of absence, coverage will not terminate because of the leave of absence as long as the Participant pays his or her required contributions on time (as determined by the Employer). Such an approved leave of absence can last up to one year. If the Participant does not return to work or fails to pay any required contributions on time, coverage will be terminated, subject to any COBRA rights or any other provision of this Plan that may provide for continued coverage. Continuation under this provision is dependent upon the Employee's compliance with all reasonable requests for documentation of his or her status.

Notwithstanding anything in this Section 2.2, the provisions in Section 2.1 may require continued coverage under certain Benefits with respect to a Participant during a period of approved leave if he or she is in a Stability Period. If those other provisions are more generous than the provisions of the previous paragraph, those other provisions will prevail

2.3 ELIGIBILITY OF FORMER PARTICIPANTS. For purposes of Section 2.1, if a former Participant once again becomes an eligible Employee for purposes of any Component Plan, his or her Participation Date for purposes of that Component Plan will be determined under Section 2.1 without regard to any previous period of employment (except to the extent that the previous period is relevant to determining status as a 4980H Employee).

Notwithstanding the preceding, a former Participant who again becomes an eligible Employee within 30 days after he or she ceased to be a Participant (because of termination of employment, reduction in hours or for any other reason) and during the same Plan Year may not make a new Code §125 pre-tax salary reduction election until the election period for the next Plan Year, except (i) to the extent that an earlier election change is permitted under Section 3.5 (because of some event other than the termination (or other loss of eligibility) and subsequent return to eligible status) or (ii) to the extent that an election change would have been permitted during an election period that occurred pursuant to Section 3.4 during the period beginning with the Employee's termination of employment or other loss of eligibility and ending on the date he or she again became an eligible Employee.

ARTICLE 3
ELECTION OF BENEFITS

3.1 ELECTION OF BENEFITS: IN GENERAL. An Employee may elect, on his or her Election Form and in accordance with the following provisions of this Article, any one or more of the Benefits available under Article 6.

3.2 ELECTION FORM. An Employee's Election Form shall contain such information as the Administrator may deem appropriate.

3.3 INITIAL ELECTION PERIOD.

(a) In General. An Employee who becomes eligible to become a Participant must complete, sign and file an initial Election Form with the Administrator during the period preceding his or her Participation Date that is identified by the Administrator as the Employee's initial "enrollment period" to enroll during his or her initial coverage period. Such an Employee's initial coverage period is the period beginning on his or her Participation Date and ending on the last day of the Plan Year in which falls the Participation Date. The elections made by the Employee on this initial Election Form shall be effective, subject to Section 2.2, for the period beginning on the Participant's Participation Date and ending on the last day of the Plan Year during which the Participant changes his or her initial elections pursuant to Section 3.4 or Section 3.5; provided, however, that an Employee's initial election of coverage under a health care flexible spending account or dependent care flexible spending account or to contribute to a health savings account will expire no later than the end of the initial Plan Year for which the initial election applies.

(b) Employees Who Fail to File an Initial Election Form. An eligible Employee who fails to complete, sign and file an Election Form with the Administrator in accordance with Section 3.3(a) above before his or her initial coverage period will automatically receive Employer-paid employee assistance plan (EAP), long term disability, and life insurance/accidental death & dismemberment coverage, but will not automatically participate in any other portion of the Plan.

3.4 ELECTION PERIODS AFTER INITIAL ELECTION PERIOD. A Participant's initial elections shall continue indefinitely, subject to Sections 2.2 and 3.5. Notwithstanding the preceding, a Participant may change his or her initial elections for any subsequent Plan Year by requesting, completing and submitting a new Election Form for the applicable Plan Year during the period preceding the applicable Plan Year that is identified by the Administrator as the Plan's annual "election period". The elections made by the Participant on each such Election Form shall be effective, subject to Sections 2.2 and 3.5, beginning on the first day of the Plan Year following the applicable election period and continuing until such elections are changed pursuant to this Section. Notwithstanding the preceding, coverage under any Component Plan for which the Employee becomes ineligible will not remain in effect beyond the date on which the Employee becomes ineligible under that Component Plan. If a Participant fails to complete and submit an Election Form during the Plan's annual "election period", he or she will be deemed to have elected the same Benefits and coverage then in effect for that Participant, at the cost determined by the Employer; provided, however, that the Employee shall not be deemed to have elected any coverage under a health care flexible spending account or dependent care flexible spending account or to contribute to a health savings account.

Notwithstanding any provision of the Plan to the contrary, within a reasonable time before the start of a new Plan Year, the Employer may announce and provide for a special mandatory election period for the following Plan Year. In such cases, a Participant's current elections based on a previous Election Form will expire at the end of the current Plan Year and an eligible Employee who fails to submit a valid Election Form during the mandatory election period will not be deemed to have elected any coverage under the Plan (except for Employer-provided coverage under a Component Plan, if any, for which no affirmative election is required under Section 3.3). The elections made by the Participant on his or her Election Form during such a special mandatory election period shall be effective, subject to Sections 2.2 and 3.5, beginning on the first day of the Plan Year following the applicable election period and continuing until such elections are changed pursuant to this Section.

3.5 STATUS CHANGE ELECTIONS; SPECIAL ENROLLMENT; OTHER ELECTION CHANGES.

(a) Status Change Rules. Within 30 days after a Status Change occurs, a Participant may, with the approval of and pursuant to guidelines established by the Administrator, change his or her election of Benefits, and any salary reduction agreement referenced in Section 5.2, in a manner which is Consistent (as defined in Section 3.5(b)) with the Status Change.

With the approval of and pursuant to guidelines established by the Administrator, an Employee who is eligible to become a Participant but has failed to complete an Election Form may become a Participant and file an Election Form within 30 days after a Status Change occurs, provided that the Employee's commencement of participation and election of Benefits is Consistent (as defined in Section 3.5(b)) with the Status Change.

Except as otherwise provided in Section3.5(c), elections made under this Section 3.5 take effect as soon as practicable after the date the eligible Employee has properly filed his or her Election Form and the election has been approved by the Administrator (or on such other date specified by the Administrator), and remain in effect until the earlier of (i) the end of the Plan Year in which the Participant makes an election pursuant to Section 3.4 (or, for elections relating to a health care flexible spending account or a dependent care flexible spending account or a health savings account, the end of the Plan Year in which the election is made), (ii) the date on which the Employee becomes ineligible for coverage under any Component Plan, or (iii) the date the Employee again changes his or her election in accordance with the Plan's procedures. Except for a change permitted under Section 3.5(c)(ii) because of a birth, adoption or placement for adoption, any change permitted by this Section 3.5 to an Employee's salary reduction agreement under Section 5.2 may be made on a prospective basis only and may not be used to pay costs of coverage provided before the effective date of such a change.

(b) "Consistent" Defined. Except as otherwise provided in this Section 3.5(b), an election change is "Consistent" with a Status Change only if the election change is on account of and corresponds with a Status Change that affects the Employee's or the Employee's Dependent's eligibility for coverage under an employer's plan. An election change to decrease or cancel coverage under a Component Plan is not Consistent with a Status Change because of an Employee or a Dependent becoming eligible for coverage under an employer's plan unless the Employee or Dependent actually elects such coverage. In determining whether an election change is Consistent for purposes of the preceding sentence, the Employer may rely on the Employee's certification that alternative coverage has been or will be obtained, unless the Employer has reason to question the accuracy of that certification.

Notwithstanding the above, all election changes by Employees with respect to Component Plans offering group term life insurance or disability coverage that are made upon the occurrence of Status Changes are automatically deemed to be Consistent with those Status Changes. For purposes of the preceding sentence, "disability coverage" means coverage under a Component Plan that provides benefits due to personal injury or sickness, but does not reimburse expenses incurred for medical care. Disability coverage also includes coverage that provides benefits because of the permanent loss or loss of use of a member or function of the body, or because of permanent disfigurement, if such coverage is provided without regard to the period that the Participant is absent from work. Also, all election changes with respect to a Status Change described in Section 1.33(g) (as determined by the Employer) that does not require a change to the

Employee's Salary Reduction Contribution election under Section 5.2 is automatically deemed to be Consistent with that Status Change.

An election change with respect to a dependent care flexible spending account is also Consistent with a Status Change if the election change is on account of and corresponds with a Status Change that affects expenses covered under that Component Plan.

(c) Special Enrollment Rights. This Section 3.5(c) applies notwithstanding any other provision of this Plan to the contrary. For purposes of the remainder of this Section 3.5(c) only, "Plan" refers only to coverage under any Component Plan that offers medical benefits that are subject to Code §9801(f) (as determined by the Administrator). This Section 3.5(c) is included in the Plan to comply with the requirements of Code §9801 and ERISA §701 and any regulations or other authoritative guidance issued pursuant to those provisions and will be construed to provide only those enrollment rights that are required by those provisions, regulations or other authoritative guidance.

The Benefit options available to an Employee under a Component Plan during a Special Enrollment Period will be the same Benefit options that would be available to such an Employee during an initial election period or, if applicable, during an annual election period (but limited to Benefit options that are subject to Code §9801(f)), regardless of whether the Employee or any Dependent was enrolled in a different Benefit option or no coverage under such a Component Plan at the time of the special enrollment election.

Notwithstanding any provision of this Plan to the contrary, for purposes of this Section 3.5(c), "Employee" is defined as described in Section 1.11, except that "Employee" does not include any person who is not, at the applicable time, a current employee of the Employer (as determined by the Employer).

For purposes of all Special Enrollment Periods described in this Section 3.5(c), if that period would otherwise begin or end during the Outbreak Period, days occurring during the Outbreak Period will be ignored. In determining if a Special Enrollment Period has ended, the Administrator will count days before the Outbreak Period, if any, and days beginning after the end of the Outbreak Period, but days occurring during the Outbreak Period will not be counted. An election of coverage may be made at any time during the extended Special Enrollment Period, with coverage effective as described in this Section 3.5(c), based on the date of the request for enrollment and the type of Special Enrollment.

(i) Special Enrollment Rights Because of Loss of Alternative Coverage. An Employee or a Dependent who is otherwise eligible for coverage under the Plan (including, for an Employee's Dependent, any requirement that the Employee also be enrolled in the Plan) is eligible to enroll in the Plan during a Special Enrollment Period, as described in this Section 3.5(c)(i), if,

(A) when coverage under the Plan was previously offered (e.g., during an initial enrollment period, a Special Enrollment Period or, if applicable, an open enrollment period), the Employee or Dependent had coverage under another group health plan or health insurance coverage (Alternative Coverage), and

(B) the Employee or the Dependent satisfies one of the following conditions:

(1) the Alternative Coverage is not COBRA continuation coverage and the Alternative Coverage terminates because of a "Loss of Eligibility" (as described later in this Section 3.5(c)(i));

(2) the Alternative Coverage is not COBRA continuation coverage and employer contributions (including contributions by any current or former employer of the Employee or Dependent) toward the Employee's or Dependent's Alternative Coverage terminate; or

(3) the Alternative Coverage is COBRA continuation coverage and the Alternative Coverage terminates because the COBRA continuation coverage is exhausted (as described later in this Section 3.5(c)(i)).

"Loss of Eligibility" includes, but is not limited to, a loss of eligibility because of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment or a reduction in the number of hours of employment. For Alternative Coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "Loss of Eligibility" also includes a loss that occurs because the Employee or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "Loss of Eligibility" occurs if the Alternative Coverage no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent.

"Loss of Eligibility" for purposes of this Section 3.5(c)(i) does not include a loss of coverage because of a failure of the Employee or Dependent to pay for coverage on a timely basis or a loss of coverage for cause (such as for making a fraudulent claim or a misrepresentation of a material fact in connection with the Alternative Coverage).

For purposes of this Section 3.5(c)(i), exhaustion of COBRA coverage occurs when COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or for cause. Exhaustion of COBRA coverage occurs when COBRA coverage ceases because an employer or other responsible party fails to remit premiums on a timely basis. For COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, exhaustion of COBRA coverage also occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available).

If an Employee loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage), the Employee (and each otherwise eligible Dependent) is eligible for special enrollment during the Special Enrollment Period. If a Dependent loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage), only the Employee and any Dependent who loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage) is eligible for special enrollment. In any case, special enrollment rights are subject to any Plan eligibility rules that condition Dependent eligibility on enrollment of the Employee.

An Employee or a Dependent who is eligible for a special

enrollment under this Section 3.5(c)(i) may be enrolled in the Plan, and the Employee may make a corresponding change in a salary reduction agreement under Section 5.2, if any, during the Employee's or Dependent's Special Enrollment Period. The Special Enrollment Period under this Section 3.5(c)(i) ends 30 days after the termination of the Alternative Coverage.

Following an election by an Employee under this Section 3.5(c)(i), the Employee's or Dependent's coverage will become effective no later than the first day of the first month that begins after the Administrator receives an Election Form submitted during the Special Enrollment Period electing coverage for the Employee or Dependent under the Plan. A Special Enrollment Period election will be treated as an initial election of coverage pursuant to Section 3.3 and is subject to all Plan provisions that apply to initial elections, except that coverage begins only as described in this paragraph.

If an Employee declines coverage for the Employee or for any Dependent because the Employee or the Dependent is covered under Alternative Coverage, the Employer may require that the Employee provide a written statement at the time that coverage is declined stating that the Employee is declining coverage under the Plan for the Employee or for a Dependent because the Employee or the Dependent has Alternative Coverage. Notwithstanding any other provision of this Section 3.5(c)(i), if the Employer requires such a written statement and informs the Employee of the requirement (and of the consequences of failing to provide the statement), an Employee who fails to provide such a statement will not be treated as being entitled to a special enrollment right for the Employee or the Dependent under this Section 3.5(c)(i).

(ii) Special Enrollment Rights Following Marriage, Birth or Adoption. Following the marriage of an Employee or a Participant, the birth of a child, or the adoption or placement for adoption of a child, the Employee, the Employee's Dependent or the Participant's Dependent, as applicable, may enroll in the Plan during a Special Enrollment Period, as follows:

(A) An otherwise eligible Employee may enroll himself or herself in the Plan, and make a corresponding change to a salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if an individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

(B) An active Participant may enroll an individual who becomes or is his or her otherwise eligible spouse (as determined under Section 1.8) and make a corresponding change to a salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if either (I) the individual becomes the Participant's spouse or (II) the individual is the Participant's spouse and a child becomes a Dependent of the Participant through birth, adoption or placement for adoption.

(C) An otherwise eligible Employee may elect to enroll in the Plan the Employee and an individual who becomes or is his or her otherwise eligible spouse (as determined under Section 1.8) and make a corresponding change to a salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if (I) the Employee and the individual become married or (II) the Employee and the individual already are married and a child becomes a Dependent of the Employee through birth, adoption or placement for adoption.

(D) An active Participant may enroll an individual in the Plan

and make a corresponding change to a salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if the individual becomes a Dependent of the Participant through marriage, birth, adoption or placement for adoption.

(E) An otherwise eligible Employee may elect to enroll the Employee and an individual who becomes a Dependent of the Employee in the Plan, and make a corresponding change to a salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if the individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

The Special Enrollment Period under this Section 3.5(c)(ii) begins on the date of the marriage, birth, adoption or placement for adoption that gives rise to the Special Enrollment Period (or, if later, on the Participant's Participation Date) and ends 30 days after that date. Following an election during a Special Enrollment Period for coverage under the Plan, the coverage will be effective, (A) for a marriage, on a date specified by the Administrator that is no later than the first day of the first month beginning after the date the Employee submits to the Administrator an Election Form electing coverage for the Employee or Dependent under the Plan, (B) for a Dependent's birth, on the date of birth, and, (C) for a Dependent's adoption or placement for adoption, on the date of the adoption or placement for adoption. A Special Enrollment Period election will be treated as an initial election of coverage pursuant to Section 3.3 with respect to medical coverage or any other coverage that is subject to the special enrollment requirements of Code §9801(f) and is subject to all Plan provisions that apply to initial elections, except that coverage begins only as described in this paragraph.

For purposes of this Section 3.5(c)(ii), "marriage" means a marriage that is recognized as a marriage for purposes of federal law.

(iii) Special Enrollment Rights Relating to Medicaid or CHIP Coverage. To the extent required by Code §9801(f)(3), an Employee or a Dependent who is eligible but not enrolled may enroll in the Plan by requesting enrollment during a Special Enrollment Period described in this Section 3.5(c)(iii) and the Employee may make a corresponding change in a salary reduction agreement under Section 5.2, if any, in either of the following situations:

(A) Termination of Medicaid or CHIP Coverage. The Employee or Dependent was covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan (CHIP) under Title XXI of the Social Security Act and coverage of the Employee or Dependent under that Medicaid or CHIP plan is terminated as a result of loss of eligibility for that coverage.

(B) Eligibility for Financial Assistance under Medicaid or CHIP. The employee or dependent becomes eligible for financial assistance for coverage under the Plan, through a Medicaid plan or a state CHIP plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Special Enrollment Period described in this Section 3.5(c)(iii) is the 60 day period that begins on the date of the termination of coverage described in (A) above or the date the Employee or Dependent is determined by the appropriate government agency to be eligible for the financial assistance described in (B) above. Enrollment that is properly requested during that Special Enrollment Period will become effective no later than the first day of the first month beginning after the date the Employee submits to the Administrator an Election Form

electing coverage for the Employee or Dependent under the Plan or, if applicable, on an earlier date by which coverage the Employer determines coverage must be made effective to comply with Code §9801(f)(3). Enrollment under this Section 3.5(c)(iii) is permitted for each Employee or Dependent who experiences an event described in (A) or (B) above and, if the Employee must be enrolled so such a Dependent may be enrolled, for the Employee as well. Enrollment for any person, other than the Employee, who has not experienced such an event will be permitted under this Section 3.5(c)(iii) only to the extent required by applicable law, as determined by the Employer.

(d) Significant Changes in Cost or Coverage. Any election change permitted under this Section 3.5(d) must be requested, pursuant to procedures established by the Administrator, within 30 days after the date of the event giving rise to the right to make the election change (as determined by the Administrator).

(i) Significant Cost Changes. If the cost payable by an Employee for coverage offered under a Benefit option significantly changes during a Plan Year, as determined by the Employer, the Employee may make corresponding changes to his or her election of Benefits and to a salary reduction agreement under Section 5.2. If the change is an increase in the Employee's cost of that coverage, an Employee who is a Participant may elect to replace his or her coverage with coverage available under another Benefit option, if any, that offers similar coverage, as determined by the Employer, or, if no other similar Benefit option is available, a Participant may drop the coverage. If the change is a decrease in the Employee's cost of coverage under a Benefit option, a Participant or an Employee who is eligible to become a Participant may elect that coverage.

For purposes of the preceding paragraph, a cost increase or decrease means an increase or decrease in the amount of the Employee's cost for a Benefit option regardless of whether the increase or decrease results from an action taken by the Employee or from an action taken by the Employer.

Notwithstanding anything else in this Section 3.5(d)(i), for any change in costs associated with a dependent care flexible spending account, an Employee may not change a salary reduction agreement or election of Benefits if the cost change is imposed by a dependent care provider who, with respect to the Employee, is a parent, grandparent, child, grandchild, brother, sister, niece, nephew, stepparent, stepchild, stepbrother, stepsister, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law or brother-in-law.

(ii) Coverage Changes.

(A) Curtailment Without Loss of Coverage. If a Participant or a Participant's Dependent experiences a significant curtailment of coverage under a Benefit option that is not a loss of coverage (under applicable law, as determined by the Employer), the Participant may elect to revoke his or her election of that Benefit option and, in lieu of that coverage, elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by the Employer, and may make corresponding changes to a salary reduction agreement under Section 5.2. Coverage under a Benefit option is significantly curtailed only if there is an overall reduction in coverage that constitutes reduced coverage to Participants generally, as determined by the Employer.

(B) Loss of Coverage. If a Participant or a Participant's

Dependent experiences a significant curtailment of coverage under a Benefit option that is a loss of coverage (under applicable law, as determined by the Employer), the Participant may elect to revoke his or her election of that Benefit option and, in lieu of that coverage, elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by the Employer, and may make corresponding changes to a salary reduction agreement under Section 5.2. If no similar coverage is available to replace the Benefit option for which a loss of coverage occurred, a Participant may elect to drop the coverage.

For purposes of this Section 3.5(d)(ii), "loss of coverage" means a complete loss of coverage under a Benefit option and includes, for example, the elimination of a Benefit option, the loss of availability of an HMO option in the area where the Participant or Dependent resides and other similar events, as determined by the Employer. In addition, the Employer, in its discretion, may elect to treat as a loss of coverage any of the following: (1) a substantial decrease in the medical care providers available under the Benefit option; (2) with regard to a specific Participant or Dependent, a reduction in benefits provided under a health plan for a specific type of medical condition or treatment with respect to which the Participant or Dependent is currently in a course of treatment; or (3) any similar fundamental loss of coverage.

(C) Addition of Option. If the Employer adds a new Benefit option or if coverage under an existing Benefit option is significantly improved during a Plan Year, as determined by the Employer, a Participant who elected a Benefit option for the Plan Year that provides similar coverage, as determined by the Employer, may change his or her election of Benefits to replace that Benefit option with the new or improved Benefit option and may make corresponding changes to a salary reduction agreement under Section 5.2, if applicable. Any Participant, or any Employee who is eligible to become a Participant, who did not elect any Benefit option for the Plan Year that provides coverage similar to that offered under a new or improved Benefit option, as determined by the Employer, may change his or her election of Benefits to elect the new or improved Benefit option and may make corresponding changes to a salary reduction agreement under Section 5.2, if applicable.

(iii) Changes Under Another Employer's Plan. A Participant, or an Employee who is eligible to become a Participant, may change his or her election of Benefits and salary reduction agreement under Section 5.2 on account of and corresponding to (A) an election change made under another employer-sponsored plan (including another plan of the Employer), if the change is one that is permitted under that other plan under provisions similar to the provisions in this Section 3.5, or (B) an election change made under another employer-sponsored plan (including another plan of the Employer) that corresponds to a period of coverage that is different from the Plan Year.

(iv) Loss of Other Group Health Coverage. If a Participant, or an Employee who is eligible to become a Participant, or his or her Dependent loses coverage under any group health coverage sponsored by a governmental entity or educational institution, the Participant or Employee may change his or her election of Benefits and salary reduction agreement under Section 5.2 to elect coverage for the affected individual.

Nothing in this Section 3.5(d) shall be construed to permit a change to an Employee's election of Benefits or salary reduction agreement under Section 5.2 with respect to a health care flexible spending account or to permit a change of election with respect to any Component Plan because of cost or coverage changes associated with a health care flexible

spending account sponsored by any employer of an Employee or a Dependent.

(e) Other Election Changes. Any election change permitted under this Section 3.5(e) must be requested, pursuant to procedures established by the Administrator, within 30 days after the date of the event giving rise to the right to make the election change (as determined by the Administrator) or as otherwise provided in this Section 3.5(e).

(i) Judgment, Decree or Order. If an Employee is subject to a judgment, decree or order (Order) resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA §609) that provides for accident or health coverage for the Employee's child, the Employee, or if required by the Order, the Employer or the Administrator, may change the Employee's election of Benefits and salary reduction agreement under Section 5.2, if any, to provide coverage for the child if the Order requires coverage under the Plan. If the Order requires the Employee's spouse, former spouse or another individual to provide coverage for the child, the Employee may change his or her election of Benefits and salary reduction agreement under Section 5.2, if any, to cancel coverage for the child, if the Employee provides adequate proof, as determined by the Administrator, that the coverage required by the Order is actually being provided.

(ii) Medicare/Medicaid Eligibility. If a Participant or a Participant's Dependent who is enrolled in a Component Plan that offers accident or health coverage, becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under §1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Participant may make an election change to cancel or reduce coverage of that Participant, or his or her Dependent, under the Component Plan that offers accident or health coverage, and may change a salary reduction agreement under Section 5.2 accordingly. If an Employee or an Employee's Dependent, who was previously enrolled under Medicare or Medicaid as described in the previous sentence, loses eligibility for such coverage, the Employee may elect coverage for that individual under a Component Plan that offers accident and/or health coverage.

(iii) Family and Medical Leave Act. A Participant taking leave under the Family and Medical Leave Act of 1993 (FMLA) may revoke an existing election of group health coverage and, upon return from FMLA leave, may make other elections concerning group health coverage that are permitted by FMLA. A Participant may make corresponding changes to a salary reduction agreement under Section 5.2 to reflect these special FMLA-permitted changes.

(iv) Health Savings Account Contributions. A Participant who is making Salary Reduction Contributions to a health savings account under the Plan or an Employee who is eligible to make such contributions may make changes to a salary reduction agreement under Section 5.2 to increase, decrease or stop such contributions on at least a monthly basis, subject to reasonable administrative rules and procedures, established by the Administrator. A Participant who ceases to be an eligible individual for purposes of Code §223 may change his or her salary reduction agreement at any time to cease health savings account contributions. Changes in Salary Reduction Contribution elections will become effective on a prospective basis only.

(v) Revoking Medical Coverage Because of Reduction in Hours. If a Participant who has been reasonably expected by the Employer to average at least 30 hours of service per week experiences a change in employment status so that the Employer no longer reasonably expects the Participant to average 30 or more hours per week (as determined by the

Employer), the Participant may change his or her election of Benefits and salary reduction agreement under Section 5.2, if any, to revoke coverage under a Component Plan that provides medical coverage that qualifies as minimum essential coverage under Code §5000A(f)(1) but only if the revocation of coverage corresponds to the intended enrollment of the Participant and all Dependents whose coverage is being revoked in another plan that provides minimum essential coverage with the new coverage to be effective no later than the first day of the second month that begins after the original coverage is revoked. The Plan Administrator may rely on the Participant's reasonable representation that all covered persons whose coverage is to be revoked have enrolled in or will enroll in new minimum essential coverage to be effective no later than the deadline indicated in the previous sentence. This paragraph will be interpreted to be consistent with guidance provided by the Internal Revenue Service in Notice 2014-55 and any applicable guidance, including regulations or proposed regulations that replace or supplement that guidance, as interpreted by the Plan Administrator.

(vi) Revoking Medical Coverage to Enroll in Marketplace Coverage. A Participant who has an enrollment opportunity to enroll in a Qualified Health Plan through an exchange or marketplace established under PPACA §1311 ("Marketplace") may change his or her election of Benefits and salary reduction agreement under Section 5.2, if any, to revoke coverage under a Component Plan that provides medical coverage that qualifies as minimum essential coverage under Code §5000A(f)(1) but only if the revocation corresponds to the intended enrollment in Marketplace coverage by the Participant and all Dependents whose coverage under this Plan is being revoked. A revocation of coverage pursuant to the preceding sentence will be treated as corresponding to enrollment in Marketplace coverage only if the Marketplace coverage (for all covered persons whose coverage would be terminated because of the revocation) is effective no later than the next day after coverage under the Plan would terminate because of the revocation of coverage under this Plan. The Plan Administrator may rely on the Participant's reasonable representation that all covered persons whose coverage is to be revoked have enrolled in or will enroll in Marketplace coverage to be effective no later than the deadline indicated in the previous sentence. This paragraph will be interpreted to be consistent with guidance provided by the Internal Revenue Service in Notice 2014-55 and any applicable guidance, including regulations or proposed regulations that replace or supplement that guidance, as interpreted by the Plan Administrator.

ARTICLE 4
PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS

4.1 PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS. The Employer or Administrator shall maintain records reflecting a Participant Account for each Participant. The Participant Account shall be divided into sub-accounts (Benefit Accounts) for each Benefit elected by the Participant.

4.2 CREDITING AND ALLOCATING ACCOUNTS. Amounts shall be credited to Participant Accounts as provided in Sections 5.1 and 5.2, and allocated to Benefit Accounts as provided in Section 5.3.

4.3 DEBITING OF ACCOUNTS. Benefit Accounts shall be debited as provided in Section 5.3.

4.4 ACCOUNTS AS BOOK ENTRIES ONLY. Participant Accounts and Benefit Accounts shall be maintained by the Employer and/or the Administrator as entries on its books.

No money shall actually be paid into any Participant Account or Benefit Account. No assets or funds shall be paid to, held in or invested in any separate trust.

No interest will be credited to or paid on amounts credited to any Participant Account or Benefit Account.

ARTICLE 5
CREDITS AND DEBITS TO ACCOUNTS

5.1 BENEFIT CREDITS. On the first day of each period, as designated by the Employer and following a Participant's Participation Date, his or her Participant Account on such date shall be credited with an amount equal to the appropriate Benefit Credits, if any (as determined by the Employer), allocable to that Participant for that period.

5.2 SALARY REDUCTION CONTRIBUTIONS. During the applicable election period determined under Article 3, a Participant may enter into a salary reduction agreement with the Employer which directs that the Participant's compensation for the period to which the election relates shall be reduced each payroll period and that the amount of such reduction will be credited to the Participant's Participant Account. For Participants who are eligible to participate in the Plan's Code §125 cafeteria plan feature, Salary Reduction Contributions will be made on a pre-tax basis to the extent permitted under Code §125 (as determined by the Employer) and only from compensation that would otherwise be payable to the Participant as an employee (within the meaning of Code §125(d)(1)(A)). For certain Benefits and to the extent permitted by the Employer, a Participant may make contributions on an after-tax basis and that amount will be credited to his or her Participant Account.

Except as otherwise provided in this Plan or a Component Plan, a Participant's pre-tax Salary Reduction Contributions for any period will be limited only by the amount of compensation payable to the Participant as an employee for that period (or the total participant cost of pre-tax benefits elected by the Participant, if less). For purposes of the preceding sentence, "employee" has the same meaning that applies for purposes of Code §125(d)(1)(A). Notwithstanding the preceding, the elected salary reduction, as applicable to any Participant, is subject to reduction by the Administrator to the extent deemed necessary by the Administrator to avoid the Plan being discriminatory for purposes of Code §125.

Pre-tax Salary Reduction Contributions will be deducted from a Participant's pay on a uniform basis throughout the applicable Plan Year or other period of coverage, with deductions made for each pay period or some other interval that is specified by the Employer. Pre-tax Salary Reduction Contributions deducted from a Participant's compensation during a Plan Year may not be used to pay for coverage or benefits provided during a later Plan Year except to the extent permitted under applicable regulations issued under Code §125. As permitted by applicable regulations, in accordance with uniform and consistent administrative and payroll procedures, Salary Reduction Contributions deducted from a Participant's compensation during the last month of a Plan Year may be used to pay for health or accident coverage provided during the first month of the next Plan Year.

A Participant's elected Salary Reduction Contribution for coverage under a Component Plan is subject at all times to the Employer's right to automatically increase or decrease the amount of a Participant's contribution to correspond to a change in the amount that a Participant

is required to pay for coverage under that Component Plan. Any automatic changes made based on the preceding sentence will apply prospectively only but otherwise may become effective on any date determined by the Employer. Such automatic changes will be made only on a reasonable and consistent basis.

For purposes of any health care flexible spending account Component Plan, for a Participant whose coverage under the Health FSA terminates before the end of a Plan Year, any amount that the Employee contributed to the Health FSA that the Employer determines would otherwise apply to pay for coverage for the period after the Participant ceases to be a Participant, will be refunded by the Employer to the Participant as taxable compensation.

Except as otherwise expressly permitted under the Plan and applicable law, a Participant who is not an active Employee shall make contributions on an after-tax basis. Also, any contributions made by or on behalf of a Participant to pay for coverage for any Dependent who is not a Code Section 152 dependent (as defined in Section 1.8), spouse (as determined for purposes of federal law) or child (as defined in the next sentence) of the Participant will be made on an after-tax basis or, if the Employer in its discretion and in accordance with uniform and consistent administrative procedures, permits such contributions to be made on a pre-tax basis, will be treated as resulting in imputed income for the Participant, to the extent required under applicable law. For purposes of the preceding sentence, "child" means any individual who qualifies as a child of the Participant under Code §152(f)(1) who will not reach age 27 before the end of the Participant's tax year.

5.3 ALLOCATIONS TO AND DEBITING OF BENEFIT ACCOUNTS. Amounts credited to a Participant's Participant Account shall be allocated, on the date credited, to the Benefit Accounts of the Participant. Such allocation shall be made pursuant to the election made by the Participant in accordance with Section 6.1. However, in no event may an amount in excess of the total amount credited to a Participant's Participant Account be credited to the Participant's Benefit Accounts. All payments of Benefit amounts under the Plan shall be debited against the appropriate Benefit Account.

5.4 CHANGES DURING PLAN YEAR. Except as provided in Sections 3.5 or 5.2 and to the extent permitted under applicable law, a Participant shall not change (a) amounts to be credited to a Participant Account during a Plan Year pursuant to Sections 5.1 or 5.2 or (b) the allocation of such amounts to Benefit Accounts during the Plan Year pursuant to Section 5.3.

ARTICLE 6
BENEFITS

6.1 AVAILABLE BENEFIT ELECTIONS. The benefits available for election pursuant to Article 3 shall be those provided through the Component Plans. The Participant cost of the Benefits will be determined by the Employer, and will be communicated to Participants from time to time.

Pursuant to a Participant's election of a Benefit provided under a Component Plan, the compensation of the Participant will be reduced by the amount necessary to provide that Benefit, and the Employer shall credit the amount of the salary reduction to the Component Plan on behalf of the Participant.

The Plan's Benefit options are as follows:

(a) Medical/Prescription Drug Coverage. Each eligible Participant may elect on his or her Election Form to have sufficient Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her Medical/Prescription Drug Coverage Account for one of the medical coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix).

(b) Dental Coverage. Each eligible Participant one of the dental coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix).

(c) Vision Coverage. Each eligible Participant may elect on his or her Election Form to have sufficient Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her Vision Coverage Account for one of the vision coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix).

(d) Basic Life Insurance/AD&D Coverage. Each eligible Participant will receive Employer-provided life insurance/AD&D coverage under one of the life insurance/accidental death & dismemberment (AD&D) coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix).

(e) Supplemental Life Insurance and/or AD&D Coverage. Each eligible Participant may elect on his or her Election Form to have sufficient after-tax Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her Supplemental Life Insurance and/or AD&D Coverage Account for one of the supplemental life insurance and/or accidental death & dismemberment (AD&D) coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix).

(f) Spouse Life Insurance and/or AD&D Coverage. Each eligible Participant may elect on his or her Election Form to have after-tax Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her Spouse Life Insurance Coverage and/or AD&D Account for one of the spouse life insurance coverage and/or AD&D options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix). Spouse life insurance is not offered under the Code §125 feature of the Plan.

(g) Dependent Life Insurance and/or AD&D Coverage. Each eligible Participant may elect on his or her Election Form to have after-tax Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her Dependent Life Insurance and/or AD&D Coverage Account for one of the dependent life insurance and/or accidental death & dismemberment (AD&D) coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix). Dependent life insurance is not offered under the Code §125 feature of the Plan.

(h) Long Term Disability Coverage. Each eligible Participant will receive Employer-provided long term disability coverage under one of the long term disability coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix).

(i) Short Term Disability Coverage. Each eligible Participant may elect on his

or her Election Form to have sufficient Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her Short Term Disability Coverage Account for one of the short term disability coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix).

(j) Employee Assistance Program. Each eligible Participant will receive Employer-provided employee assistance program coverage (as described in the Component Plan included in the Appendix).

(k) Health Savings Account. Each eligible Participant who participates in a High Deductible Health Plan (as defined in Code §223(c)(2)) offered under the Plan and who qualifies as an "eligible individual" for purposes of Code §223(c)(1) may elect on his or her Election Form to have sufficient Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her health savings account. A Participant is eligible to make Salary Reduction Contributions or Benefit Credit contributions to a health savings account only with respect to months during which the Participant is an "eligible individual" for purposes of Code §223(c)(1). The total amount credited to an Employee's health savings account through Employer contributions or Employee Salary Reduction or Benefit Credit contributions for a calendar year may not exceed the applicable limit that applies under Code §223. The Employer may limit contributions to a Participant's health savings account as needed to ensure that the applicable limit is not exceeded, but the Employer is not responsible for monitoring contributions that are made to a Participant's health savings account from outside the Plan. All contributions to a health savings account become the property of the Participant in accordance with applicable law. A Participant's health savings account that is funded through this Plan is not a Component Plan and is not an employee benefit plan for purposes of ERISA.

(l) Health Care Flexible Spending Account. Each eligible Participant may elect on his or her Election Form to have Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her health care flexible spending account (Health FSA) according to guidelines established by the Administrator. The amount of Benefit Credits, if any, and Salary Reduction Contributions that may be credited to a Participant's Health FSA for a Plan Year shall be no greater than the limit that applies under Code §125(i) (as adjusted pursuant to Code §125(i)(2) for the applicable Plan Year (e.g., $3,050 for the Plan Year beginning in 2023), unless a lower limit is announced prior to the beginning of the Plan Year.

The Plan offers both general-purpose and HSA-compatible, limited-purpose Health FSAs. Notwithstanding any provision of this Plan to the contrary, an eligible Participant who is participating in a general purpose Health FSA is not eligible to make or to be credited with health savings account contributions under the Plan for any month when he or she is considered a participant in a general purpose Health FSA, except to the extent, if any, permitted under applicable regulations and other authoritative guidance. A Participant is eligible to elect to participate in a limited-purpose Health FSA for a Plan Year only if he or she has also elected coverage under a high deductible health plan for the same Plan Year.

Payments from a Health FSA will be made to the Participant as a reimbursement for health-related expenses incurred by the Participant or his or her spouse (determined under federal law) or any person who is a dependent of the Participant under Code §152 (as modified for purposes of Code §105(b)) or any child of the Participant who will be 26 years of age or younger on the last day of the calendar year, that:

(i) Are not covered, paid or reimbursed under any other health plan coverage;

(ii) Qualify as expenses for "medical care" (as defined in Code §213(d)), including expenses that qualify as "medicine and drugs" (whether or not requiring a prescription) within the meaning of Treasury Regulations §1.213-1(e)(2), but only if the medicine or drug is prescribed by a qualified provider (regardless of whether the medicine or drug is available without a prescription) or is insulin) or as expenses incurred for menstrual care products (as defined in Code §223(d)(2)(D));

(iii) Qualify as reimbursable medical expenses under Code §125; and

(iv) Are not taken as a deduction from income on the Participant's federal income tax return in any tax year.

In addition to the above requirements, payments from a Participant's limited-purpose Health FSA will be made only for expenses that qualify for reimbursement under a limited-purpose health care flexible spending account pursuant to applicable IRS regulations and other authoritative guidance, such as vision care, dental care or preventive care (as defined for purposes of Code §223(c)(2)(C)) or other benefits that may be provided to the Participant without affecting his or her status as an "eligible individual" for purposes of an HSA (as defined in Code §223(c)(1).

Notwithstanding any provision of the Plan to the contrary, to the extent permitted under applicable regulations issued under Code §125, otherwise eligible expenses for orthodontia services that are paid before the services are provided will be treated as incurred at the time that the payment is actually made but only to the extent that the Participant is required to make the advance payment to receive the services.

Any Participant (or former Participant) who wishes to receive a reimbursement from his or her Health FSA must submit to the Administrator a request for reimbursement on a form provided by the Administrator, along with such evidence as the Administrator requires regarding the amount, nature and payment of such reimbursement. The Administrator may establish reasonable rules regarding the minimum amount of eligible expenses that must be submitted for reimbursement to be made under the Plan. Unless the Administrator designates a later date, requests for reimbursement must be submitted by 5.5 months after the earlier of (1) the end of the Plan Year or (2) the date the Participant ceases to be a Participant for purposes of the Health FSA. If the time period for submitting claims, as described in the previous sentence includes any day of the Outbreak Period, the time period for submitting claims (as calculated as a number of days from the Participant's termination of eligibility or the end of a Grace Period) is determined without counting the number of days in the Outbreak Period.)

Requests from a Participant (or former Participant) for reimbursement of eligible expenses that exceed the accrued balance in his or her Health FSA will be paid at any time during the Plan Year upon submission of satisfactory documentation of the expense, but only up to the maximum annual amount elected by the Participant for the Plan Year, notwithstanding that the Participant's Health FSA has not been credited with sufficient Salary Reduction Contributions to cover the reimbursement. Any amount remaining in a Participant's Health FSA after the deadline for reimbursement requests for the applicable Plan Year and after all properly submitted reimbursement requests have been paid will be forfeited.

For purposes of this Section 6.1(l), the "Grace Period" for a Plan Year is the two and one-half month period that begins on the day following the last day of the Plan Year. Notwithstanding the preceding, expenses incurred during the Grace Period for a Plan Year are reimbursable only if the Participant is a Participant in the Health FSA, including participation as a result of a COBRA election, on the last day of the Plan Year. If a Participant's participation in the Health FSA ends before the end of the Plan Year, there is no Grace Period.

The Administrator may permit Participants to use a debit card to pay for eligible expenses that may be reimbursed from the Participant's Health FSA. If so, before any Participant receives a debit card, the Participant must agree in writing that he or she will use the card only to pay for eligible medical expenses (as defined in Code §213(d)) of the Participant, his or her spouse or dependents, that he or she will not use the debit card for any medical expense that has already been reimbursed, that he or she will not seek reimbursement under any other health plan for any expense paid with a debit card, and that he or she will acquire and retain sufficient documentation (including invoices and receipts) for any expense paid with the debit card. The debit card will include an appropriate statement indicating that, by using the card, the Participant agrees that the card will be used only in accordance with the restrictions described in the previous sentence. In addition, the Plan will comply with all applicable regulations and other authoritative guidance regarding the use of debit cards for Health FSA reimbursements, including substantiation requirements.

(m) Dependent Care Flexible Spending Account. Each eligible Participant may elect on his or her Election Form to have Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 in an aggregate amount not to exceed $5,000 per calendar year (or, for a married Participant filing a separate return for the calendar year in question, $2,500 per calendar year) credited to the Participant's dependent care flexible spending account (Dependent Care FSA) according to guidelines established by the Administrator. Payments from this Account shall be made to the Participant in the form of an Employer-provided payment in accordance with the following provisions which the Employer intends will be interpreted in a manner which is consistent with Code §129.

(i) A Participant (or former Participant) is eligible to receive reimbursement for Employment Related Expenses (as defined below) incurred during the applicable Plan Year (or during the Grace Period for the Plan Year) and while he or she is a Participant for purposes of the Dependent Care FSA.

(ii) The aggregate amount of reimbursements from the Dependent Care FSA which may be received by the Participant (or former Participant) on a tax-free basis shall not exceed the Earned Income (as defined below) of the Participant, or, if the Participant is married at the end of the Participant's applicable tax year, the Earned Income of the Participant's spouse, if less. Any amount of reimbursement received from the Dependent Care FSA during the Participant's tax year that exceeds the lesser of the Earned Income of the Participant or, if the Participant is married at the end of that tax year, the Earned Income of the Participant's spouse, shall be taxable to the Participant.

For purposes of this subsection, "Earned Income" means wages, salaries, tips and other employee compensation, including net earnings from self-employment, for the tax year of the Participant (computed without regard to any community property laws), and excluding pension and annuity income and income as a non-resident alien not connected with a United States

business. The Earned Income of a spouse who is a full-time student at an educational institution or who is physically or mentally incapable of self-care is deemed to be not less than $250 per month if there is one Qualifying Individual (as defined below) or $500 per month if there are two or more Qualifying Individuals.

(iii) For purposes of this Section, "Employment Related Expenses" for which reimbursement may be made from the Dependent Care FSA are amounts paid by the Participant for:

(A) expenses for Household Services (as defined below); and

(B) expenses for the care of a Qualifying Individual;

so long as such expenses are incurred to enable the Participant or the Participant's spouse to be gainfully employed for a period for which there is at least one Qualifying Individual with respect to the Participant.

(iv) For purposes of this Section, "Household Services" means ordinary and usual services necessary for the maintenance of the Participant's home performed in and about the home and which are attributable in part to the care of a Qualifying Individual, as more fully defined by applicable law.

(v) For purposes of this Section, "Qualifying Individual" means:

(A) a Participant's dependent who is a "qualifying child" (within the meaning of Code §152) under the age of 13, or

(B) a dependent (within the meaning of Code §152, as it applies for purposes of a dependent care assistance program described in Code §129) or spouse (determined under federal law) of the Participant who is physically or mentally incapable of self-care and who has the same principal place of abode as the taxpayer for more than one-half of the applicable tax year of the Participant. An individual is physically or mentally incapable of self-care if, because of a physical or mental defect, he or she is incapable of caring for his or her own hygiene or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others. The inability of an individual to engage in any substantial gainful activity or to perform the normal household functions of a homemaker or to care for minor children does not by itself establish that the individual is physically or mentally incapable of self-care.

Notwithstanding any provision of this Plan to the contrary, "Qualifying Individual" at all times shall be interpreted to have the same meaning as that term has under Code §21(b)(1), as it applies for purposes of a dependent care assistance program described in Code §129.

(vi) Employment Related Expenses that are incurred for services outside the Participant's household will be entitled to reimbursement only:

(A) if incurred for the care of (i) a Qualifying Individual who is a "qualifying child" (within the meaning of Code §152) under 13 years of age, or (ii) another Qualifying Individual who regularly spends at least eight hours each day in the Participant's household; or

(B) if incurred for services performed outside the Participant's household by a Dependent Care Center (as defined below), only if such Center complies with the applicable laws and regulations of a state or unit of local government and care is rendered to (i) a Qualifying Individual who is a qualifying child (within the meaning of Code §152) of the Participant under 13 years of age, or (ii) another Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. A "Dependent Care Center" means any facility that (a) provides care for more than six individuals (other than individuals who reside at the facility), and (b) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

(vii) Any provision of the Plan to the contrary notwithstanding, no payments shall be made to a Participant for Employment Related Expenses for services rendered by an individual:

(A) for whom the Participant or his or her spouse (determined under federal law) is entitled to a deduction under Code §151(c) for the applicable tax year of the Participant or spouse, or

(B) who is a son, stepson, daughter, stepdaughter or foster child of the Participant who will be under the age of 19 at the end of the tax year of the Participant during which the services are performed.

(viii) Notwithstanding any provision of the Plan to the contrary, only expenses incurred during the Plan Year (or during the Grace Period for the Plan Year) are subject to reimbursement. In addition, an individual who ceases to be an eligible Participant for purposes of the Dependent Care FSA during a Plan Year may not make any additional contributions to his or her Dependent Care FSA but may continue to be reimbursed for eligible expenses incurred during that Plan Year (or during the Grace Period for that Plan Year) but only until his or her account balance is exhausted.

(ix) Any Participant (or former Participant) who wishes to receive a reimbursement from his or her Dependent Care FSA must submit to the Administrator a request for reimbursement on a form provided by the Administrator, along with such evidence as the Administrator requires regarding the amount, nature and payment of such reimbursement. The amount of any reimbursement may not exceed the remaining amount credited to the Participant's Dependent Care FSA at the time the claim for reimbursement is submitted. Requests from a Participant (or former Participant) for reimbursement of eligible expenses which exceed the accrued balance in the Participant's Dependent Care FSA will be held until the Account has been credited with sufficient amounts to permit such reimbursement, provided that such additional credits are made within the Plan Year in which the expense was incurred. The Administrator may establish reasonable rules regarding the minimum amount of eligible expenses that must be submitted for reimbursement to be made under the Plan. Unless the Administrator designates a later date, requests for reimbursement for expenses incurred during a Plan Year (or a Grace Period for that Plan Year) must be submitted by 5.5 months following the earlier of (1) the end of the Plan Year or (2) the date the Participant ceases to be a Participant for purposes of the Dependent Care FSA.

Any amount remaining in a Participant's Dependent Care FSA after the deadline for reimbursement requests for the applicable Plan Year and after all

properly submitted reimbursement requests have been paid will be forfeited.

(x) On or before each January 31 during which this Plan is in effect, the Administrator shall furnish to each Participant (or former Participant) a written statement, which may be the Participant's W-2, showing the amounts paid or expenses incurred by the Employer in providing dependent care assistance to such Participant during the previous calendar year.

(xi) No amount will be reimbursed to a Participant or former Participant unless he or she provides the Administrator with the name, address and tax identification number of the person performing services or if the service provider is an organization exempt under Code §501(a), the name and address of such service provider. This provision will not apply if the Participant exercises due diligence in attempting to provide this information.

For purposes of this Section 6.1(m), the "Grace Period" for a Plan Year is the two and one-half month period that begins on the day following the last day of the Plan Year. Notwithstanding the preceding, expenses incurred during the Grace Period for a Plan Year are reimbursable only if the Participant is a Participant in the Dependent Care FSA on the last day of the Plan Year. If a Participant's participation in the Dependent Care FSA ends before the end of the Plan Year, there is no Grace Period.

The Administrator may permit Participants to use a debit card to pay for eligible expenses that may be reimbursed from the Participant's Dependent Care FSA. If so, the debit card may be used only to reimburse a Participant for incurred expenses that have been substantiated in accordance with applicable regulations or other authoritative guidance.

6.2 UNUSED BENEFIT CREDITS. Benefit Credits, if any, not otherwise utilized pursuant to this Article will be forfeited to the Employer.

6.3 INSURANCE CONTRACTS. The Employer has the right to enter into contracts with one or more insurance companies for the purpose of providing any Benefits under the Plan and to replace any such insurance company from time to time. If any Benefit is intended to be provided under an insurance contract, a Participant or other covered person may look only to the insurance company for payment of that benefit.

Any amounts payable by an insurance company with respect to or because of a contract entered into by the Employer (other than amounts payable on behalf of a covered person pursuant to a claim covered by the insurance contract), including but not limited to dividends, retroactive rate adjustments, medical loss ratio payments, experience adjustments or refunds of any type or any amount payable by the insurance carrier because of a court judgment, settlement agreement or arbitration decision in response to actual or potential litigation, arbitration or any other dispute between the insurance company and the Employer shall be the property of, and shall be retained by, the Employer, except to the extent, if any, that the Plan Administrator determines that a portion of any such amount is required to be treated as Plan assets under applicable law. To the extent that any portion of such a payment is required to be treated as Plan assets, as determined by the Plan Administrator, that amount will be used to pay reasonable Plan expenses or to provide Benefits or will be used for any other purpose that is consistent with applicable law regarding the use of such assets.

6.4 SOURCE OF BENEFITS. The Employer will pay any Benefits intended to be self-funded from its general assets.

6.5 MAXIMUM CONTRIBUTIONS AND BENEFITS. The maximum amount of contributions and Benefits made available under the Plan to any Participant in any Plan Year shall be limited as provided in the Code.

6.6 QUALIFIED RESERVIST DISTRIBUTIONS. Notwithstanding any provision of this Plan to the contrary, the Plan will permit Qualified Reservist Distributions from health care flexible spending accounts (Health FSA) of eligible Participants in accordance with the provisions of this Section 6.6 and Code §125(h).

A Qualified Reservist Distribution is a distribution, made at the election of the Participant, of all or a portion of a Participant's Unused Balance (as defined in this Section) in his or her Health FSA to a Participant whose service with the Employer is interrupted because the Participant has been ordered or called to active duty as a member of a United States reserve component for a period of one hundred eighty days or longer or for an indefinite period, including a period of active duty that is originally scheduled to be less 180 days but is later extended to a period of 180 days or longer or an indefinite period.

An eligible Participant may request a Qualified Reservist Distribution at any time between the date of the order or call to active duty and the last day of the Grace Period (as described in Section 6.1(l)) for the Plan Year in which the call or order to active duty occurred. Notwithstanding any provision of this Section to the contrary, no Qualified Reservist Distribution may be made before the later of the effective date of this Section 6.6 or the date this Amendment and Restatement of the Plan is formally adopted.

Qualified Reservist Distributions will be available to all Participants in the Plan on a uniform and consistent basis. The Employer may establish uniform and consistent administrative procedures for eligible Participants to request Qualified Reservist Distributions and may require that the Participant provide such evidence, including a copy of the order or call to active duty, as is needed to verify that a Participant is eligible for such a distribution. A Qualified Reservist Distribution will be paid to the eligible Participant within a reasonable time (and no later than 60 days) after the Participant has submitted a proper request for a distribution. A Qualified Reservist Distribution will be treated as taxable compensation to the Participant (except as otherwise provided under applicable law, including to the extent that any portion of the distribution is attributable to after-tax contributions).

If a Participant requests a Qualified Reservist Distribution, any claims for reimbursement from the Participant's Health FSA for eligible medical expenses incurred before the date the Participant requested the Qualified Reservist Distribution will be processed and paid in accordance with the Plan's standard procedures for processing Health FSA claims until the Qualified Reservist Distribution is made. Reimbursements or payments made through the Health FSA for eligible medical expenses during the period between the time a distribution is requested and the date the distribution is made will reduce the amount available for a Qualified Reservist Distribution as described in the definition of Unused Balance below. After a Qualified Reservist Distribution equal to the Participant's entire Unused Balance has been made, the Participant will cease to be a Participant for purposes of the Health FSA for the Plan Year and no further claims will be paid, regardless of the date an expense was incurred.

For purposes of this Section 6.6, an eligible Participant's Unused Balance on any specified date is equal to the total amount actually contributed to the Health Care FSA on behalf

of the Participant for the Plan Year through that date minus any reimbursements paid through the Health Care FSA on behalf of the Participant through that date.

ARTICLE 7
HEALTH INFORMATION PRIVACY AND SECURITY

7.1 SCOPE OF ARTICLE. This Article 7 is intended to provide for the Plan's compliance with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and published as the "Standards for Privacy of Individually Identifiable Health Information" (the Privacy Regulations) and the "Health Insurance Reform: Security Standards" (the Security Regulations) and other applicable guidance, as well as all applicable requirements of Subtitle D of the "Health Information Technology for Economic and Clinical Health Act" (the HITECH Act) and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan.

Each Component Plan that is a group health plan subject to the Privacy and Security Regulations (each of which is referred to separately in this Article as the "Health Plan) will comply with all applicable requirements of the Privacy Regulations, the Security Regulations and Subtitle D of the HITECH Act, as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Privacy and Security Regulations or Subtitle D of the HITECH Act and any provision of this Plan, applicable law will control. Also, any amendment or revision or authoritative guidance relating to the Privacy and Security Regulations or of Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with that guidance.

7.2 PROTECTED HEALTH INFORMATION. For purposes of the Health Plan, "Protected Health Information" has the same meaning as provided for that term in the Privacy Regulations and is limited to information that is Protected Health Information with respect to the Health Plan.

7.3 DISCLOSURES TO EMPLOYER. The Health Plan will disclose Protected Health Information to the Employer only as follows:

(a) Summary Health Information. The Health Plan, or a health insurance issuer or HMO with respect to the Health Plan may disclose Protected Health Information that is summary health information (as defined in §164.504(a) of the Privacy Regulations) to the Employer, if the Employer requests the summary health information for the purpose of:

(i) Obtaining premium bids from insurance issuers for providing health insurance coverage under the Health Plan; or

(ii) Modifying, amending or terminating the Health Plan.

(b) Enrollment Information. The Health Plan, or a health insurance issuer or HMO with respect to the Health Plan, may disclose to the Employer information on whether an individual is participating in the Health Plan, or is enrolled in or has disenrolled from a health option or HMO offered by the Plan.

(c) Other Disclosures to Employer. Except as provided in Sections 7.3(a) and

7.3(b), or under the terms of an applicable individual authorization, the Health Plan may disclose Protected Health Information to the Employer and may permit the disclosure of Protected Health Information by a health insurance issuer or HMO with respect to the Health Plan to the Employer only if the Employer requires the Protected Health Information to administer the Health Plan. The Employer, by signing this Plan document, certifies that it:

(i) will not use or further disclose Protected Health Information other than as permitted by the Health Plan or as required by law;

(ii) will ensure that any agents to whom it provides Protected Health Information received from the Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(iii) will not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(iv) will report to the Health Plan any use or disclosure, of which it becomes aware, of Protected Health Information that is inconsistent with the uses or disclosures permitted under the Plan;

(v) will make Protected Health Information available to the individual who is the subject of that information in accordance with §164.524 of the Privacy Regulations;

(vi) will consider requested amendments to an individual's Protected Health Information in accordance with §164.526 of the Privacy Regulations;

(vii) will make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with §164.528 of the Privacy Regulations;

(viii) will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with the Privacy Regulations;

(ix) if feasible, will return or destroy all Protected Health Information received from the Health Plan that the Employer still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) will ensure that the adequate separation of the Health Plan and the Employer as required in this Article is established.

(d) Prohibited Disclosures. The Health Plan will not disclose Protected Health Information to the Employer for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

7.4 SEPARATION OF HEALTH PLAN AND THE COMPANY. The Employer has

designated and trained certain employees to be the only employees of the Employer who will have access to Protected Health Information on behalf of the Health Plan. Those employees are identified on the attached Schedule A. If there are any changes to the group of employees who are authorized to have access to Protected Health Information on behalf of the Health Plan, Schedule A will be revised to reflect those changes. Any revised Schedule A is incorporated into the Plan as of the effective date of the revision without the need for further amendment to the Plan. Except as otherwise permitted under applicable law and this Plan, employees listed on Schedule A will use or disclose Protected Health Information only to the extent appropriate for performing administrative services that the Employer provides for the Health Plan.

The Employer will work with the Health Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that employees of the Employer who have access to Protected Health Information use that Protected Health Information only for the purposes specified in this Article.

7.5 PRIVACY NOTICE. The Health Plan will comply with the applicable requirements of the Privacy Notice issued by the Plan pursuant to the requirements of the Privacy Regulations and the Plan's Privacy Notice is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Health Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Health Plan as of the effective date of each revision without the need for further amendment of the Plan.

7.6 SECURITY REGULATIONS. The Health Plan will comply with all applicable requirements of the Security Regulations, as provided in this Article and in the Security Regulations and as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Security Regulations and any provision of this Plan, the Security Regulations will control. Also, any amendment or revision or authoritative interpretation of the Security Regulations is incorporated into the Plan on the effective date of that guidance.

In addition, the Employer, by adopting this document, certifies that it will

(i) Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained, or transmitted to or by the Employer on behalf of the Health Plan;

(ii) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Health Plan;

(iii) Ensure that the adequate separation required by §164.504(f)(2)(iii) of the Privacy Regulations is supported by reasonable and appropriate security measures;

(iv) Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect that information; and

(v) Report to the Health Plan any security incident of which it becomes

aware.

7.7 BREACH REPORTING. The Employer will promptly report to the Health Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

ARTICLE 8
ADMINISTRATION

8.1 THE ADMINISTRATOR. Except as to those functions reserved within the Plan or a Component Plan to the Company or an Insurer, the Administrator controls and manages the operation and administration of the Plan and is a "named fiduciary" for purposes of ERISA. The Administrator is the Company or any other person or committee appointed by the Company to administer the Plan. The Administrator or any person who is a member of a committee that is appointed to be the Administrator may or may not be a Participant in the Plan.

8.2 ADMINISTRATIVE RULES AND DETERMINATIONS. Subject to the limitations of the Plan, the Administrator shall establish rules for the administration of the Plan and the transaction of its business. The Administrator has the exclusive right (except as to matters reserved to the Company or an Insurer by the Plan or a Component Plan) to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Administrator or the Company in respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator has the following powers and duties:

(a) To require any person to furnish such information, including, but not limited to, the execution of any agreements, as the Administrator may request for the purpose of the proper administration of the Plan as a condition to receiving any Benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as the Administrator deems necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any employee to participate in the Plan, in accordance with the provisions of the Plan; and

(d) To determine the amount of Benefits which shall be payable to any person in accordance with the provisions of the Plan, to inform the Employer of the amount of such Benefits and to provide a full and fair review to any Participant whose claim for Benefits has been denied in whole or in part.

In carrying out its duties herein, the Administrator shall have discretionary authority to exercise all powers and to make all determinations, including but not limited to discretionary authority to interpret plan provisions and to make all determinations of facts, including factual determinations relating to benefit eligibility, and all determinations that require application of facts to the terms of the Plan, consistent with the terms of the Plan, in all matters entrusted to it, and its determinations shall be given deference and shall be final and binding on all interested parties.

Benefits under the Plan will be paid only if the Administrator decides in its discretion that the applicant is entitled to them. Because of this reservation of discretionary power to Plan fiduciaries, any judicial review of a Plan fiduciary's decision would not be made on a "de novo" basis, but would be made under the deferential "arbitrary and capricious" standard of review described in Firestone v. Bruch, 489 U.S. 101 (1989).

8.3 DELEGATION AND RELIANCE. The Administrator, subject to approval of the Company, may employ the services of such firms or persons as it may deem necessary or desirable in connection with the Plan. The Administrator may delegate any of its powers or duties to another person or persons. Without limiting the generality of the preceding sentence, the Administrator shall specifically have the power to delegate to any Insurer the power and responsibility to determine claims and benefits under any policy issued by such Insurer, and the Administrator shall be protected in relying upon such Insurer's determinations. The Administrator and the Company (and any person to whom the Administrator may delegate any duty or power in connection with the administration of the Plan) and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant (including employees of the Employer who are actuaries or accountants) or legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive upon all persons.

8.4 COMPENSATION, EXPENSES AND BOND. Unless otherwise agreed to by the Company, the Administrator shall serve without compensation for its services as such, but all reasonable expenses incurred in the performance of its duties shall be paid by the Employer. Unless otherwise determined by the Company or unless required by any federal or state law, the Administrator shall not be required to give any bond or other security in any jurisdiction.

8.5 ADMINISTRATIVE EXPENSES PAID BY EMPLOYER. All administrative expenses incurred in connection with the Plan, including but not limited to administrative expenses and compensation and other expenses and charges of any actuary, counsel, accountant, specialist or other person who shall be employed by the Administrator in connection with the Plan, shall be paid by the Employer or from Participant contributions, as determined by the Employer.

ARTICLE 9
CLAIMS PROCEDURES

9.1 CLAIMS PROCEDURES: IN GENERAL. This Article 9 is based on final regulations issued by the Department of Labor and codified at 29 C.F.R. §2560.503-1 and, for any claim involving coverage that is subject to PPACA, the Final Regulations codified at 29 C.F.R. §2590.715-2719 and 26 C.F.R. §54.9815-2719. If any provision of this Article 9 conflicts with the requirements of those regulations, the requirements of those regulations will prevail. For any insured Benefits offered under the Plan, the claims procedures established by the Insurer for that benefit will apply instead of the procedures described in this Article except to the extent those procedures conflict with the requirements of applicable law.

Notwithstanding any provision of this Article to the contrary, for any claim for a benefit under the Plan that is not subject to ERISA, the claims procedures that apply for benefits other than health and disability benefits will apply, except that any requirement to provide notice about any right that may apply under ERISA will not apply to such a claim. Health savings account reimbursement and withdrawal procedures are established by the financial institution that administers the health savings account and are not subject to the requirements of this Article.

For purposes of this Article 9, the term "health benefit" refers to any Benefit offered under a medical, prescription drug, dental, vision, health reimbursement arrangement or health care flexible spending account Component Plan and the term "disability benefit" refers to a benefit under any Component Plan that and is conditioned on a determination of disability by the Plan.

For all benefits that are subject to ERISA, for purposes of all time periods for submitting a claim or requesting an appeal (or external review) of an Adverse Determination described in this Article 9, if that period would otherwise include any day of the Outbreak Period, days occurring during the Outbreak Period will be ignored. In determining if claim or appeal is timely, the Plan will count days before the Outbreak Period, if any, and days beginning after the end of the Outbreak Period, towards the applicable time limit, but days occurring during the Outbreak period will not be counted.

9.2 INITIAL CLAIMS. A Participant or a Participant's spouse, Dependent or beneficiary who believes he or she is eligible for any Benefit under this Plan (referred to in this Article as a "Claimant"), may file a claim with the Administrator, or Insurer, if applicable (referred to in this Article as the "Reviewer"). "Claimant" also includes any properly authorized representative (as determined by the Reviewer) of the person who is the subject of the claim. All claims must be submitted in writing, except to the extent oral notice is permitted for certain urgent care health benefit claims, as described in this Article. The Reviewer will review the claim itself or appoint an individual or an entity to review the claim. Unless a different deadline expressly applies under a Component Plan or insurance contract, no initial claim for any Benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred.

(a) Non-Health and Non-Disability Benefit Claims. For a claim for a benefit other than a health or disability benefit, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that special circumstances require an extension of the time for decision, such extension not to extend beyond the day which is 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If a claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notice may be oral unless written notice is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

If any person fails to follow the Plan's procedures for submitting an urgent care claim, but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided identifies a specific Participant or Dependent, a specific medical condition or symptom and a specific treatment, service, or product for which approval is requested; the Administrator or Reviewer will notify the potential Claimant, as soon as reasonably possible but no later than 24 hours after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting the claim. This notice may be oral unless written notice is requested by the Claimant.

A health benefit claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. The Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Pre-service Health Benefit Claims. For a pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. However, if an extension is necessary because the Claimant failed to submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

If any person fails to follow the Plan's procedures for submitting a pre-service health benefit claim, but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided identifies a specific Participant or Dependent, a specific medical condition or symptom and a specific treatment, service, or product for which approval is requested; the Administrator or Reviewer will notify the potential Claimant as soon as possible but no later than five days after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting a pre-service claim. The notice may be oral unless written notice is requested by the Claimant.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(iii) Post-service Health Benefit Claims. For a post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's Adverse Determination (as defined in Section 9.4) within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Reviewer receives the claim, of those circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. However, if such an extension is necessary because the Claimant failed to

submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services which the Claimant has already received.

(iv) Concurrent Care Claims. Notwithstanding any other provision of this Article, if the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments will constitute an adverse initial benefit determination. These determinations will be known as "concurrent care" decisions. The Reviewer will notify the Claimant of an adverse concurrent care decision at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that the claim is submitted at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(v) Disability Benefit Claims. For a disability benefit claim, the Reviewer will notify the Claimant of the Plan's Adverse Determination within a reasonable period of time, but not later than 45 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Plan receives the claim, of those circumstances and of the date by which the Plan expects to make its decision, which date will be no later than 75 days after the Plan receives the claim. If the Reviewer still needs additional time to process a claim, the Claimant will be notified during the first extension period (i.e., within 75 days after the Plan receives the claim), of those circumstances and of the date by which the Reviewer expects to make its decision, which date will be no later than 105 days after the Plan receives the claim. Any extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and any additional information needed from the Claimant to resolve those issues, and the Claimant will be afforded at least 45 days to provide any requested additional information.

(c) Manner and Content of Notice of Adverse Determination for Initial Claims. If the Reviewer denies an initial claim in whole or in part, it will provide to the Claimant a written or electronic notice of Adverse Determination that includes:

(i) a description of the specific reasons for the Adverse Determination;

(ii) a reference to any Plan provision or insurance contract provision upon which the determination is based;

(iii) a description of any additional information or material that the Claimant must provide in order to perfect the claim and an explanation of why such additional

material or information is necessary;

(iv) a statement that the Claimant has a right to request a review of the Adverse Determination and information on the steps to be taken to request a review; and

(v) if applicable, a statement of the participant's right to bring a civil action under ERISA §502(a) following an Adverse Determination on review of the initial denial and a description of any time limit that would apply under the Plan for bringing such an action.

(vi) In addition, for any notice of Adverse Determination regarding health benefits, the following will be provided:

(A) a copy of any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination (or a statement that the same will be provided without charge upon request by the Claimant); and

(B) if the Adverse Determination is based on a medical necessity requirement, an experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment applying the restriction to the Claimant's medical circumstances or a statement that an explanation will be provided upon request and without charge; and

(C) For any Adverse Determination concerning an urgent care health claim, a description of the expedited review process applicable to such claims, including, if applicable, a statement that the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notice in accordance with this Section is furnished not later than three days after the oral notice.

(vii) For any claim for disability benefits, the notice of Adverse Determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices and also will include the following:

(A) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

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

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

(D) 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.

9.3 REVIEW PROCEDURES.

(a) Non-Health and Non-Disability Benefit Claims. A request for review of a denied claim for a benefit other than health or disability benefits must be made in writing to the Reviewer within 60 days after receiving notice of denial. The decision upon review will be made within a reasonable time, but not later than 60 days after the Reviewer receives the request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after the request for review is received. A notice of such an extension must be provided to the Claimant within the initial 60-day period and must explain the special circumstances and provide an expected date of decision.

The Reviewer will afford the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit documents, records, comments and other relevant information in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health and Disability Benefit Claims. A request for review of a denial of an initial claim for health or disability benefits must be submitted in writing to the Reviewer no later than 180 days after the Claimant receives the notice of denial of the initial claim.

Notwithstanding the preceding, following a denial of an initial urgent care health benefits claim, the Claimant may request an expedited review of the claim and such a request may be submitted orally or in writing at the discretion of the Claimant. If an expedited review is requested, all necessary information, including the plan's benefit determination on review, will be transmitted between the Reviewer and the Claimant by telephone, facsimile, or other available similarly expeditious method, whenever possible.

In addition to providing the Claimant the right to review documents and submit comments as described in (a) above, a review of a denial of a health or disability benefit claim will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial Adverse Determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal and who is not a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional with appropriate training and experience in the field of medicine involved

in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations regarding whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation described in the preceding sentence will be an individual who was not consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review, without regard to whether the advice was relied upon in making the benefit review determination.

(iv) For purposes of any benefit option that is subject to PPACA and for claims for disability benefits, the Plan or Insurer will allow a Claimant to review the claim file and to present evidence and testimony as part of its internal claims and appeals process and will comply with the following requirements:

(A) The Plan or Insurer will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by or on behalf of the Plan or Insurer in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be provided under this Article (and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan or Insurer issues a final internal Adverse Determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for its decision as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is to be provided under this Article (and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial Adverse Determination.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial Adverse Determination.

(B) For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial Adverse Determination.

(iii) Disability Benefit Claims. For disability claims, the decision on

review will be made within a reasonable time but not later than 45 days after the Reviewer receives a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review. A notice of such an extension will be provided to the Claimant within the initial 45-day period and will explain the special circumstances and provide an expected date of decision.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an initial Adverse Determination, the Reviewer will provide the Claimant written or electronic notice of its decision on review. For any Adverse Determination on review, that notice will include:

(i) a description of its decision;

(ii) an explanation of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claim for benefits;

(v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA §502(a) and a description of any time limit that applies under the Plan for bringing such an action (including, for disability benefit claims, the date on which any applicable time limit for bringing such an action would expire); and

(vi) if applicable, a statement describing any voluntary appeal procedures offered by the Plan and about the Claimant's rights to obtain information about such procedures.

(vii) In addition to other applicable requirements of this Section 9.3(d), for any notice of Adverse Determination regarding health benefits, the following will be provided:

(A) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to the Claimant upon request; and

(B) if the Adverse Determination on review is based on a medical necessity requirement, an experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that an explanation will be provided without charge upon request; and

(viii) In addition to other applicable requirements of this Section 9.3(d), for claims for disability benefits, the notice of Adverse Determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices and will include:

(A) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(B) If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

9.4 ADVERSE DETERMINATION. For purposes of this Article, an Adverse Determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in a Component Plan, and including, with respect to any group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

For purposes of any health plan that is subject to PPACA and any disability claim, Adverse Determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission. For purposes of the preceding sentence, "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent that (i) it is attributable to a failure of the Participant to timely pay required premiums or contributions towards the cost of coverage or (ii) for medical coverage, it is otherwise excluded from the definition of "rescission" under 29 CFR §2590.715-2712.

9.5 ADDITIONAL NOTICE REQUIREMENTS. For any Adverse Determination involving coverage that is subject to PPACA, any notice of Adverse Determination will include (in addition to other requirements described in this Article):

(a) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(b) as part of the explanation of the Adverse Determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's or Insurer's standard, if any, that was used in denying the claim;

(c) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(d) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to PPACA to assist individuals with internal claims and appeals and external review processes; and

(e) a statement describing the availability, upon request by the claimant, of the diagnosis code (and an explanation of its meaning) and the treatment code (and an explanation of its meaning).

The Plan or Insurer will comply with a request described in paragraph (e) above by providing the requested information as soon as practicable after the Plan receives the request. The Plan or Insurer will not treat such a request as a request for an appeal or for an external review of any Adverse Determination.

Any Adverse Determination regarding coverage that is subject to PPACA will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices.

9.6 AVOIDING CONFLICTS OF INTEREST. For claims involving coverage that is subject to PPACA or disability claims, the Plan or Insurer will ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any individual involved in making claims decisions will support the denial of benefits.

9.7 CALCULATION OF TIME PERIODS. For purposes of the time periods specified in this Article, the period during which a benefit determination must be made begins when a claim is filed in accordance with Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for non-urgent care health benefits or for disability benefits, the period for making the determination will be tolled from the date the notice requesting the additional information is sent to the Claimant until the day the Claimant responds. If a time period is extended because a Claimant fails to submit all information necessary for an appeal of an Adverse Determination for benefits other than health benefits, the period for making the determination on appeal will be tolled from the date the notice requesting the additional information is sent to the Claimant until the day the Claimant responds.

9.8 FAILURE OF PLAN TO FOLLOW PROCEDURES. If the Plan fails to substantially follow the claims procedures required by this Article, a Claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA §502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim involving coverage that is subject to PPACA, a Claimant is deemed to have exhausted the Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the applicable requirements of Department of Labor Regulations §2590.715-2719(b)(2) (or corresponding regulations issued by the Department of the Treasury or the Department of Health and Human Services) unless the Plan's failure to adhere to those requirements is a "*de minimis* violation" (as defined in this Section). If a claimant is deemed to have exhausted the Plan's internal claims and appeals process based on the preceding sentence, in addition to the right to pursue any available remedy under ERISA, the Claimant will have the right to pursue any remedy under any available external review process provided under federal or state law and will be treated as having received a final internal Adverse Determination for purposes of Section 9.10(b).

For disability claims, a Claimant is deemed to have exhausted the Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the applicable requirements of Department of Labor Regulations §2560.503-1 unless the Plan's failure to adhere to those requirements is a "*de minimis* violation" (as defined in this Section).

For purposes of this Section, the Plan's failure to satisfy applicable claim procedure regulations is a "*de minimis* violation" if (i) the violation does not cause, and is not likely to cause, prejudice or harm to the Claimant, (ii) the violation was for good cause or due to matters beyond the control of the Plan or Insurer, (iii) the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant and (iv) the violation is not part of a pattern or practice of violations by the Plan or Insurer. If an issue arises regarding whether this *de minimis* violation exception applies, a claimant may request a written explanation of the violation from the Plan or Insurer, and the Plan or Insurer will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

For claims involving medical coverage, if an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the *de minimis* violation exception described above, the Claimant will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon Claimant's receipt of the notice.

For disability claims, if a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the *de minimis* violation exception described above, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. In such cases, within a reasonable time after the Plan's receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

9.9 FAILURE OF CLAIMANT TO FOLLOW PROCEDURES. Except to the extent that a Claimant is deemed under Section 9.8 to have exhausted the Plan's claims procedures, a Claimant's compliance with the foregoing provisions of this Article 9 is a mandatory prerequisite to the Claimant's right to commence any legal action with respect to any claim for Benefits under the Plan.

9.10 EXTERNAL REVIEW.

(a) External Review Process. For purposes of any health plan that is subject to PPACA, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of PPACA and regulations at 26 C.F.R. §54.9815-2719, 29 C.F.R. §2590.715-2719 or 45 C.F.R. §147.136 (whichever is applicable) and any subsequent applicable guidance relating to external review requirements.

(b) Availability of External Review. External review under this Section is available only for:

(i) any final internal Adverse Determination (or an initial internal Adverse Determination that qualifies for the expedited external review process under Section 9.11) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal Adverse Determination that involves a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time);

(iii) items and services within the scope of the requirements under the No Surprises Act (i.e., emergency services provided by a nonpreferred provider, air ambulance services provided by a nonpreferred provider, ancillary services, and other non-emergency services), except that external review is not available when:

(A) adjudication of the claim results in a decision that does not affect the amount the Participant or covered Dependent owes;

(B) the dispute involves only payment amounts due from the Plan to the provider; and/or

(C) the provider has no recourse against the Participant or covered Dependent; or

(iv) any other final Adverse Determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

(c) Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives a notice of Adverse Determination for which external review is available under Section 9.10(b).

(d) Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) the Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the

time the health care item or service was provided;

(ii) the Adverse Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) the Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) the Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe why external review is not available and will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the Claimant receives the notice. For purposes of the time periods described in the previous sentence, days during the Outbreak Period will not count towards the Claimant's time period for perfecting a request for external review.

(e) Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan will take action against bias and to ensure independence and will contract with at least three IROs for external review assignments under the Plan and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods).

No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

The Plan will maintain a contract with each IRO that handles external reviews for the Plan that provides the following:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to, accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the Adverse Determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide

the documents and information, the IRO may terminate the external review and make a decision to reverse the Adverse Determination. Within one business day after making such a decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving any information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider the Adverse Determination under review but any reconsideration by the Plan must not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its Adverse Determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving such a notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(A) the Claimant's medical records;

(B) the attending health care professional's recommendation;

(C) reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating provider;

(D) the terms of the Plan, unless the terms are inconsistent with applicable law;

(E) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(F) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(G) the opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.

(vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.

(vii) The IRO's notice will include:

(A) a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its

corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) the date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;

(F) a statement that judicial review may be available to the Claimant; and

(G) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA.

(viii) The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by the Claimant, Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(f) Effect of External Review Decision. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal Adverse Determination, the Plan will provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

9.11 EXPEDITED EXTERNAL REVIEW.

(a) Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an Adverse Determination that otherwise qualifies for external review under Section 9.10(b) and that is:

(i) an Adverse Determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under this Article 9 and applicable regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) a final Adverse Determination, if the Claimant has a medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(b) Procedures for Expedited External Review.

(i) In General. The procedures described in Section 9.10 apply to expedited external review except as otherwise provided in this Section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review under Section 9.10(b). The Plan will immediately send the Claimant a notice of its eligibility determination that meets the notice requirements of Section 9.10(d).

(iii) Referral to IRO. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements of Section 9.10(e). The Plan will provide or transmit all necessary documents and information considered in making the Adverse Determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide notice of its final external review decision, in accordance with the requirements of Section 9.10(e) as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

9.12 PREEMPTION OF STATE LAW. For any insured benefit under this Plan, nothing in this Article shall be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of this Article.

ARTICLE 10
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT. The Company reserves the power at any time and from time to time, and retroactively if deemed necessary or appropriate, to modify or amend, in whole or in part, any or all of the provisions of the Plan or the insurance contracts maintained to provide Benefits under the Plan. All amendments to the Plan will be in writing.

Notwithstanding the preceding, to the extent that any amendment affects the Plan's Code §125 cafeteria plan feature, the amendment will be effective no earlier than the date the written amendment is adopted by the Company, except to the extent an earlier effective date is permitted under applicable guidance from the Internal Revenue Service or the Department of the Treasury. For any amendment that adds a new Component Plan or a new benefit under an existing Component Plan to the Plan, to the extent that the new benefit is made available under the Plan's cafeteria plan feature, the Plan will not pay or reimburse any expenses relating to that benefit,

unless the expenses were incurred after the later of the amendment's adoption date or effective date.

10.2 TERMINATION. The Company reserves the power to discontinue or terminate the Plan at any time. In the event of the dissolution, merger, consolidation or reorganization of the Company, the Plan shall terminate unless it is continued by a successor to the Company.

10.3 REDUCTION OR TERMINATION OF BENEFITS. Participants in the Plan, including future retirees and retirees who have already retired, if any, have no right to Plan Benefits after a Plan termination or a partial Plan termination affecting them, and have no right to Plan Benefits to the extent that they are eliminated or reduced by a Plan amendment, except that such Participants are entitled to Benefits with respect to covered events giving rise to Benefits and occurring before the effective date of the Plan termination or applicable Plan amendment.

10.4 EFFECTIVE DATES. Any such amendment, discontinuance or termination shall be effective at such date as the Company shall determine.

10.5 PROCEDURE. An amendment, discontinuance or termination under this Article shall be valid only if it is approved by the Company's Board of Directors at a duly called meeting at which a quorum thereof is present or by written consent of the members of the Company's Board of Directors executed in accordance with applicable state law.

ARTICLE 11
GENERAL PROVISIONS

11.1 NO EMPLOYMENT CONTRACT. Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any employee, or as a right of any employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its employees with or without cause.

11.2 APPLICABLE LAW. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and, where not preempted by federal law, the laws of the State of Maryland.

11.3 NON-ALIENATION PROVISIONS. Notwithstanding the terms of any Component Plan, no Benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No Benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person. Subject to the preceding sentence, the Administrator shall be permitted, in its discretion, to make a direct payment to a provider of services for which benefits are available under a Component Plan and such direct payment to the provider by the Plan shall not be considered an assignment or alienation under the Plan or any Component Plan, and neither the direction by a Participant, or Dependent to make such payment nor the payment itself shall be construed as an assignment of benefits or as any recognition whatsoever by the Administrator of the validity of any attempted alienation or assignment of benefits hereunder nor to confer on the payee any rights besides the right to receive the payment in the amount of that payment.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order (QMCSO) which provides for Plan coverage for an Alternate Recipient, in the

manner described in ERISA §609(a) and in the Plan's QMCSO Procedures.

11.4 PAYMENTS TO INCOMPETENTS. If the Administrator knows that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, age or some other cause, it may cause all payments thereafter becoming due to such person to be made to the person's legal guardian for the person's benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Administrator and the Employer.

11.5 INABILITY TO LOCATE RECIPIENT. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited 18 months after the date such payment first became due or after such period as is provided in the applicable insurance contract.

11.6 PLAN COMMUNICATIONS. All communications in connection with the Plan made by a Participant will become effective only when duly executed on forms provided by and filed with the Administrator.

11.7 SOURCE OF BENEFITS. The Company (and any insurance contracts purchased or held by the Company) shall be the sole source of Benefits under the Plan. No Employee or other person shall have any right to, or interest in, any assets of the Company upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or other person.

11.8 INTERPRETATION. This Plan is to be interpreted so as to be consistent in all respects with the requirements of the Code and ERISA.

11.9 SUBROGATION. As a condition of receiving benefits under the Plan, all covered persons, including all covered dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person, organization or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Furthermore, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance

coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to the "make whole" doctrine, the "common-fund" doctrine or other or other similar common-law subrogation rules or legal theories.

Also, each Participant and each covered person, as a condition for and consequence of receiving medical, disability or any other benefits under the Plan with respect to any amount that is subject to this subrogation provision, agrees as follows:

(1) The Participant and each covered person (or their attorneys or other authorized representatives) will promptly inform the Plan of any settlement agreement and to provide reasonable advance notice of any plans for the disbursement of any settlement funds to the Participant or covered person (or to any other person on behalf of the covered person);

(2) The Participant and each other covered person (or their attorneys or other authorized representatives) will hold any settlement funds received with respect to a claim that is subject to the Plan's subrogation rights in trust for the benefit of the Plan until all obligations to the Plan under this subrogation provision are satisfied (or to disburse such funds to the Plan to satisfy any obligations to the Plan under this subrogation provision);

(3) The Participant and each other covered person (or their attorneys or other authorized representatives) will maintain and treat any settlement funds received by or on their behalf, as Plan assets, to the full extent of any benefits paid by the Plan with the Participant or other covered person being a trustee of Plan assets with respect to such amounts until the covered person's obligations under this subrogation provision are satisfied; and

(4) The Participant and each other covered person (or their attorneys or other authorized representatives) agree that the Plan has an equitable lien on any settlement funds payable to or on behalf of the Participant to the full extent of any benefits paid by the Plan amounts until the covered person's obligations under this subrogation provision are satisfied in full.

11.10 MEDICARE, MEDICAID AND TRICARE SECONDARY PAYER RULES. The Plan at all times will be operated in accordance with any applicable Medicare and Medicaid secondary payer and non-discrimination rules, including, but not limited to the rules of §1144(a) of the Social Security Act. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over, and rules concerning working disabled individuals. In addition, the Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

11.11 NON-DISCRIMINATION AND OTHER RULES. All benefits and elections under this Plan shall be subject to all applicable non-discrimination and other rules under the Code and other applicable law (e.g., the non-discrimination rules of Code §§105(h), 125, 129 and 79, the Code §125 key employee 25% concentration rules, the Americans with Disabilities Act rules, etc.) and the Employer shall test the Plan for compliance with such rules and may take any actions it considers advisable for the purpose of ensuring the Plan's compliance with such rules.

11.12 HEALTH CARE CONTINUATION COVERAGE RULES. Notwithstanding any

provision of the Plan to the contrary, the Employer shall provide Participants and Dependents with all health care continuation coverage rights to which they are entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any other similar, applicable state law. In addition, the Plan will comply with COBRA premium assistance provisions of the American Rescue Plan Act of 2021 to the extent that they apply to continuation coverage available under the Plan.

11.13 HIPAA RULES. Notwithstanding any provision of the Plan to the contrary, the Plan shall be administered at all times in accordance with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

11.14 STATUTE OF LIMITATIONS. Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 12 months after the final review decision by the Administrator has been rendered (or deemed rendered).

11.15 COORDINATION OF BENEFITS. The coordination of benefits provisions specified in the Appendix, as interpreted by the Administrator in its discretion, shall control coordination of benefits situations involving the Plan and other payers. Notwithstanding any provision of this Plan to the contrary, in any case where a claimant receives benefits under a Component Plan that could have been paid in part under another plan, the Administrator has the right to seek reimbursement from that other plan.

11.16 HEALTHCARE INTEGRITY AND PROTECTION DATA BANK. To the extent required by §221(a) of the Health Insurance Portability and Accountability Act of 1996 (as codified at 42 U.S.C. §1320a-7e) and applicable regulations, the Plan will report any "final adverse action" (as described under those regulations) taken on behalf of a group health plan offered under the Plan to the Healthcare Integrity and Protection Data Bank.

11.17 MEDICAL NECESSITY REQUIREMENT. For purposes of medical benefits provided under the Plan, except as otherwise expressly provided in a Component Plan, no benefits will be provided for services that are not medically necessary, as determined by the Administrator or, if applicable, by the Insurer. Except as otherwise expressly provided in a Component Plan, a service will be considered medically necessary only if the Administrator or Insurer determines that it is provided or prescribed by a qualified provider and is (i) essential for the symptoms and the diagnosis or treatment of a condition, illness or injury; (ii) provided for the diagnosis or the direct care and treatment of a condition, illness or injury; (iii) consistent with current standards of good medical practice; (iv) not primarily for the convenience of the covered person or the provider; (v) not considered experimental or investigative; (vi) approved by applicable government agencies, if required; and (vii) the most appropriate level of service or supplies that can be safely provided to the covered person. Medical necessity is only one requirement for benefits to be covered and nothing in this Section shall be construed to require that the Plan cover any service merely because it is medically necessary under this Section.

11.18 CLAIMS SUBSTANTIATION REQUIREMENT. All claims for Benefits offered through the Plan's Code §125 cafeteria plan feature must be substantiated by information provided by an independent third party in accordance with applicable regulations before benefits may be paid. However, the Plan is not responsible for substantiating claims for reimbursement from a Participant's health savings account.

11.19 MENTAL HEALTH PARITY. Notwithstanding any provision of the Plan to the contrary, mental health and substance abuse benefits provided under any Component Plan will comply in all respects with all applicable requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

11.20 GINA. Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with the applicable requirements of the Genetic Information Nondiscrimination Act of 2008.

11.21 HEALTH CARE REFORM. Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with any applicable requirement of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 beginning on the applicable effective date.

For any Component Plan that is subject to PPACA, no lifetime limit on essential health benefits will apply and no annual limits on essential health benefits will apply, except to the extent permitted under PPACA and applicable regulations. For purposes of the preceding sentence, "essential health benefits" has the meaning that applies under PPACA and applicable regulations issued pursuant to PPACA, once those regulations are issued and become applicable to the Plan. Notwithstanding the preceding, until regulations defining the term essential health benefits become applicable to the Plan, the Administrator has discretion to interpret that term and any available guidance to determine whether any lifetime or annual limit that might otherwise apply under the terms of any Component Plan is to be disregarded for the Plan to comply with PPACA.

11.22 CONSOLIDATED APPROPRIATIONS ACT. Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with the applicable requirements of the Consolidated Appropriations Act of 2021 (including, but not limited to, the No Surprises Act) beginning on the applicable effective date.

11.23 RESCISSION OF COVERAGE. Notwithstanding any provision of the Plan to the contrary, the Plan may rescind coverage under any Component Plan for any individual (or a Participant or Dependent covered under the same coverage as that individual) who engages in fraud with respect to the Plan, or who makes an intentional misrepresentation of material fact. Except as otherwise prohibited by law, the Plan may rescind coverage under a Component Plan for other reasons in accordance with the terms of the applicable Component Plan.

The Plan will not rescind coverage under any Component Plan that is subject to PPACA, for any individual covered under that Component Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In cases where rescission is permitted, the Plan will provide at least thirty days advance written notice to each Participant or Dependent who would be affected before coverage will be rescinded under this Section. This paragraph is included in the Plan to comply with the requirements of PPACA and applicable regulations, including Treasury Regulations §54.9815-2712T (and any subsequent regulations that amend or replace those regulations) and shall be interpreted to be consistent with such regulations and to permit rescissions to the extent permitted under those regulations.

For purposes of this Section, a rescission is a cancellation or discontinuance of

coverage under a Component Plan that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if (i) it is effective retroactively only to the extent it is attributable to a failure to timely pay required participant contributions towards the cost of coverage or (ii) the Administrator determines the Plan is not required by law to treat the retroactive termination as a rescission under applicable law.

IN WITNESS WHEREOF, the Company has caused this document to be executed, effective as specified herein.

HOOD COLLEGE

By: 

Print Name: Rob Klinedinst

Title: Vice President for Finance and Treasurer

Date: 9/11/25

SCHEDULE A: HIPAA PRIVACY-TRAINED EMPLOYEES

The following persons have been designated by the Plan Sponsor as authorized to use or disclose Protected Health Information for purposes of the Plan and have received appropriate training regarding the Plan's Health Information Privacy Policies and Procedures and the applicable requirements of the Privacy Regulations. Any person on this list is authorized to access PHI on behalf of the Plan beginning on the date training has been completed and ending on the date that he or she is no longer authorized to access PHI (e.g., because of termination of employment or a change in responsibilities).

Name	Date training completed	Date no longer authorized to access PHI

APPENDIX

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

Effective July 1, 2023

ABOUT THIS SUMMARY

The following is a summary of some of the principal features of the Hood College Health and Welfare Benefits Plan (the Plan). We urge you to read this summary carefully.

This summary is the "Summary Plan Description" for the Plan and is meant to summarize the Plan in easy-to-understand language. However, in the event of any ambiguity or any inconsistency between this Summary Plan Description and any formal Plan documents, the Plan documents will control.

Copies of the formal Plan documents for the Plan are on file at Hood College (the Employer) and are available to you for inspection at a time and place mutually agreeable to you and to Hood College. If anything in this Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator.

NOTE: In a few places in this Summary, you will see special temporary rules that apply during the COVID-19 "Outbreak Period". Those rules extend the time period for you to take certain actions. Under rules provided by the Internal Revenue Service and the U.S. Department of Labor, the "Outbreak Period" is a time period that began on March 1, 2020 or if later, the date that the applicable time period would have started under the normal plan rules. The Outbreak Period for any event cannot last longer than one year, but, for all events, it will end 60 days after the end of the federally declared National Emergency, as determined by the IRS and the Department of Labor (or on another date announced by the IRS and the Department of Labor announce a different ending date). Any extension of time based on these Outbreak Period rules applies only to a time period that otherwise would have included at least one day of the Outbreak Period.

For example: Assume an employee is eligible for a special enrollment period (as described in the "Participation" section of this Summary) because the employee got married on September 15, 2021. That employee normally would have had 30 days (until October 15, 2021) to request enrollment in medical coverage for the employee's new spouse. However, because that special enrollment period began during the Outbreak Period, the normal 30-day special enrollment period would not start until the end of the Outbreak Period, so the employee would have until 30 days after the end of the Outbreak Period to request enrollment for the new spouse. The Outbreak Period for this employee's special enrollment opportunity will end no later than September 15, 2022, which would mean the employee would have until October 14, 2022 to request enrollment for the spouse. However, if the IRS and the Department of Labor announce an earlier end to the Outbreak Period, the employee's deadline would be earlier (30 days from the end of the Outbreak Period). Note that the employee can request enrollment at any time before that extended deadline, but the spouse's enrollment in that case would not take effect until after the employee requests enrollment, so it may still be in the employee's interest to request enrollment as soon as possible, if the employee wants coverage for the spouse to begin earlier.

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

Effective July 1, 2023

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GENERAL INFORMATION ABOUT THE PLAN

Name of Plan

Hood College Health and Welfare Benefits Plan

Name and Business Address of Employer

Hood College
401 Rosemont Avenue
Frederick, MD 21701-8575

Employer's Taxpayer Identification Number

52-0591608

Plan Number

506

Type of Administration

The Plan is administered by the Plan Administrator. Please note that participant benefit accounts under the Plan are merely bookkeeping entries, no assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. Some benefits may be provided through insurance contracts. To the extent that any benefits are not provided through insurance contracts, they are paid from the Employer's general assets.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's discretionary authority includes but is not limited to, discretionary authority to interpret plan provisions and to make all determinations of facts, including factual determinations relating to eligibility for benefits, and to make all determinations that require application of facts to the terms of the Plan. The Plan Administrator's determinations shall be given deference and are final and binding on all interested parties. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Health Coverage Insurance and Funding Information

UMR, a United Healthcare Company, 115 W. Wausau Avenue, Wausau, WI 54401-2875 is the claims processor of your medical benefits under the Plan. The Plan's medical benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance carrier.

OptumRx, 3500 Blue Lake Drive, Suite 200, Birmingham, AL 35243 is the claims

processor of your prescription drug benefits under the Plan. The Plan's prescription drug benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance carrier.

United Healthcare Insurance Company, 185 Asylum Street, Hartford, CT 06103-3408 is the insurer and claims processor of your dental benefits under the Plan. The Plan's dental benefits are fully guaranteed under the policy of insurance issued by this company.

United Healthcare Insurance Company, 185 Asylum Street, Hartford, CT 06103-3408 is the claims processor of your vision benefits under the Plan. The Plan's vision benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance carrier.

Affordable Care Act

This Summary includes various provisions that are required to comply with the requirements of the federal health care reform law, (the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010) and with regulations and other guidance issued under that law. Whenever this Summary refers to the "Affordable Care Act" it is referring to the PPACA, as amended, and any applicable regulations. The health care reform requirements of the Affordable Care Act generally apply only to the Plan's medical coverage. When this Summary refers to coverage that is subject to the Affordable Care Act, it means the Plan's medical coverage.

Notice of Right to Designate a Primary Care Provider

For purposes of the Plan's medical/prescription drug coverage, you (or your covered family members) generally are permitted to designate a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator at the address provided in this Summary.

Plan Year

The Plan Year is the period beginning each July 1 and ending each June 30 while the Plan is in effect.

Name, Business Address and Telephone Number of Plan Administrator

Hood College
c/o Human Resources Department
401 Rosemont Avenue
Frederick, MD 21701-8575
(301)696-3590

Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Type of Plan

This Plan is a form of employee welfare benefit plan called a "cafeteria plan" because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the Employer to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan. For certain benefits, because your salary is reduced before federal taxes (and, in most states, state taxes) are imposed, you pay less in taxes if you participate in the Plan. (Some benefits may require that you make after-tax contributions.)

Eligibility

If you are a full-time or part-time regular employee of the Employer (i.e., one with an established full-time equivalency (FTE) of .5 or greater, except for long term disability which required a full-time employee with an FTE of .75 or greater (as determined by the Employer), you and your eligible dependents are eligible to participate in the Plan beginning on the first day of the month coincident with or following the date you become an eligible employee of the Employer (your "Participation Date").

Leased employees, seasonal employees (as defined under Affordable Care Act regulations), persons classified by the Employer as temporary employees of the Employer (as determined by the Employer), adjunct professors, graduate assistants, coaches and student employees are not permitted to participate in the Plan except as provided below in the "New Additional Eligibility Opportunities" section.

In no event are the following individuals eligible to participate in the Plan, regardless of the provisions in the "New Additional Eligibility Opportunities" section: (1) employees covered by a collective bargaining agreement and their dependents unless Plan participation is provided for in the collective bargaining agreement and (2) a person who is not characterized by the Employer as an employee of the Employer, but who is later characterized by a regulatory agency or court as being an employee, for the period during which he or she is not characterized as an employee by the Employer.

Except as provided in the "New Additional Eligibility Opportunities" section below, if your employment terminates while you are a participant in the Plan (or if you cease to be an eligible employee for any other reason) and you later become an eligible employee again, you will be treated as a new employee and you will need to satisfy the Plan's eligibility requirements without counting any previous period of employment. However, if you are rehired (or again become an eligible employee for any other reason) during the same Plan Year and within 30 days after your previous period of eligible employment ended, you generally will not be permitted to make a new election of benefits for that Plan Year, but your previous election of benefits will be reinstated.

Please note that your eligibility for any particular benefit is determined under Plan terms applicable to that benefit. The Benefit Booklets delivered with this Summary include information about any additional or different eligibility requirements that may apply to specific benefits.

The next section describes some special eligibility rules that apply for employees who are not eligible for coverage under the rules described above. If you are eligible for coverage based on the rules above, the rules in the next section will not affect you at this time so you may want to

just skip to the "Dependent Eligibility" section.

Additional Eligibility Opportunities Based on Measurement Periods

If you do not qualify as an eligible employee based on the rules described in the "Eligibility" section above (and you are not excluded from eligibility under this section based on the "Eligibility" section above), you may still become eligible for medical/prescription drug coverage under the Plan based on the following rules that apply in determining if someone is a full-time employee for purposes of the Affordable Care Act.

These rules vary depending on whether you are considered a "new employee" or not. You are considered a new employee until you have been employed for a full "Standard Measurement Period", as described below. Anyone who is not a "new employee" is considered an "ongoing employee".

Measurement Periods for Ongoing Employees

If you are not eligible for coverage based on the rules in the "Eligibility" section, you will be considered a full-time employee for a Plan Year (and eligible for medical/prescription drug coverage for that Plan Year), if you average at least 130 Hours of Service per month during a 12-month "Standard Measurement Period" that ends shortly before the Plan Year.

The plan uses a Standard Measurement Period lasting from April 3 through the next April 2 and then offers coverage to employees who are determined to be full-time based on that Measurement Period sometime between the end of that period and the start of the next Plan Year (your "Participation Date").

Example: If you average at least 130 Hours of Service per month during the Measurement Period lasting from April 3, 2022 through April 2, 2023, you would be considered a full-time employee for the Plan Year that begins on July 1, 2023 and you would be eligible to elect medical/prescription drug coverage to be effective starting July 1, 2023.

If you become eligible for coverage based on your hours worked during a Standard Measurement Period, note that you will be eligible only for the next Plan Year following the end of that Standard Measurement Period. To be eligible for future periods, you must again qualify based on hours worked during a later Standard Measurement Period (or based on the rules in the "Eligibility" section).

Measurement Periods for New Employees

Different rules apply for new employees.

First, if you are not eligible based on the rules described in the "Eligibility" section but on the date you become an employee of the Employer, you are reasonably expected to work at least 130 Hours of Service per month for the Employer, and you are not classified as a seasonal employee (as determined by the Employer), you and your eligible dependents are eligible to participate in medical/prescription drug coverage under the Plan beginning on the first day of the month coincident with or following the month in which you become an employee of the Employer (your "Participation Date"). If you become eligible for coverage based on this paragraph, note that your eligibility will last only until the start of the first Plan Year that begins after you have

been employed for a full Standard Measurement Period. To be eligible for coverage on or after that date, you must be eligible based on the Measurement Period rules that apply to ongoing employees (or based on the rules in the "Eligibility" section).

If the previous paragraph does not apply, a New Employee Measurement Period applies for any person who has not been employed for a full Standard Measurement Period. For example, if you started work on January 15, 2022, you would be considered a new employee for this purpose until the end of the next 12-month Standard Measurement Period that begins after your start date. The next Standard Measurement Period would start April 3, 2022 so you would be a new employee for this purpose until April 2, 2023.

The New Employee Measurement Period is based on each employee's start date so it is different for each new employee. It begins on the date the employee commences employment and ends 12 months later. If you are a new employee and you average at least 130 Hours of Service per month during your New Employee Measurement Period, you (and your eligible dependents) will become eligible to enroll in medical/prescription drug benefits under the Plan beginning on your Participation Date, which will be the first day of the month that begins after the last day of your New Employee Measurement Period.

For example, if you start work on January 15, 2022, your New Employee Measurement Period would begin on your start date and would end on January 14, 2023. If you average at least 130 Hours of Service per month during your New Employee Measurement Period, you would then be given an opportunity to enroll in the Plan's medical/prescription drug benefits effective February 1, 2023.

If you become eligible to participate in the Plan based on hours worked during a New Employee Measurement Period, your "Initial Eligibility Period" generally will last until the end of the 12-month period that begins on your Participation Date. However, if your New Employee Measurement Period ends before the start of the first Plan Year that begins after you have completed a full Standard Measurement Period, your Initial Eligibility Period will last until that Plan Year starts. To be eligible for any coverage after your Initial Eligibility Period ends, you must qualify for a later period based on the Measurement Period rules that apply to ongoing employees (or based on the rules in the "Eligibility" section).

An employee or a former employee who returns to work with the Employer after a period of 26 weeks or longer during which he or she was not credited with an Hour of Service with the Employer is considered to be a new employee for purposes of the Measurement Period rules.

If you experience a material change in position or employment status, during your New Employee Measurement Period that results in you becoming reasonably expected to work at least 130 Hours of Service per month for the Employer, you will become eligible to enroll in medical/prescription drug coverage under the Plan beginning on the date that would be your Participation Date under the second paragraph of this *Measurement Periods for New Employees* subsection if the date of your change in employment status was treated as your start date (except that, if an earlier Participation Date would apply without this paragraph, that earlier Participation Date would apply). You will be informed by the Employer if this applies to you.

Calculating Hours of Service

For purposes of these rules, an "Hour of Service" is defined based on IRS regulations and

generally includes any hour for which you are paid, or entitled to payment, for performing services for the Employer (or for certain related employers) plus any hour for which you are paid, or entitled to be paid for periods when you are not working, such as for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or other paid leaves of absence.

In determining if an employee averages at least 130 Hours of Service per month during any Measurement Period, certain periods of time are ignored (so that they do not reduce your average). This includes periods of unpaid leave for jury duty or for military service that is subject to the federal law known as USERRA as well as unpaid FMLA leave.

Also, if you are a continuing employee who does not work during a break in the Employer's academic year that lasts four weeks or longer (but no longer than 26 weeks), you generally will be credited with hours (solely for purposes of computing your average Hours of Service during any Measurement Period) equal to the average hours you worked during the rest of that Measurement Period, but no more than 501 Hours of Service will be credited for this purpose. Your average Hours of Service for the entire Measurement Period (including the break period) would then be computed by including those additional hours.

In computing your hours of service, for any period when you are not paid on an hourly basis, you will be credited with exactly eight Hours of Service for each day for which you would be credited with at least one Hour of Service.

Because hours are tracked on a payroll period basis and the Plan's Measurement Periods do not always begin on the same date as a payroll period, if you are paid on a weekly, biweekly or semi-monthly basis, you will be credited with Hours of Service for a Measurement Period starting on the first day of the pay period that includes the first day of the Measurement Period and ending with the last day of the last pay period that ends on or before the last day of that Measurement Period.

If you are an adjunct faculty employee of the Employer, the Plan will calculate Hours of Service by crediting you with 2.25 Hours of Service per week for each hour of scheduled classroom teaching (for teaching time, plus class preparation time and time for grading) plus one Hour of Service per week for each additional hour spent outside of the classroom for other required purposes (e.g., required office hours or required attendance at faculty meetings).

Dependent Eligibility

(NOTE: This Dependent Eligibility section does not apply to flexible spending account benefits. For details on whether a family member's expenses can be covered under a flexible spending account, see the separate explanations of those benefits in the "Summary of Available Benefits" section.)

For purposes of benefits offered under the Plan that allow you to enroll dependents, your *spouse* is considered an eligible dependent (*spouse* and other *italicized* terms used in this section are defined below).

Your *child* is eligible for coverage offered to dependents under the Plan based on the following rules:

1. Medical/Prescription Drug, Dental and Vision Coverage for Children under Age 26. For

purposes of medical/prescription drug, dental and vision benefits offered under the Plan, your eligible dependents include your *child* who is under age 26, regardless of the child's marital status, tax dependent status or student status and regardless of whether the child lives with you.

2. Medical/Prescription Drug, Dental and Vision Coverage for Children with Disabilities. For purposes of medical/prescription drug, dental and vision benefits offered under the Plan, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable calendar year is an eligible dependent if he or she is physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 26.

3. Dependent Life Insurance Coverage. For purposes of dependent life insurance benefits, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable calendar year is your eligible dependent if he or she is:

   - at least 14 days old but under age 18; or
   - a full-time student who is at least 18 but under age 26 (to be a full-time student, the child must regularly attend an educational institution that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on); or
   - physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 26, or while the child was 18 or over but under age 26 and enrolled as a full-time student.

   The following definitions apply for purposes of this Dependent Eligibility section:

   Child means a natural child, a legally adopted child who is under age 18 at the time of the adoption, a child placed with you for adoption who is under age 18 at the time of the placement, a foster child (if the child is an "eligible foster child", as defined in the Internal Revenue Code), or a stepchild. *Child* also includes any other person whose welfare is your legal responsibility under a legal guardianship, written divorce settlement, written separation agreement or a court order.

   Spouse means a person who is treated as your spouse for purposes of federal law. For purposes of determining if someone is eligible for coverage as your spouse, the Plan does not recognize "common law" marriages, regardless of whether the marriage is recognized in any state.

   Dependent for Federal Income Tax Purposes

   Whether someone is your *dependent for federal income tax purposes* is determined under IRS rules. For details on the requirements for someone to be your federal income tax dependent, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* under the Plan. However, for purposes of this Plan's health benefits, note that even if your family member would not

qualify as your dependent for federal income tax purposes under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for purposes of the Plan's dependent eligibility requirements.

Also, in determining if your child is your *dependent for federal income tax purposes*, a special rule applies in cases of divorce or legal separation or if you and your child's other parent live apart for all of the last six months of the calendar year if either you or the child's other parent has custody of the child and is actually entitled to claim the child as a dependent for tax purposes. In those cases, as long as at least half of the child's support for the applicable calendar year is being provided by you and the other parent (and your current spouses, if any) together, the child can be considered your *dependent for federal income tax purposes* for purposes of the Plan's health benefits.

A person otherwise qualifying as your eligible dependent will not be covered for any coverage providing benefits to dependents unless you have elected to pay and have paid the required additional contributions, if any, for dependent coverage. Also, unless otherwise required by law, note that your spouse or child will not qualify as an eligible dependent while on active duty in the armed forces of any country.

You are responsible for determining if someone qualifies as your spouse or dependent for purposes of the Plan's dependent eligibility rules, subject to the Employer's final approval. The Employer may require you to provide proof that an individual satisfies all of the Plan's eligibility requirements. Also, if at any time during a Plan Year your eligible spouse or dependent becomes ineligible for coverage, you are responsible for notifying the Employer of that change in eligibility. If, at any time, the Plan pays benefits for any person you elected to enroll in your coverage who is later determined not to qualify as your eligible dependent, the Plan may recover from you any amounts paid for such benefits, using any recovery means available under applicable law (including, but not limited to, wage garnishment).

If you and your eligible spouse or dependent are both employees of the Employer and each of you meets the Plan's eligibility requirements to participate in the Plan as employees, you may elect employee-only medical, dental or vision coverage or one of you may elect family (or employee and spouse or dependent) coverage. However, no employee can be covered under the Plan's medical, dental and vision coverage as another employee's spouse or dependent at the same time that he or she is also covered under the Plan as an employee/participant.

For purposes of the Plan's medical/prescription drug, dental and vision coverage, if a child would otherwise qualify as a dependent of more than one participant, the child may be treated as the dependent of only one participant. If this applies to you, you and the child's other parent must decide who will elect coverage for the child.

For any insured coverage offered under the Plan, the terms of the insurance contract, instead of this "Dependent Eligibility" section, will determine whether any person is your dependent for purposes of that benefit (if there is any difference between the language in this Dependent Eligibility section and the terms of the contract). The Benefits Booklets provided to you with this Summary will include any additional or different dependent eligibility requirements that apply for any insured coverage.

All Qualified Medical Child Support Orders that require the Plan to provide coverage for so-called "Alternate Recipients" will be honored by the Plan in accordance with applicable law. (These orders are a type of order by a court or by an administrative agency providing coverage for children of Plan participants.) As required by applicable law, the Plan uses procedures to determine whether a medical child support order is a "Qualified Medical Child Support Order" that must be honored by the Plan. Upon request to the Plan Administrator, you may receive, without any charge, a summary of these procedures.

Participation

(a) Initial Election Period. If you are not already a participant in the Plan, to become a participant on your Participation Date, you must be an active employee of the Employer on your Participation Date and you must properly complete and submit an initial Election Form to the Plan Administrator (or complete a designated electronic enrollment process, if available) before your Participation Date and during the period designated by the Plan Administrator as your initial "enrollment period".

Your benefit elections made during your initial enrollment period will be effective from your Participation Date until the last day of the Plan Year in which you change your initial benefit election (see subsection (b) below) or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (see subsections (d) and (e) below).

If you fail to properly complete and submit an Election Form to the Plan Administrator during your initial election period, you will automatically receive Employer-paid employee assistance plan (EAP), life insurance/accidental death and dismemberment (AD&D) and long term disability coverage, but you will not automatically participate in any other feature of the Plan.

(b) Election Periods after Initial Election Period. After you complete the initial Election Form, your initial benefit election will remain in effect indefinitely or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (as described in subsections (d) and (e) below). However, this automatic carry-over of previous elections does not apply to your elections to contribute to the Plan's health care flexible spending account or dependent care flexible spending account or to a health savings account. If you fail to complete and submit a new Election Form for those benefits, you will not automatically receive coverage.

Although your benefit elections normally will carryover from one Plan Year to the next as described above, the Employer may announce before the start of a Plan Year that new elections will be required for all eligible employees to participate in benefits for that upcoming Plan Year. In such cases, a special required election period will be announced for all eligible employees to make new elections, which will take effect at the beginning of the next Plan Year. An employee who fails to make an election of available benefits for the following Plan Year during that special required election period will cease to participate in the Plan (except for purposes of any Employer-paid benefits that may be provided automatically without the need for an election, as described in subsection (a) above) at the end of the Plan Year in which the special required election period occurs.

If you are eligible to make contributions to a health savings account (HSA) under the Plan (as determined by the Plan Administrator), you may change the amount you contribute to your health savings account at least once per month, for any reason. This includes the right to stop making contributions if you are no longer eligible to contribute to the health savings account. Generally, any change to your HSA contribution elections will take effect as soon as practicable after the date you complete and submit any required election change form or process designated by the Plan Administrator and after your election change request is approved by the Plan Administrator. Your new election will remain effective until for the balance of the Plan Year in which the new election becomes effective or, if earlier until you change your elections according to the Section entitled "Election Periods After Initial Election Period" or you experience another Status Change.

(c) Changes of Election to Reflect Status Change. If you are currently participating in the Plan, you may, with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, change your elections by filing a Status Change Form within 30 days after a Status Change event. If you are not currently a participant in the Plan but you have satisfied all the requirements to be eligible to participate (except that you do not have a current benefit election in place), with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, you may become a participant by filing an Election Form and a Status Change Form within 30 days after a Status Change event occurs.

Under applicable law, to be permitted to make a change in your benefit elections because of a Status Change event, the Status Change event must result in you or your spouse or dependent gaining or losing eligibility for that coverage or similar coverage under the Plan, a plan sponsored by another employer by whom you are employed or a plan sponsored by the employer of your spouse or other dependent. (For dependent care flexible spending account benefits, you are also permitted to make an election change if a Status Change increases or decreases your eligible dependent care expenses and the election change corresponds to the change in expenses.)

Any change that you wish to make to your benefit elections also must be consistent with the Status Change event that occurred. The Employer will determine whether, under applicable law, a requested change (or a new election) is consistent with the Status Change you experience. For example, if you become eligible for health coverage offered by your spouse's employer because you get married or because your spouse changes employers, you may cancel your health coverage under this Plan only if you certify to the Employer that you have actually enrolled or intend to enroll in the other plan. Under applicable law, it would not be consistent with the Status Change if you merely dropped coverage under this Plan without enrolling in the other plan. However, for purposes of group term life insurance, accidental death or dismemberment insurance or disability coverage, any change you wish to make because of a Status Change, such as increasing coverage, decreasing coverage or dropping coverage, will be treated as consistent with the Status Change.

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the elections are approved by the Plan Administrator, and will be effective, for health care flexible spending account or dependent care flexible spending account coverage or, for employee contributions to a health savings account, for the balance of the Plan Year in which the new election becomes effective or, for all other coverage, until you change your elections according to the Section entitled "Election Periods After Initial

Election Period" or you experience another Status Change.

You will experience a Status Change if:

(1) your legal marital status changes including changes because of marriage, the death of your spouse, divorce or legal annulment;

(2) there is an event that causes you to gain or lose a dependent;

(3) you, your spouse or your dependent terminates or begins employment;

(4) there is an increase or reduction in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or the beginning or ending of an unpaid leave of absence) by you or your spouse or other dependent;

(5) you, your spouse or your dependent becomes eligible or loses eligibility for coverage under a plan offered by that person's employer because of a change in employment status (for example, if your dependent switches from salaried to hourly employment and the dependent's employer's medical plan covers only salaried employees);

(6) an event happens that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or similar circumstance;

(7) there is a change in location of the residence or worksite of you or your spouse or other dependent;

(8) for purposes of dependent care flexible spending account benefits, there is an event that changes the number of your dependents who are under the age of 13 or mentally or physically incapacitated; or

(9) for any election made on an after-tax basis, you experience any event which, in the Administrator's sole discretion, qualifies as a Status Change.

(d) Changes of Election Because of Changes in Cost or Coverage. You may make certain changes, as described below, because of changes in cost or coverage of benefits available under the Plan. You must request such an election change within 30 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion). Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the Election Form, if required, and the elections are approved by the Plan Administrator, and will be effective, for dependent care flexible spending account coverage, for the balance of the Plan Year in which the new election becomes effective or, for all other coverage, until you change your elections according to the Section entitled "Election Periods After Initial Election Period".

The rights described in paragraphs (i)-(iv) below are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan. Also, the rights described in (i)-(iv) below do not apply to elections involving a health care flexible spending account. You may not change the amount you contribute to a health care flexible spending account because of a change in cost or a change in coverage of another benefit option and you may not make an election change for any other benefit option because of a

change in the cost or coverage under your health care flexible spending account or the health care flexible spending account of your spouse or dependent.

(i) Significant Cost Changes. If the amount that you are required to pay for a benefit option significantly increases (as determined by the Employer) while you are covered under that benefit, you may elect to revoke your election for that benefit and elect another similar benefit option, if one is available (as determined by the Employer). If no similar benefit option is available, you may elect to drop your coverage because of the increased cost.

If the amount that you are required to pay for a benefit option significantly decreases (as determined by the Employer) during the Plan Year, you may elect that benefit option for yourself or an eligible spouse or dependent.

Ordinarily, you may change the amount you contribute to a dependent care flexible spending account because of a significant increase or decrease in cost. However, under applicable law, if the dependent care provider who is imposing the increased cost is a close relative of yours, you cannot change your election. For this purpose, a close relative includes your parent, grandparent, child, grandchild, brother, sister, niece, nephew, stepparent, stepchild, stepbrother, stepsister, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law or brother-in-law.

You may change your elections because of a significant cost change, as described above, regardless of the reason for the increase or decrease in your cost. It does not matter whether the change in cost results from an action taken by the Employer or if it occurs because of something you do (such as switching from part-time to full-time employment if that changes the amount you have to pay for coverage).

(ii) Coverage Changes. If your coverage under a benefit is significantly curtailed during the Plan Year, you may revoke your election of that benefit and elect another benefit option that offers similar coverage (as determined by the Employer), if any. Coverage is significantly curtailed only if there is an overall reduction of the coverage provided to all participants (as determined by the Employer).

If your coverage under a benefit is significantly curtailed during the Plan Year (as determined by the Employer), and the significant curtailment amounts to a complete loss of coverage (as determined by the Employer), you may change your elections as described in the previous paragraph. In addition, if you experience a complete loss of coverage and no other benefit option that provides similar coverage is available, you may drop the coverage entirely. A loss of coverage includes, for example, the elimination of a benefit option, the loss of availability of an HMO option in the area where you or your dependent reside, or a loss of coverage for you or a dependent under a health plan option because your expenses exceed an annual limit. The Employer, in its discretion, will determine when a curtailment of a benefit amounts to a complete loss of coverage.

If the Employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year (as determined by the Employer), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

(iii) Changes in Coverage of Dependents Under Other Plans. You may also change your elections to correspond to certain changes made under another employee benefit plan. For example, if your spouse's employer has a cafeteria plan with an election period that is different from this Plan's annual election period, you may change your benefit elections to correspond to the changes elected by your spouse during his or her employer's annual election period. Also, if another employer sponsors a cafeteria plan that allows participants to make changes during a Plan Year, such as the ones permitted by this Plan, and a permitted change under that other plan affects you or your eligible dependent, you may elect changes to your coverage under this Plan, as long as your change corresponds with the change made under that other plan. For example, if your spouse revokes a benefit election for a medical plan offered by his or her employer because of an increase in cost, you could change your elections under this this Plan to elect coverage for your spouse.

(iv) Loss of Other Group Health Coverage. If you or your eligible spouse or dependent loses coverage for any group health coverage sponsored by a governmental entity or an educational institution (as determined by the Employer), you may change your election of benefits to elect coverage for the affected individual.

(e) Other Election Changes. Except as otherwise provided below, if you are entitled to an election change described below, you must request the change within 30 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

(i) Orders Requiring Coverage. If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical coverage for your child, you, or, if required by the order, the Plan Administrator, may change your health coverage elections (to the extent permitted by the Plan Administrator, in its discretion) to provide such coverage and you, or if required by the Order, the Plan Administrator, may change the amount of your salary reduction contributions to cover the cost of such coverage. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order and you provide evidence to the Employer that such coverage is actually being provided, subject to the Employer's approval, you will be permitted to change your election to stop providing medical coverage for your child.

(ii) Medicare or Medicaid Enrollment. If you or your spouse or dependent becomes enrolled in Medicare or Medicaid, subject to the Employer's approval, you may change your election to cancel or reduce medical coverage for that individual. If you or your spouse or dependent loses eligibility for Medicare or Medicaid, again subject to the Employer's approval, you may change your election to commence or increase medical coverage for that individual.

(iii) Revoking Medical Coverage Because of Reduction in Hours. If you are enrolled in medical coverage under this Plan and you are reasonably expected to average at least 30 hours of service per week (as determined by the Employer) but you experience a change in employment status so that the Employer no longer reasonably expects that you will work an average of 30 or more hours per week (as determined by the Employer), you may change your benefit election to cancel your medical coverage (for you and all covered dependents) to enroll in other medical coverage that qualifies as minimum essential coverage for purposes of the Affordable Care Act (such as coverage under another employer's plan or coverage offered through a state or federal exchange or marketplace) if that new coverage is effective no later than the first day of the second month that begins after your medical coverage under this Plan terminates. To qualify to change your coverage, you must provide a signed statement certifying that that you (and

all dependents whose coverage under this Plan is also being terminated) have enrolled in or will enroll in the other coverage by the deadline described in the previous sentence. The Employer, in its discretion, may require additional documentation of the other coverage. Note that this rule applies only to medical coverage (not including any Health FSA) and does not allow you to change your election of benefits for any other coverage offered under the Plan.

(iv) Revoking Medical Coverage to Enroll in Marketplace Coverage. If you have an enrollment opportunity to enroll in a Qualified Health Plan through an exchange or marketplace established under the Affordable Care Act ("Marketplace Coverage"), you may change your benefit elections under this Plan to cancel medical coverage under this Plan but only if you (and all dependents whose coverage under this Plan is being cancelled) are also enrolling in Marketplace Coverage. Cancelling coverage under this Plan based on this rule will be permitted only if the Marketplace Coverage (for all covered persons whose coverage under this Plan is being cancelled) is effective no later than the next day after coverage under this Plan would terminate because of the cancellation of coverage. The Plan may rely on your reasonable representation that all covered persons whose coverage is being cancelled have enrolled in or will enroll in Marketplace Coverage to be effective no later than the deadline indicated in the previous sentence, but the Employer, in its discretion, may also require additional documentation of the Marketplace Coverage. Note that this rule applies only to medical coverage (not including any Health FSA) and does not allow you to change your election of benefits for any other coverage offered under the Plan. Also, note that you are permitted to enroll in Marketplace Coverage only during the annual Marketplace enrollment period or based on a Marketplace special enrollment opportunity. Details about the enrollment periods for Marketplace Coverage are available at: www.HealthCare.gov.

(v) FMLA Leave. If you take leave under the Family and Medical Leave Act of 1993 (FMLA), you may make certain election changes that are permitted by the Employer in accordance with the FMLA.

(f) Special Enrollment Periods for Employees and Dependents. If you decline enrollment in the Plan's medical coverage options 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 the Plan's medical coverage if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Note that days during the "Outbreak Period", as defined on the "About This Summary" page at the beginning of this document, are not counted in determining if you have requested enrollment within that 30-day period (so the 30-day period is extended to also include the full Outbreak Period).

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 and your dependents in the Plan's medical coverage. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Note that days during the "Outbreak Period" are not counted in determining if you have requested enrollment within that 30-day period (so the 30-day period is extended to include the full Outbreak Period).

If you or your eligible dependent are covered under Medicaid or a State Children's Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and

any affected dependent in this Plan's medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. Also, if you or your eligible dependent become eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days after the date a government agency determines that you are eligible for that financial assistance. Note that days during the "Outbreak Period" are not counted in determining if you have requested enrollment within that 60-day period (so the 60-day period is extended to include the full Outbreak Period).

If you are eligible to make a special enrollment election described in this section, you may elect coverage under any medical coverage options for which you are eligible under the Plan. If you are eligible for more than one medical coverage option and you are currently enrolled in one coverage option, you may change to a different medical coverage option that is available to you. Benefits elected during a special enrollment period become effective no later than the first day of the first month that starts after you properly elect coverage. However, for a special enrollment election based on a birth, adoption or placement for adoption, your coverage would be effective starting on the date of the birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator at the address provided in this Summary.

Termination of Participation

Coverage for a participant generally terminates on the earliest of the following dates:

(a) The day the participant terminates employmen.t

(b) Except for certain leaves of absence, the day the participant ceases to qualify as an eligible employee of the Employer.

(c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.

(d) Except to the extent required by law, the day the participant reports for active duty as a member of the armed forces of any country.

(e) The day all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

Coverage for an eligible dependent of a participant generally terminates on the earliest of the following dates:

(a) The day the participant terminates employment.

(b) Except for certain leaves of absence, the day the participant ceases to qualify as an eligible employee of the Employer.

(c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.

(d) Except to the extent required by law, the day the eligible dependent reports for active duty as a member of the armed forces of any country.

(e) The day all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

(f) The day the eligible dependent ceases to be an eligible dependent.

Coverage under the Plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.

For coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may occur in only two situations. First, as indicated above, if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with respect to the Plan, or makes an intentional misrepresentation of a material fact. In that case, the Plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the Plan. See the "Continuation and Conversion Rights" and "COBRA Notice" sections of this Summary for more details.

Also, if you take a leave of absence from employment with the Employer because of military service and your health coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue health coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in the COBRA notice section of this Summary and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different and the special COBRA coverage limits that apply to health care flexible spending accounts do not apply to USERRA continuation coverage under a Health FSA. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the date coverage would terminate under the Plan's normal termination provisions for a reason other than your military service (2) the last day of the 24-month period beginning on the date your military leave of absence begins; or (3) the day after the date on which you fail to timely apply for or return to a position of employment with the Employer. Please contact the Employer if you have questions about coverage during periods of military service.

If you are on an approved leave of absence, your coverage will not terminate because of the leave of absence as long as you pay your share of any required contributions on time (as determined by the Employer). Such an approved leave of absence can last up to one year. If you do not return to work when your leave of absence ends or if you fail to pay any required contributions on time, coverage will be terminated, subject to any COBRA rights or any other provision of this Plan that may provide for continued coverage. Continuation under this provision is dependent upon your compliance with all reasonable requests for documentation of your status.

In some cases, the measurement period rules described in the "Additional Eligibility Opportunities Based on Measurement Periods" section of this Summary may provide that you will remain eligible for continued medical coverage during a period when you are not actively at work but are on approved leave. If those provisions require that coverage continue during an applicable stability period for a period that is longer than would otherwise apply under other terms of the Plan, including under the rules described above in this "Termination of Participation" section (as determined by the Employer), those measurement period provisions will prevail.

Summary of Available Benefits

The following benefits are available under the Plan. Any salary reduction contributions you will be required to make to obtain any elected benefit will be determined by the Employer, and will be communicated to you from time to time. Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect you or require a change to your elections or benefits, you will be notified.

Medical/Prescription Drug Coverage. If you are eligible to participate in the Plan, you may purchase medical/prescription drug coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Medical coverage under the Plan will comply with the reconstructive surgery requirements of the Women's Health and Cancer Rights Act of 1998.

Dental Coverage. If you are eligible to participate in the Plan, you may purchase dental coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Vision Coverage. If you are eligible to participate in the Plan, you may purchase vision coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Basic Life Insurance/AD&D Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense basic life insurance/accidental death and dismemberment (AD&D) coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Supplemental Life Insurance and/or AD&D Coverage. If you are eligible to participate in the Plan, you may purchase supplemental life insurance and/or AD&D coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Spouse Life Insurance and/or AD&D Coverage. If you are eligible to participate in the Plan, you may purchase spouse life insurance and/or AD&D coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Dependent Life Insurance and/or AD&D Coverage. If you are eligible to participate in the Plan, you may purchase dependent life insurance and/or AD&D coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Long Term Disability Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense long term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Short Term Disability Coverage. If you are eligible to participate in the Plan, you may purchase short term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, will be after-tax, and will be communicated to you from time to time.

Employee Assistance Program Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense employee assistance program coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Health Savings Account Contributions. If you are a participant in a High Deductible Health Plan offered under the Plan and you qualify as an HSA-eligible individual under rules that apply under federal tax law, you may elect to make salary reduction contributions to a health savings account (HSA) established in your name. Any limits on the amount you may contribute to your health savings account will be determined by the Employer and announced to participants from time to time. Health savings account contributions also are subject to limits that apply under the Internal Revenue Code and the Employer may limit the amount you may contribute to your health savings account through the Plan if it appears that contributions to the HSA exceed any limit that applies to you. You may also be able to make additional tax-deductible contributions to your HSA outside of the Plan, based on procedures established by the financial institution that maintains the account on your behalf.

To be an "eligible individual" for purposes of HSA contributions, in addition to being enrolled in a High Deductible Health Plan, note that you may not be enrolled at the same time in certain other types of medical coverage that does not qualify as a High Deductible Health Plan. For example, if you are covered under a spouse's health plan that is not a high deductible health plan or if you are covered under Medicare, you are not an eligible individual and so you

may not receive or make HSA contributions through the Plan. Also, if you are covered under the Plan's General-Purpose health care flexible spending account, you are not considered an "eligible individual". Whether you are an eligible individual is determined on a monthly basis. If you have any questions about whether any other coverage you have disqualifies you from being an "eligible individual", please contact the Plan Administrator.

Your HSA is considered your property and is not an Employer-sponsored plan. Payments provided through your HSA are not provided under this Plan and are not subject to the federal law known as ERISA or to the claims procedures described in this Summary. The "Your Rights under ERISA" section of this Summary does not apply to these benefits. Generally, your HSA can be used to pay or reimburse eligible medical expenses, including amounts that are counted towards the deductible for your High Deductible Health Plan. For details about the HSAs that may be funded through the Plan, you should contact the financial institution that maintains your HSA or contact the Employer if you need help in getting those details.

Health Care Flexible Spending Account. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed $3,050 (for the Plan Year beginning in 2023). The Plan's maximum contribution amount is required by federal law. The maximum amount is adjusted by the IRS each year based on inflation. The Plan's maximum contribution amount will also be automatically adjusted each year based on the new maximum announced by the IRS unless the Employer specifies a lower limit during the applicable enrollment period.

You can receive amounts from this Account as reimbursement for eligible medical expenses (as defined in the Plan) incurred during the Plan Year and while you are a participant in the Health FSA.

If you do not use up your entire Health FSA balance with expenses incurred by the end of the Plan Year, there is also a "grace period" that lasts two and one-half months after the end of the Plan Year. Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Health FSA on the last day of the Plan Year. You will still be treated as participating in the Health FSA for this purpose if you elected COBRA continuation coverage under the Health FSA and that COBRA coverage is in effect on the last day of the Plan Year. If your participation in the Health FSA ends before the end of the Plan Year, there is no grace period.

The Plan offers two types of Health FSAs. You may enroll in only one type of Health FSA at a time. The **General-Purpose Health FSA** is a traditional type of Health FSA that allows you to be reimbursed for eligible medical expenses that are not covered by other insurance (as detailed below). However, employees who participate in a General Purpose Health FSA are not eligible to make or receive health savings account contributions, so, for employees who are enrolled in a High Deductible Health Plan, the Plan also offers an HSA-compatible Health FSA, which is called a **Limited Purpose Health FSA**. You are eligible to participate in the Limited Purpose Health FSA for a Plan Year only if you have also elected coverage under the Plan's High Deductible Health Plan option for the same Plan Year.

Generally, eligible medical expenses are expenses that you or your eligible dependent (determined as described below) have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of medical expenses (including legally obtained prescription drugs, over-the-counter medicine and menstrual

care products), and that have not been taken as a deduction in any year. (However, not all of those expenses can be reimbursed, by a Limited-Purpose Health FSA, as described below.)

In addition to the above requirements, payments from a Limited-Purpose Health FSA will be made only for expenses that qualify for reimbursement under an HSA-compatible limited-purpose health care flexible spending account under IRS regulations and other guidance, such as expenses for vision care, dental care or preventive care.

Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

For purposes of Health FSA reimbursements, "dependent" includes:

(1) your spouse (as determined under federal law);

(2) your biological, adopted or step-child or your eligible foster child if the child will be younger than 27 on the last day of the calendar year in which the expense is incurred (even if the child is not your dependent for tax purposes); and

(3) any person who is expected to be your *dependent for federal income tax purposes* (as defined below) for the calendar year in which the expense is incurred.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Health FSA benefits. However, for purposes of the Health FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for Health FSA benefits. The Plan Administrator always has the right to require documentation that an individual qualifies as your spouse or dependent for Health FSA purposes and to deny benefits if you fail to provide adequate documentation when required. If you have any question about whether someone qualifies as your dependent for purposes of the Health FSA, you should consult a tax advisor.

To be reimbursed from your Health FSA, you must submit to the Plan Administrator a request for reimbursement on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than 5 ½ months days after the earlier of (1) the last day of the Plan Year in which the expenses were incurred or (2) the date your participation in the Health FSA ends. Note that the time limit for submitting claims described in the preceding sentence is extended if that time limit would otherwise end during the Outbreak Period (as defined on the "About This Summary" page at the beginning of this document). Days during the Outbreak Period do not count for purposes of any such time limit.

You may be provided with a debit card that may be used to pay for eligible expenses directly from your Health FSA. If so, before you may use the debit card, you must agree in writing that you will use the card only to pay for eligible medical expenses for you or your spouse or dependents (as determined under federal tax law), that you will not use the debit card for any medical expense that has already been reimbursed, that you will not seek reimbursement under any other health plan for any expense paid with a debit card, and that you will obtain and keep sufficient records (including invoices and receipts) for any expense paid with the debit card. You may be required to provide receipts to the Plan to substantiate the expenses paid through a debit card. Additional details about the use of the debit card will be provided to you at the time the card is provided.

Please note that amounts held in your Health FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited, unless the amount is eligible to be carried over to the next Health FSA Plan Year, as described below.

Qualified Reservist Distributions

If you are called or ordered to active duty in a United States reserve component for a period of 180 days or longer or for an indefinite period (or for a shorter period that is later expanded to 180 days or longer), and the amount you have received in reimbursements from your Health FSA for the Plan Year is less than the amount you have contributed, you may request a Qualified Reservist Distribution of your unused balance (the difference between what you have contributed and the amount of reimbursements you have received). The distribution generally would be treated as taxable compensation to you. You must request the distribution before the end of the grace period for the Plan Year during which you are called or ordered to active duty. If you request a distribution, you may continue to submit claims for expenses incurred before you made your request, but you may not submit claims for expenses incurred after that date. Your request must include a copy of the document that orders or calls you to active duty (if not already provided to the Employer). If you qualify for a Qualified Reservist Distribution, the distribution will be made within a reasonable period (no later than 60 days) after you request it. Once you receive a distribution equal to your entire unused balance, you will no longer be a participant in the Health FSA for that Plan Year and will not be able to submit or be reimbursed for any additional claims for eligible medical expenses. To request a Qualified Reservist Distribution or for more information, you should contact the Plan Administrator at the address provided in this Summary.

Dependent Care Flexible Spending Account. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed $5,000 per calendar year or, for married participants filing separately, $2,500 per calendar year, credited to your dependent care flexible spending account (Dependent Care FSA).

You can receive amounts from this Account, in cash, as reimbursement for Employment Related Expenses incurred during the Plan Year and while you are a participant in the Dependent Care FSA. However, if you do not use up your entire Account balance with expenses incurred by the end of the Plan Year, there is also a "grace period" that lasts two and one-half months after the end of the Plan Year (that is, until September 15 of the next Plan Year). Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Dependent Care FSA on the last day of the Plan Year. If your participation in the Dependent Care FSA ends before the end of the Plan Year, there is no grace period.

The amount of any reimbursement for Employment Related Expenses may not exceed the amount credited to your Account at the time of your reimbursement request. Generally, under federal law, Employment Related Expenses are expenses for household services and expenses related to the care of a "Qualifying Individual", which you incur to enable you to work.

"Qualifying Individual" is defined under federal law and currently means someone who is:

(1) your child (including a stepchild), brother, sister, stepbrother or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13 who has the same principal residence as you for at least half of the calendar year and who does not provide at least half of his or her own support for the current calendar year,

(2) your spouse (for purposes of federal law) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year or

(3) your *dependent for federal income tax purposes* (as defined below) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Dependent Care FSA benefits. However, for purposes of the Dependent Care FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for Dependent Care FSA benefits.

The Plan Administrator always has the right to require documentation that an individual qualifies as a Qualifying Individual under the above rules and to deny benefits if you fail to provide adequate documentation when required or if the Administrator determines that expenses for any person are not eligible for reimbursement. If you have any question about whether someone qualifies as your dependent for purposes of the Dependent Care FSA, you should consult a tax advisor. Also, note that the determination of whether someone is a Qualifying Individual must be made each time expenses are incurred. For example, if your child is age 12 at the start of the calendar year, otherwise eligible expenses for that child can be reimbursed under the Dependent Care FSA only for services provided before the child's 13th birthday (unless the child is mentally or physically incapable of taking care of himself or herself).

The amount of reimbursements that you may receive from your Dependent Care FSA on a tax-free basis in a calendar year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. Thus, for example, if you have $5,000 in your Dependent Care

FSA and you and your spouse have Earned Income of $20,000 and $4,000, respectively, you can receive $4,000 worth of reimbursement from the Account on a tax-free basis, and you will be taxed on $1,000 worth of the reimbursement you receive. If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have Earned Income for each month that he or she is a full-time student or incapacitated. The amount of deemed earnings will be $250 a month, if you provide care for one Qualifying Individual, or $500 a month, if you provide care for more than one Qualifying Individual.

Employment Related Expenses that are incurred for services outside your household may be reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under thirteen years of age (category (1) in the above definition of Qualifying Individual), or (ii) another Qualifying Individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center (as defined below), the Center must comply with applicable laws and regulations of a state or local government. A "Dependent Care Center" is any facility that provides care for more than six individuals who do not reside at the center and receives a fee, payment or grant for providing services for any of the individuals.

No reimbursements will be made for Employment Related Expenses for services rendered by any person for whom you or your spouse is entitled to a deduction on your federal income tax return for the applicable calendar year or who is your child (including a stepchild or a foster child) who will be under the age of 19 at the end of the year.

To be reimbursed from your Dependent Care FSA, you must submit a reimbursement request to the Plan Administrator on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit such requests no later than three months after the earlier of (1) the last day of the grace period for the Plan Year in which the expenses were incurred or (2) the date your participation in the Dependent Care FSA ends.

If your employment terminates during the Plan Year (or if you cease to be eligible to participate in the Dependent Care FSA for any other reason), your contributions to your Dependent Care FSA will cease, but, if you still have a balance credited to your Dependent Care FSA, you may still submit claims for reimbursement for eligible expenses incurred during the rest of the Plan Year or the grace period for that Plan Year, until your account balance is exhausted. The rules and deadlines for submitting requests for reimbursements are the same as those that apply for active eligible employees.

You may be provided a debit card that you may use to pay for eligible expenses that may be reimbursed from your Dependent Care FSA. If so, the debit card may be used only to reimburse incurred expenses that have been substantiated under rules that apply under IRS regulations. Details of the requirements for using the debit card will be provided at the time you receive the card.

Please note that amounts held in your Dependent Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts which you exclude from income under the

Dependent Care FSA will reduce, dollar for dollar, the tax credit available. Attached as an Exhibit is a notice which further explains the dependent care tax credits and the income exclusions. The notice also provides a worksheet to help you determine which tax reduction method is more beneficial for you.

Dependent Care FSA benefits are not subject to the federal law known as ERISA, so the "Your Rights under ERISA" section of this Summary does not apply to these benefits.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your health care continuation or conversion rights, please contact the Plan Administrator. Also, please review the next section regarding continuation coverage under the federal law known as "COBRA".

Continuation Coverage Under COBRA (COBRA Notice)

This "COBRA Notice" section of your Summary Plan Description applies to employees and covered spouses and dependents who have health coverage under the Plan. For purposes of this notice, "Plan" refers only to the medical/prescription drug, dental, vision, employee assistance program, and health care flexible spending account benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

You're getting this notice because you are covered 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. (Both you and, if you are married and your spouse is covered by the plan, your spouse should take the time to carefully read this notice.)

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 review the Plan's Summary Plan Description or 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 known as 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).

You must give notice of some qualifying events

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 later of (1) the date the qualifying event occurs or (2) the date that coverage would otherwise end because of the qualifying event. You must

provide this notice, along with any required documentation to:

Hood College
c/o Human Resources Department
401 Rosemont Avenue
Frederick, MD 21701-8575

Note that the 60-day period described above is extended for any qualifying event, if that 60-day period otherwise would have included any day of the Outbreak Period (as defined on the "About This Summary" page at the beginning of this booklet). Days during the Outbreak Period do not count towards the 60-day time limit.

Your notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- Your name, address, phone number and health plan ID number.
- The name, address, phone number and health plan ID number for any dependent or spouse whose eligibility is affected by the qualifying event.
- A description of the qualifying event and the date on which it occurred.
- The following statement: "By signing this letter, I certify that the qualifying event described in this letter occurred on the date described in this letter."
- Your signature.

You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided in this notice.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, you may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

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. (NOTE: The rest of this paragraph applies to health plans other than the health care flexible spending account plan. For the rules that apply to the health care flexible spending account, see the "Special Rules for Health Care Flexible Spending Accounts" section below.) COBRA coverage generally lasts for 18 months if the qualifying event is 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 two 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 the Social Security Administration 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 total 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. To notify the Plan Administrator of a disability determination, you should follow the same procedures described above under "You Must Give Notice of Some Qualifying Events". Your notice must include documentation of the Social Security Administration's decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event. However, regardless of the deadline described in the previous sentence, your notice must be provided no later than the date your COBRA coverage would terminate without a disability extension.

Note that the 60-day period for you to provide notice of a disability determination is extended if that 60-day period otherwise would have included any day of the Outbreak Period (as defined on the "About This Summary" page at the beginning of this booklet). Days during the Outbreak Period do not count towards that 60-day time limit.

Second qualifying event extension of 18-month period of COBRA 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 (following the same procedures described above under "*You Must Give Notice of Some Qualifying Events*"). 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), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but this extension is available only 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.

Special rules for health care flexible spending accounts

For a health care flexible spending account (Health FSA), COBRA continuation coverage is available **only if** the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs (plus any grace period that applies after the end of that Plan Year (as described in the Plan's SPD), but only if the qualified beneficiary keeps COBRA coverage in effect through the last day of the Plan Year). COBRA coverage under the Health FSA cannot be extended beyond that time for any reason.

> *EXAMPLE: Assume that an employee elected to contribute a total of $1,200 to her Health FSA account for a Plan Year and then her employment terminates six months after the beginning of the Plan Year. By that time, she has contributed $600 to her FSA account*

through payroll deductions. Assume that she has already received $800 in reimbursements from her account for expenses incurred before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is $400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of $588 or less before her termination date, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay ($612).

Any deadlines or other rules for filing a request for reimbursement under the Health FSA will continue to apply if you elect continuation coverage under the Health FSA. See your Summary Plan Description for more details.

Additional continuation coverage election period for "TAA-eligible individuals"

In addition to the other COBRA rules described in this section of your Summary Plan Description, there are some special rules that apply if you are classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.)

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than six months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this Notice, your coverage period will be measured from the date of your TAA-related loss of coverage.

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 Program (CHIP), 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 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.

Plan Contact Information

If you have questions or need more information about COBRA continuation coverage under the Plan or to report any address changes, please contact the Plan Administrator at the address or phone number provided in this Summary.

Emergency Medical Care

If you believe you need emergency medical care, you should not forego that care because you believe it will not be covered by the Plan. Also, in accordance with the No Surprises Act, if you are covered under the plan's medical coverage, the Plan must cover services, supplies, and treatment for the stabilization, evaluation, and/or initial treatment of an emergency medical

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

condition when provided on an outpatient basis at a hospital emergency room or department or at a freestanding independent emergency department ("Emergency Services") without prior authorization and with in-network cost-sharing. In addition, the No Surprises Act prohibits balance billing by nonpreferred providers. As a result, your responsibility for Emergency Services will be limited to your deductible and coinsurance amounts.

Patients to Evaluate Care

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any practitioner. Each patient should evaluate the quality of care and act accordingly. No Plan provision expressed in this Summary or the Plan documents should be interpreted to restrict the access to or delivery of medically necessary services. A patient's decision to forego such care should not be based on his or her interpretation of this Summary Plan Description or the Plan documents.

Health Information Privacy

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. If you are an employee and you are covered under any of the Plan's health benefit options, you should have received a copy of the Plan's Privacy Notice with this Summary (if you did not previously receive one). In addition, a copy of the Plan's current Privacy Notice is always available upon request. Please contact the Plan Administrator at the address indicated later in this Summary if you would like to request a copy of the Notice or if you have questions about the Plan's privacy policies. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Medical Benefits Following Childbirth

The Plan and any health insurance company insuring health benefits under the Plan, 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 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 and/or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, the Plan and any health insurance company may not, under federal law require that a provider obtain authorization from the Plan or health insurance company, if any, for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

Notice of Required Coverage Following Mastectomies

If you are covered under medical coverage offered under the Plan and 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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Please contact the Plan Administrator or refer to the Benefit Booklet for your medical coverage for more detailed information regarding deductibles and coinsurance for these benefits under the Plan.

If you would like more information on WHCRA benefits, please contact the Plan Administrator at the address provided in this Summary.

Claims Procedures

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and for certain medical benefits, the applicable requirements of regulations issued under the Affordable Care Act and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures generally will apply instead of the claims procedures described in this Summary. This Claims Procedure section includes descriptions of the minimum requirements for claims procedures that apply to insured benefits, but full details of claims procedure rules for insured benefits are described in the insurer's Benefit Booklet that describes the specific insured benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims, including claims for dependent care flexible spending account benefits, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator (or an insurer) provide notice to a claimant about any right under ERISA will not apply to such a claim. This claims procedure section does not apply to any health savings account. Procedures for requesting and receiving payments from your health savings account are established by the financial institution that administers the HSA.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act and for purposes of any disability benefits that are subject to ERISA, "adverse determination" also includes any rescission of coverage. A rescission of coverage generally is a retroactive termination of coverage because of fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a "rescission" and is therefore an adverse determination that is subject to these claims procedures will be determined by the Reviewer based on applicable law.

Temporary "Outbreak Period" Extension of Time Periods for Filing Claims and Appeals

Note that any time limit described in this Claims Procedure Summary or in a Benefits Booklet for submitting an initial claim or requesting a review or appeal or external review of an adverse determination regarding a claim under a benefit that is subject to ERISA is extended if that time limit would otherwise include any day in the Outbreak Period (as defined on the "About This Summary" page at the beginning of this document). Days during the Outbreak Period do not count for purposes of any such time limit.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. Claims should be submitted promptly after an expense is incurred. Unless a different deadline expressly applies in this Summary or under a Benefits Booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred. (For deadlines for submitting flexible spending account reimbursement requests, see the "Summary of Available Benefits" section of this Summary.)

The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, using the following procedures.

For purposes of these procedures, "health benefit" or "health claim" refer to benefits or claims involving medical, dental, vision or health care flexible spending account coverage. Also, a benefit or claim is considered a "disability benefit" or "disability claim" for purposes of these procedures if the benefit or claim, including claims for accidental death and dismemberment benefits, requires that the Plan or an Insurer make a determination of whether a claimant has experienced a disability.

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of

the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. The Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

(A) For any pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable

period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(B) For any post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services or other benefits already provided (or any other health benefit claim that is not a pre-service claim).

(c) Disability Benefit Claims. For any disability benefit claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial;

(ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information that the Claimant must provide to perfect the claim (including an explanation of why the information is needed);

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;

(v) A statement of the Claimant's right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial and a description of any time limit that would apply under the Plan for bringing such an action.

In addition, for a denial of health benefits, the following will be provided to the Claimant:

(vi) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and

(vii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).

(viii) For an adverse determination concerning an urgent care health claim, the notice will also include information about the expedited process that applies to such claims and the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

For any claim for disability benefits, the notice will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and also will include the following:

(ix) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(x) If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or

a statement that such explanation will be provided free of charge upon request;

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

(xii) 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.

Reviews of Initial Adverse Determinations

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

(a) Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after you receive notice of the initial denial of the claim. The decision on review will be made within a reasonable time but no later than 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the

medical judgment before making a decision on review of any adverse initial determination based in whole or in part 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 professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) For purposes of any medical coverage and for claims for disability benefits, the Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:

(A) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by or on behalf of the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(B) For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within a reasonable time but not later than 45 days after the Reviewer's receipt of a request

for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

(i) a description of its decision;

(ii) a description of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claim for benefits;

(v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA section 502(a) and a description of any time limit that applies under the Plan for bringing such an action (including, for disability benefit claims, the date that any applicable time limit for bringing such an action would expire).

(vi) if applicable, a statement describing any voluntary appeal procedures offered by the Plan and about the Claimant's rights to obtain information about such procedures

(vii) in addition to items (i)-(vi) above, for any notice of adverse determination regarding health benefits, the following will be provided:

(A) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(B) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request; and

(viii) in addition to items (i)-(vi) above, for claims for disability benefits, the notice of Adverse Determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices and will include:

(A) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(B) If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

Additional Requirements for Medical and Disability Claims

For any adverse determination involving medical coverage, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Also, for all claims involving coverage that is subject to the Affordable Care Act and for disability benefit claims, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the

denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the determination will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits other than health benefits, the period for making the determination on appeal will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant's Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan's Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim involving medical coverage, you will be deemed to have exhausted the Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the Plan's claim procedures (and applicable regulations) unless the Plan's failure to adhere to those requirements is a minor violation, as defined below. If are you are deemed to have exhausted the Plan's internal claims and appeals process based on the preceding sentence, in addition to the right to pursue any available remedy under ERISA, you will have the right to pursue any remedy under any available external review process provided under federal or state law.

Also, for claims for disability benefits, you will be deemed to have exhausted the Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the requirements of applicable requirements of applicable regulation unless the Plan's failure to adhere to those requirements is a "minor violation" (as defined below).

For purposes of this Section, the Plan's failure to satisfy applicable claim procedure regulations is a "minor violation" if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this minor violation exception applies, you may request a written explanation of the violation from the Plan, and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that

the violation should not cause the internal claims and appeals process to be deemed exhausted.

For claims involving medical coverage, if an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon your receipt of the notice.

For claims involving disability benefits, if a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, the claim will be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. In such cases, within a reasonable time after the Plan's receives the decision, the Plan will provide you with notice of the resubmission.

External Review

(a) External Review Process. For purposes of any coverage that is subject to the Affordable Care Act, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with the interim procedures for federal external review in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance. The Plan will begin complying with any new requirements for external review guidance on or before the date that those requirements become applicable to the Plan.

(b) Availability of External Review. External review is not available for all adverse determinations. For example, external review is not available for an adverse determination based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan. External review is available only for:

(i) any final internal adverse determination (or an initial internal adverse determination on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal adverse determination that involves a rescission of coverage; or

(iii) items and services within the scope of the requirements of the federal law known as the No Surprises Act (i.e., emergency services provided by a nonpreferred provider, air ambulance services provided by a nonpreferred provider, ancillary services, and other non-emergency services), except that external review is not available when:

(A) adjudication of the claim results in a decision that does not affect the

amount the Participant or covered Dependent owes;

(B) the dispute only involves payment amounts due from the Plan to the provider; or

(C) the provider has no recourse against the Participant or covered Dependent.

(iv) Any other final adverse determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

(c) Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives notice of an adverse determination for which external review is available.

(d) Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the time the health care item or service was provided;

(ii) The adverse determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe the reasons external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the Claimant receives the notice. However, the time period for a Claimant to respond to a notice regarding an incomplete request is extended during the Outbreak Period (as defined on the "About This Summary" page at the beginning of this Summary). Days in the Outbreak period are not counted in determining if the information needed to perfect a request for external review is provided within the specified time period.

(e) Referral to Independent Review Organization. External reviews are conducted by independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized

accrediting organization to conduct the external review. The Plan will contract with at least three different IROs. The Plan will take action against bias and to ensure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Under a contract between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving any information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(A) The Claimant's medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating provider;

(D) The terms of the Plan, unless the terms are inconsistent with applicable law;

(E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(G) The opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.

(vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.

(vii) The IRO's notice will include:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;

(F) A statement that judicial review may be available to the Claimant; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA.

(viii) The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by the Claimant, Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(e) Effect of External Review Decision. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse determination, the Plan will provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

(a) Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an adverse determination that otherwise qualifies for external review (as described above) and that is:

(i) An adverse determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under the Plan's normal procedures for urgent care claims would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final adverse determination, if the Claimant has a medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(b) Procedures for Expedited External Review.

(i) In General. The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review. The Plan will immediately send the Claimant a notice of its eligibility determination that meets the preliminary review notice requirements described above.

(iii) Referral to IRO. Upon a determination that a request is eligible for external review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide review as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

Insured Benefits and State Law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Termination or Amendment of Plan

The Employer expects to maintain the Plan indefinitely as a program of employee benefits. However, the Employer has the right, in its sole discretion, to terminate or amend any provision of the Plan at any time. Therefore, no Plan participant (including any future retiree or retiree who has already retired) has a right to the continued enjoyment of any particular benefit under the Plan after a Plan termination or amendment affecting those benefits.

No Right to Continued Employment

No provision of the Plan or this Summary shall be interpreted as giving any employee any rights of continued employment with the Employer or in any way prohibiting changes in the terms of employment of any employee covered by the Plan.

Non-Assignment of Benefits; Payments to Providers

No participant or beneficiary may transfer, assign or pledge any Plan benefits. Notwithstanding any provision of any Benefits Booklet or other document describing the benefits offered under the Plan, no benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. Also, no benefit under the Plan will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person. The Administrator may, in its discretion, elect to make a direct payment to a provider of services for which benefits are available under a Component Plan and such direct payment to the provider by the Plan shall not be considered an assignment or alienation under the Plan or any Component Plan, and neither the direction by a Plan participant, or any eligible or covered dependent to make such payment nor the payment itself shall be construed as an assignment of benefits or as a recognition by the Administrator of the validity of any attempted alienation or assignment of benefits under the Plan nor will any such payment confer on the payee any rights besides the right to receive the payment in the amount of that specific payment.

The Plan will honor any Qualified Medical Child Support Order (QMCSO) that provides for Plan coverage for an Alternate Recipient, in the manner described in ERISA §609(a) and in the Plan's QMCSO Procedures.

Coordination of Benefits

The coordination of benefits provisions described in the Benefits Booklets delivered to you with this Summary, as interpreted by the Plan Administrator (or insurer, if applicable) in its discretion, control all coordination of benefits situations involving the Plan and other payers.

Subrogation/Right of Reimbursement

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

Also, each participant and each covered person, as a condition for and consequence of receiving medical, disability or any other benefits under the Plan with respect to any amount that is subject to this subrogation provision, agrees as follows:

(1) The participant and each covered person (or their attorneys or other authorized representatives) will promptly inform the Plan of any settlement agreement and to provide reasonable advance notice of any plans for the disbursement of any settlement funds to the Participant or covered person (or to any other person on behalf of the covered person);

(2) The participant and each other covered person (or their attorneys or other authorized representatives) will hold any settlement funds received with respect to a claim that is subject to the Plan's subrogation rights in trust for the benefit of the Plan until all obligations to the Plan under this subrogation provision are satisfied (or to disburse such funds to the Plan to satisfy any obligations to the Plan under this subrogation provision);

(3) The participant and each other covered person (or their attorneys or other authorized representatives) will maintain and treat any settlement funds received by or on their

behalf, as Plan assets, to the full extent of any benefits paid by the Plan with the Participant or other covered person being a trustee of Plan assets with respect to such amounts until the covered person's obligations under this subrogation provision are satisfied; and

(4) The participant and each other covered person (or their attorneys or other authorized representatives) agree that the Plan has an equitable lien on any settlement funds payable to or on behalf of the Participant to the full extent of any benefits paid by the Plan amounts until the covered person's obligations under this subrogation provision are satisfied in full.

Insurance Contracts

The Employer has the right to enter into contracts with one or more insurance companies for the purpose of providing any Benefits under the Plan and to replace any such insurance company from time to time. If any Benefit is intended to be provided under an insurance contract, a Participant or other covered person may look only to the insurance company for payment of that benefit.

Any amounts payable by an insurance company with respect to or because of a contract entered into by the Employer (other than amounts payable on behalf of a covered person pursuant to a claim covered by the insurance contract), including but not limited to dividends, retroactive rate adjustments, medical loss ratio payments, experience adjustments or refunds of any type or any amount payable by the insurance carrier because of a court judgment, settlement agreement or arbitration decision in response to actual or potential litigation, arbitration or any other dispute between the insurance company and the Employer shall be the property of, and shall be retained by, the Employer, except to the extent, if any, that the Plan Administrator determines that a portion of any such amount is required to be treated as Plan assets under applicable law. To the extent that any portion of such a payment is required to be treated as Plan assets, as determined by the Plan Administrator, that amount will be used to pay reasonable Plan expenses or to provide Benefits or will be used for any other purpose that is consistent with applicable law regarding the use of such assets

Your Rights Under ERISA

As a participant in the Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA):

- You can examine, free of charge, at the Plan Administrator's office and at other locations, all of the Plan documents, including insurance contracts, if any, collective bargaining agreements and copies of all documents filed by the Plan (such as detailed annual reports) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- You can obtain copies of all Plan documents governing the operation of the Plan, by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

- In some cases, the law may require the Plan Administrator to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people

who operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. As described above, if your claim for a Plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision, without charge and have the Plan review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials from the Plan and do not receive them within 30 days, you may file suit in 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 Plan Administrator. If you have a claim for benefits which is denied after review and reconsideration by the Plan or is 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 considering the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse Plan funds, if any, 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.

You may have the right to continued health 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. You should review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, 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.

Further Information

If you have further questions regarding the Plan or this Summary Plan Description, please contact the Plan Administrator at (301)696-3590.

EXHIBIT: Dependent Care Tax Credit vs. Dependent Care FSA

If you have qualifying dependent care expenses, you may be able to choose one or both of two ways to reduce your taxes. You may be able to obtain a tax credit (which is a direct reduction in the amount of taxes you otherwise would owe) or you may be able to reduce your taxable income by contributing to a dependent care flexible spending account (Dependent Care FSA). This worksheet will help you decide which is better for you.

DEPENDENT CARE TAX CREDIT

If you qualify for the tax credit, you are allowed to deduct from the taxes you owe a percentage of the lesser of (1) your actual qualifying dependent care expenses or (2) $3,000 if you have one dependent or $6,000 if you have two or more dependents. The percentage is based on your adjusted gross income for the year (including your spouse's income if you file a joint return). The following chart will help you determine your percentage.

If your adjusted gross income is		The percentage of the cost of dependent care you can deduct from your taxes is:
over	to	
$0	$15,000	35%
$15,000	$17,000	34%
$17,000	$19,000	33%
$19,000	$21,000	32%
$21,000	$23,000	31%
$23,000	$25,000	30%
$25,000	$27,000	29%
$27,000	$29,000	28%
$29,000	$31,000	27%
$31,000	$33,000	26%
$33,000	$35,000	25%
$35,000	$37,000	24%
$37,000	$39,000	23%
$39,000	$41,000	22%
$41,000	$43,000	21%
$43,000	unlimited	20%

Example: An employee's adjusted gross income for the year is $34,000 and the employee spends $2,600 each year for day care for one dependent. When you compare $2,600 with the $3,000 allowed for one dependent, the lesser of the two amounts is $2,600. To find the employee's allowable percentage, you use the above chart. Since the employee's adjusted gross income is $34,000, the employee's percentage will be 25%. Therefore, the amount the employee will be able to deduct from his or her taxes will be $2,600 x 25% or $650.

INCOME EXCLUSION (DEPENDENT CARE FSA CONTRIBUTIONS)

Instead of the Dependent Care Tax Credit, each year you may elect to have a designated amount taken out of your paycheck before taxes and put into your Dependent Care FSA. This amount must be used during the year to pay for qualifying dependent care expenses. You will not have to pay taxes on the amount you put into the FSA that will be used to pay your qualifying dependent care expenses. If, however, either you or your spouse has Earned Income (as defined in the Plan) of less than $5,000, your income exclusion will be limited to the Earned Income of you or your spouse, whichever is less. Note that your maximum Dependent Care FSA contribution for any calendar year is $5,000 ($2,500, if you are married but file a separate federal income tax return), regardless of the number of qualifying dependents.

Example: The following is an example of an employee's comparison of the Dependent Care Tax Credit and the Dependent Care FSA. Assume the employee is married and the employee and spouse together expect to have $75,000 in adjusted gross income (AGI), and they expect to have $3,000 in qualifying dependent care expenses for the year for one qualifying child. They plan to file a joint federal income tax return. After taking the standard deduction ($25,900), their federal taxable income would be $49,100. Assume they live in a state that uses the same definition of taxable income as the IRS and a 5% tax rate. (Note that state income tax rates vary from zero to about 13% and states may use different definitions of taxable income. The federal tax rates and standard deduction amounts in this example are for the 2022 tax year.)

	Using the Tax Credit	Using the FSA
Federal Taxable Income (without Dependent Care FSA)	$49,100	$49,100
Subtract: Dependent Care FSA contribution	(0)	(3,000)
Federal Taxable Income	$49,100	$46,100
Taxes		
Federal (10% of first $20,550 of taxable income + 12% of amounts from $20,550 up to $83,550)	$5,481	$5,121
Social Security and Medicare (7.65% of AGI (minus Dependent Care FSA contributions))	5,737	5,508
State (5.0% of taxable income)	2,455	2,305
Total	$13,673	$12,934
Subtract: Tax Credit (20% of $3,000)	(600)	(0.00)
Total Taxes	$13,073	$12,934

In this example, the employee would pay $139 less in taxes by using the Dependent Care FSA. Of course, this is just one example. Other employees might pay lower taxes using the tax credit, so you should perform the calculations using your own estimated income, qualifying expenses and filing status. Also, note that participation in the FSA may affect other tax credits or deductions that you may qualify for, such as the Earned Income Tax Credit or the Child Tax Credit. You should consult with a tax advisor to determine which approach is best for you.

CALCULATE YOUR TAX CREDIT

Use the following chart to determine if you should use the Dependent Care Tax Credit or the Dependent Care FSA.

	Using the Tax Credit	Using the Income Exclusion (FSA)
Federal Taxable Income (before Dependent Care FSA)	$_____.	$_____.
Subtract: Dependent Care FSA contribution		($_____.)
Taxable Income	$.	$.
Taxes		
Federal* (_____%)	$_____.	$_____.
State* (_____%)	_____.	_____.
Social Security (generally 7.65% of total wages B remember to subtract FSA contributions for the second column)	_____.	_____.
Total	$_____.	$_____.
Subtract: Tax Credit (% from chart on previous page based on your adjusted gross income X your expected qualifying dependent care expenses)	($_____.)	
Total Taxes	$.	$.

*Federal and state tax rates vary depending upon your taxable income and filing status. Estimate your tax liability or check with your tax consultant. Also, note that Pennsylvania and New Jersey, unlike other states, do not exclude Dependent Care FSA contributions from state income tax.

USE OF BOTH DEPENDENT CARE TAX CREDIT AND INCOME EXCLUSION

You may use both the Dependent Care Tax Credit and the Dependent Care FSA (although not for the same qualifying dependent care expenses.) However, any amounts that you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the $3,000 or $6,000 Dependent Care Tax Credit figure, whichever is applicable.

Example: An employee's adjusted gross income for the year is $34,000 and the employee spends $2,600 during the year for qualifying day care for one dependent. The employee elects to contribute $1,200 into a Dependent Care FSA to pay for a portion of the dependent care expenses. When you compare the employee's remaining dependent care expenses of $1,400 with $1,800 ($3,000 - $1,200), the lesser of the two amounts is $1,400. Given the employee's adjusted gross income of $34,000, the employee's percentage from the chart is 25%. Therefore, the amount the employee may deduct from the employee's taxes will be $1,400 x 25% or $350.

ALWAYS DISCUSS THESE ISSUES WITH YOUR TAX ADVISOR.

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN	STATUS CHANGE FORM Please print neatly in ink
Name:	
SSN:	Telephone No.:
Address:	

You may change your elections under the Plan during a period of coverage if you experience a "status change", if you have a "special enrollment right" or under certain other circumstances. For status change elections (Part A below), the election change must be consistent with that Status Change. Please complete Part A below if you believe you have experienced a Status Change and want to change your coverage under the Plan, in a manner that is consistent with that Status Change.

Complete Part B below if you believe you have a "special enrollment right", as described in your Summary Plan Description. The election changes that are permitted because of a special enrollment right vary depending on the type of special enrollment right you experience. If you believe you have experienced both a status change and a special enrollment right, you should complete both Part A and Part B.

Complete Part C below if you want to change your election because of certain other changes described in Part C if the change you desire is consistent with a change described in Part C. Whether you complete Part A, Part B or Part C, you must sign at the bottom of Page 2.

The Employer may require additional information regarding certain types of changes. For example, if you wish to make a change because you become (or your spouse or dependent becomes) eligible for coverage under a Plan sponsored by another employer or for Marketplace coverage, you will be required to provide evidence that you have obtained or intend to obtain (or that your spouse or dependent has obtained or intends to obtain) that coverage. Please attach a copy of any documentation that you have regarding the change or event that has occurred.

NOTE: You also must complete a new Election Form to indicate the specific election changes you are requesting. The Employer will determine if you are eligible for any election changes you are requesting. Also, note that there are time limits for requesting election changes, so you should complete and submit this form as soon as possible after you experience one of the changes listed on this form (see your SPD for details).

PART A: STATUS CHANGE

You may change your elections due to a Status Change only if the Status Change affects your eligibility or the eligibility of your spouse or dependent for coverage under the Plan or under a plan sponsored by another employer.

Under penalties of perjury, by signing below, I certify that (i) to the best of my knowledge, the Status Change indicated below affected my eligibility or the eligibility of my spouse or dependent for coverage under the Plan, a plan sponsored by another employer by whom I am employed or a plan sponsored by the employer of my spouse or dependent, (ii) if I am dropping coverage for any person because of a change in eligibility under another plan, I have obtained or will obtain (within 30 days of the change in eligibility) coverage for that person under that other health plan, and (iii) the above election changes are being made due to, and are consistent with (Check One):

___ My marriage.

___ The death of my spouse or dependent.

___ My divorce, legal separation or legal annulment.

___ The birth, adoption or placement for adoption of my child.

___ The termination of my spouse's or dependent's employment.

___ The commencement of my spouse's or dependent's employment

___ The reduction or increase in hours of employment (including a switch between part-time and full-time employment, a strike or a lockout, or the commencement or return from an unpaid leave of absence) by me.

___ The reduction or increase in hours of employment (including a switch between part-time and full-time employment, a strike or a lockout, or the commencement or return from an unpaid leave of absence) by my spouse or dependent.

___ A change in my eligibility for coverage, under a plan offered by my employer, resulting from a change in my employment status.

___ A change in my spouse's or a dependent's eligibility for coverage, under a plan offered by my spouse's or a dependent's employer, resulting from a change in employment status.

___ The attainment of a particular age by a dependent that causes him or her to qualify or cease to qualify for coverage under the Plan.

___ The change in student status of a dependent that causes the dependent to qualify or cease to qualify for coverage under the Plan.

___ The attainment of a particular age by a dependent or other change that causes him or her to become or cease to be a Qualifying Individual for purposes of dependent care flexible spending account benefits offered under the Plan.

___ The change in location of my residence or worksite.

___ The change in location of my spouse's or a dependent's residence or worksite.

PART B: SPECIAL ENROLLMENT RIGHTS

Under penalties of perjury, I hereby certify that to the best of my knowledge, the change indicated below has occurred and that I am requesting an election change because of a special enrollment right that resulted from that change:

___ I have experienced a loss of eligibility for coverage under a group health plan or an insurance policy. (NOTE: A "loss of eligibility" occurs you are no longer eligible to be covered under a plan or insurance policy because you fail to satisfy the eligibility requirements for any reason. It also occurs if you are covered under an HMO or other plan that is limited to a specific geographic area and you move out of that coverage area. A "loss of eligibility" also occurs if you have COBRA coverage and you reach the end of the maximum COBRA coverage period . However, a voluntary decision to drop health coverage or a loss of coverage because the covered person fails to pay premiums is not a loss of eligibility.)

___ My spouse or dependent has experienced a loss of eligibility for coverage under a group health plan or an insurance policy. (See explanation of "loss of eligibility" above.)

___ I am covered or my spouse or dependent is covered under another employer's group health plan and that other employer has stopped contributing to the cost of that other coverage.

___ I have gained a dependent or a spouse because of a marriage, birth, adoption or placement for adoption.

___ I or my spouse or dependent was covered under Medicaid or under a State Children's Health Insurance Program (CHIP) and lost eligibility for that coverage.

___ I or my spouse or dependent have been determined by a government agency to be eligible for financial assistance from a State CHIP or Medicaid program to pay for a portion or all of the cost of coverage under the Plan.

PART C: OTHER CHANGES

Under penalties of perjury, I hereby certify that to the best of my knowledge, the change indicated below has occurred and that I am requesting an election change that corresponds to the indicated change because of that change (*Check One*) (*NOTE: The events marked with an asterisk (*) do not apply to coverage under a health care flexible spending account. You may not change your Health FSA elections because of any of those events)*:

___ A change in my eligibility for coverage under Medicaid or under Part A, Part B or Part D of Medicare.

___ A change in my spouse's or my dependent's eligibility for coverage under Medicaid or under Part A, Part B or Part D of Medicare.

___ A judgment, decree or order that makes another individual responsible for providing accident or health coverage for my covered dependent. I understand that I may not cancel coverage for my dependent unless I provide adequate evidence that the coverage required by the judgment, decree or order is actually being provided as required.

___ A significant change in the cost of coverage for a benefit other than dependent care flexible spending account benefits under this Plan (subject to the Employer's determination).*

___ A significant change in the cost of coverage for dependent care flexible spending account benefits (subject to the Employer's determination). By signing below, I certify that the dependent care provider is not a close relative of mine, including a parent, grandparent, child, grandchild, brother or sister, niece or nephew, stepparent, stepchild, stepbrother or stepsister, son-in-law or daughter-in-law, mother-in-law or father-in-law or sister-in-law or brother-in-law.

___ A significant curtailment of coverage for a benefit under the Plan (subject to the Employer's determination).*

___ The availability of a new benefit option under the Plan or the significant improvement of an existing benefit option (subject to the Employer's determination).*

___ A change made by my spouse or my dependent to an election for benefits under a cafeteria plan or another qualified benefit plan offered by my spouse's or my dependent's employer during an election period that corresponds to a period of coverage different from the period of coverage under this Plan.*

___ A change made by my spouse or my dependent to an election for benefits under a cafeteria plan or another qualified benefit plan offered by my spouse's or my dependent's employer during a period of coverage.*

___ My spouse's or my dependent's loss of group health coverage sponsored by a governmental entity or an educational institution.*

___ My loss of group health coverage sponsored by a governmental entity or an educational institution.*

___ My hours have been reduced, so that I am now working less than 30 hours per week and I wish to drop medical coverage (for myself and all covered dependents) to enroll in other medical coverage, which will be effective on (*enter date):* _____.

___ I am eligible to enroll in medical coverage through a federal or state exchange (Marketplace) and I wish to drop medical coverage (for myself and all covered dependents) to enroll in that Marketplace coverage, which will be effective on (*enter date):* _____.

Date: _____ Signature of Participant:_____

PLAN ADMINISTRATOR's USE: ☐ APPROVED ☐ DENIED

Date: _____ Signature: _____

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN	HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT REQUEST FORM

This form is for the Plan Year ending on June 30, 2024. Only expenses incurred between July 1, 2023 and September 15, 2024 may be reimbursed using this Form.
For expenses incurred after September 15, 2024 you must use the Form that applies for that period.

Please Print In Ink:

Employee's Name:

Employee's SSN:

Has Your Address Changed? (Check One): □ No □ Yes

If Yes, New Address:

Reimbursement request is for (Check one or both): □ Dependent Care FSA Expenses □ Health Care FSA Expenses

DEPENDENT CARE FSA REIMBURSEMENT:

Dependent Name	Date of Birth	Relationship to Employee

For each Provider of Services, please provide the following information (attach additional sheets if necessary):

Name:	Name:
Address:	Address:
Tax ID or SSN:	Tax ID or SSN:
Dates of Service: to	Dates of Service: to

If dependent care was provided in your home, complete the following:

Household services relating to the care of a qualifying individual	$
FICA and FUTA taxes on wages paid to a housekeeper	$
Room and board expenses incurred outside the home for a housekeeper	$
Transportation expenses of a housekeeper	$
Other (please list)	$
	$
	$
	$

If your eligible expenses were incurred outside of your home, complete the following:

Services related to the care of qualified individuals and incurred in a day care provider's home/day care center	$
TOTAL DEPENDENT CARE FSA REIMBURSEMENT REQUESTED:	$

HEALTH CARE FSA REIMBURSEMENT:

Items to be Reimbursed:	**Amount Requested:**
Medical/Dental/Prescription Deductible or Coinsurance	$
All Other Out-of-Pocket Health Care Expenses	$
TOTAL HEALTH CARE FSA REIMBURSEMENT REQUESTED:	$

EMPLOYEE SIGNATURE

I certify that I or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Flexible Spending Account(s). I further declare that I have not and will not deduct these expenses on my Individual Income Tax Returns. I also certify that these expenses have not been reimbursed by any other party and that I will not seek reimbursement for expenses that are reimbursed from my FSA from any other party. If the reimbursement claim is for Dependent Care FSA Expenses, I certify that the above eligible expenses have been (or will be) paid for the care of a qualified individual(s).

Date: _____ Signature:_____

Your check will be available at _____ after the _____ of each month.

IMPORTANT INSTRUCTIONS

1. Review the eligibility requirements which are attached to this form.
2. Fill out the information requested on this form.
3. Submit supporting documentation:
   For Dependent Care Reimbursement: A written statement from your day care provider, including the dates of service, the amount charged, and the provider's Social Security number or Tax ID Number.
   For Health Care Reimbursement: If the expense is at least partially covered by your medical plan, submit the Explanation of Benefit Statement, indicating the deductible and/or coinsurance amounts. If the expense is not covered by your medical plan, submit an itemized bill with the date of service and the amount charged.
4. Keep a copy of the supporting documentation for your records, along with a copy of this form.

ELIGIBILITY REQUIREMENTS FOR REIMBURSEMENT OF DEPENDENT CARE EXPENSES

1. Your expenses for dependent care services are eligible for reimbursement only if the services are performed for the benefit of a "Qualifying Individual." A Qualifying Individual is:
   (a) A child (including a step-child), sister, brother, stepsister or stepbrother of yours (or a descendent of your child, sister, brother, stepsister or stepbrother) who is under the age of 13, whose principal place of abode for at least one-half of your tax year is your home and who does not provide at least half of his or her own support for the tax year; or
   (b) Your spouse or a dependent of yours (for example, an elderly parent) whose principal place of abode for at least one-half of your tax year is your home, if he or she is incapable of self-care.

A "dependent" generally is someone you claim as a dependent on your federal income tax return (see your SPD for a full definition).

2. Eligible Dependent Care services include:
   (a) Service for the care of a Qualifying Individual; and
   (b) Household services (such as a maid's or cook's wages) provided they are related to the care of a Qualifying Individual.

   The expenses to be reimbursed must have been incurred to enable you or your spouse to remain gainfully employed during a period in which there was at least one Qualifying Individual residing in your household.

3. Other specific expenses for reimbursement might include:
   (a) FICA and FUTA taxes on wages paid to a housekeeper; and
   (b) Room and board expenses incurred for a housekeeper.

4. You cannot be reimbursed for expenses incurred for transportation of a Dependent to a day care center or for services provided by:
   (a) One of your (or your spouse's) dependents; or
   (b) One of your children (including a stepchild or a foster child) who is under the age of 19 at the end of the tax year.

5. In addition, the Flexible Spending Account cannot reimburse expenses for out-of-home care unless the Dependent spends at least 8 hours at home each day.

6. If you use the services of a "dependent care center", the center must meet all requirements of state and local law. A "dependent care center" means any facility which provides care for more than six individuals (other than individuals who reside there) and receives a payment or grant for providing dependent care services.

7. If you are married, you will only be eligible for reimbursement of dependent care expenses if your spouse is also employed, or if he or she is a full-time student or incapable of self-care.

8. You may not claim dependent care expenses which exceed the lowest of:
   (a) The fixed dollar maximum of your plan;
   (b) Your gross income; or
   (c) (If you are married) your spouse's gross income.

   If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have qualifying earnings for each month he or she is a full-time student or incapacitated. The amount of deemed earnings will be:
   (a) $250 a month, if you provide care for one Qualifying Individual, or,
   (b) $500 a month, if you provide care for more than one Qualifying Individual.

ELIGIBLE EXPENSES FOR YOUR HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Health Care Eligible Expenses. Health care expenses that are eligible for reimbursement include any amounts you pay toward the deductible and your share of other expenses covered by you or your spouse's health insurance plans. They include prescription medicine. Over-the-counter medicine that you purchase to treat a disease or injury is covered only if you have a prescription for the medicine.

They also include most health care expenses that may not be covered by a health plan, such as vision and hearing exams, eyeglasses and contact lenses, hearing aids, and routine physical exams. Keep in mind that health care expenses for your spouse, and any person who qualifies as your dependent for federal income tax purposes and for your child (a biological, adopted or step-child or an eligible foster child) who will be age 26 or under on the last day of the calendar year also are eligible. (For more details on deductible medical expenses, see IRS Publication 502, but note that although certain insurance premiums may be deductible as described in Publication 502, they are not eligible expense for purposes of the FSA.)

Following is a more complete list of eligible expenses. For many expenses, you will first file a claim for coverage under your or your spouse's health insurance plans. Any amount not paid by that plan can be reimbursed through the flexible spending account. Note that certain items on this list may be eligible expenses only if they are used to treat specific conditions, so you may be required to provide proof of a qualifying condition in addition to proof of the qualifying expense.

Abortion
Acupuncture (performed by a licensed practitioner)
Alcoholism or drug dependency (payment to a treatment center)
Ambulance
Analysis (psychotherapy by a licensed practitioner)
Artificial teeth
Birth control pills
Braille books and magazines
Car controls (special controls for the handicapped)
Chiropractors (services within scope of license)
Christian Science practitioners
Contact lenses
Crutches (purchase or rental)
Deductibles and co-payment (balance not paid by other medical insurance)
Dental fees (x-rays, fillings, braces, extractions, false teeth, treatments, etc.)
Doctor's fees
Drug addiction treatment
Eyeglasses (lenses, frames, exams)
Fertility enhancement
Founder's fee (monthly lump-sum fee to a retirement home (covers portion specifically for medical care))
Guide dog (purchase, for blind or deaf)
Halfway house (care to help individual adjust from life in mental hospital to community living)
Health care equipment (not for general use articles for furniture, household items, or appliances)
Health aids
Hospitalization (Including private room coverage)
Hypnosis (for treatment of illness)
Insulin
Laboratory fees
Laser eye surgery
Lead based paint removal
Learning disability (tutoring by a licensed school or therapist for a child with a severe learning disability)
Lifetime care (advance payment to private institution for lifetime care, treatment, or training of mentally or physically handicapped patient)
Medical information plan (fees paid to a plan maintaining individual's medical information by computer)
Menstrual Care Products (including tampons, pads, liners, cups, sponges, or similar products used by individuals with respect to menstruation)
Nursing home (confinement for treatment of illness or injury)
Nursing services (by registered nurse or licensed practical nurse for medical care)
Operations (not for unnecessary cosmetic surgery)
Optometrist (services within scope of license)
Over-the-counter medicine purchased for the treatment of an illness or injury
Oxygen
Physical therapy
Prescribed medicine (legally obtained drugs purchased based on a valid prescription)
Psychologist (services within scope of license)
Schools (special schooling to relieve handicap)
Sterilization
Stop smoking programs (excluding drugs provided without a prescription)
Surgery (including experimental procedures)
Syringes, needles, and injections
Telephone (special for deaf)
Television (audio display equipment for deaf)
Therapy (physical or occupational therapy by a licensed therapist)
Transplants
Vitamins and mineral supplements (only if prescribed for the treatment of illness)
Wheelchairs
Vaccinations and immunizations
Vasectomy
Weight loss program (undertaken at a physician's direction to treat an existing disease, including obesity)
Wheelchair
X-ray fees

Explanation of Health Plan Compliance Forms

1. COBRA Forms

a. Initial COBRA Notice. The Initial COBRA Notice must be provided by the sponsoring employer to the employee within 90 days after the employee becomes covered under the employer's group health plan. In addition, the Initial COBRA Notice must be provided by the sponsoring employer to the employee's spouse (if any) within 90 days after the spouse becomes covered under the employer's group health plan. Note that, if a COBRA qualifying event occurs during the first 90 days of coverage and before the initial COBRA notice is provided, the initial notice requirements still apply, i.e., the qualifying event notice is not a substitute for the initial COBRA notice. In such cases, the initial notice must be provided by the earlier of the normal 90-day deadline or the deadline for providing the qualifying event notice.

Note that the SPD content regulations require that details about COBRA coverage be included in Summary Plan Descriptions. The Plan's SPD includes the equivalent of an Initial COBRA Notice, so there is no need to provide this Notice separately to anyone who receives a copy of that SPD within the required time period for providing the initial notice. (Note that providing the notice in an SPD does not qualify as notice to a covered spouse if the SPD is provided to the employee at work or by email.)

Also, note that the notice requirements for both the employee and the spouse may be satisfied by mailing a single Notice (or an SPD containing the equivalent of the Notice) to a home address within the required time period, as long as the mailing is addressed to both the employee and the covered spouse, if they live at the same address. Of course, if the employee and spouse live at different addresses or if they become covered at different times (so that a single notice cannot be provided within the separate 90-day periods that apply to both parties, separate notices (or SPDs) must be provided to the employee and spouse.

Employers should keep proof that the Initial COBRA Notice (or an SPD that includes the Notice) was delivered to each employee and the covered spouse.

b. Notice of Health Care Continuation Coverage and Election Form. This Notice is used to inform affected qualified beneficiaries of their right to elect health care continuation coverage under COBRA. The Employer must notify any qualified beneficiaries within 44 days after the Employer has or receives notice of a qualifying event.

The Form must be completed by filling in the names and dates where indicated. If the name of a qualified beneficiary is not known, they may be referred to by their status (i.e., "employee's spouse" or "any dependent children covered under the Plan immediately before the qualifying event"). The Election Form may need to be revised to indicate the coverage options and premium amounts.

If the last known address of more than one qualified beneficiary is the same, a single first class mailing sent to that address and addressed on its face to the employee (if it applies to the employee) and the spouse (if it applies to the spouse) is adequate--there is no need to also address the notice to a dependent, if the dependent lives with an employee or spouse who is also receiving the same mailing as a qualified beneficiary. However, in any case where a single mailing is intended for more than one qualified beneficiary, the envelope must contain either (1) separate notices for each qualified beneficiary or (2) a single notice clearly identifying all qualified beneficiaries covered by the notice and the separate right that each has to elect COBRA continuation coverage. A separate notice must be provided to each qualified beneficiary known to be living at a different address.

Also, if an election notice is being provided to a qualified beneficiary who has not previously received a copy of the Plan's SPD, a copy should be included with the notice.

A qualified beneficiary must be given at least 60 days from the date the Notice is mailed to elect health care continuation coverage under COBRA.

c. Notice of Termination of COBRA Coverage. This Form must be provided by the Employer to qualified beneficiaries with respect to whom COBRA coverage has lapsed (for any reason other than the end of the maximum COBRA coverage period). If the Plan offers any conversion rights or any other alternative for continuing coverage following termination of COBRA coverage, information about those rights must be provided with the notice. This Notice must be provided as soon as practicable after the Plan determines that coverage will be terminated.

Even if the coverage lapses because of the end of the maximum coverage period has arrived, we recommend using this form anyway to help ensure against allegations of continued coverage based on, for example, the inadvertent acceptance by the Employer of a COBRA payment, verbal representations by the Employer's representatives and the like.

d. Notice of Unavailability of COBRA Coverage. This Form must be provided to any individual who notifies the Plan of a potential qualifying event (including a second qualifying event or a determination of disability by the Social Security

Administration) if the Plan determines that COBRA coverage (or an extension of the maximum period of COBRA coverage) is not available because of that event. The notice must be provided within 14 days after the plan receives notice of a potential qualifying event. For example, if a COBRA beneficiary informs the plan that he or she has been determined by the Social Security Administration to be disabled, but the Plan determines that the disability started more than 60 days after COBRA coverage began, the Plan would use this Notice to provide an explanation of why the qualified beneficiary is not entitled to an extension of COBRA coverage. For example, the form might explain, "Under the Plan, the maximum COBRA coverage period will be extended because of a determination of disability only if the disability started within the first 60 days of COBRA coverage. Therefore, no extension of coverage is available because the Social Security Administration determined that your disability started 90 days after your COBRA coverage began."

2. Notice of Special Enrollment Periods. The Employer must provide this Notice to each employee on or before the time the employee is first offered the opportunity to enroll in the Plan. The Notice provides a description of the Plan's special enrollment periods during which certain individuals who decline enrollment in the Plan's medical coverage because of alternative health coverage or who acquire a spouse or dependent may enroll in the Plan's medical coverage at a time other than an open enrollment period.

3. Qualified Medical Child Support Order (QMCSO) Procedures. This form describes the Plan's procedures for handling QMCSOs. The form includes a checklist that may be used as a tool in reviewing potential QMCSOs. Also, whenever the Plan receives a child support order, the Plan must promptly notify the participant and each proposed alternate recipient (or an authorized representative of the alternate recipient, such as a custodial parent or an attorney) that it has received the order. A copy of this form should be included with that letter. The form should also be provided on request to any participant who requests a copy.

4. Notice of Required Coverage Following Mastectomies. Provide this Notice to each participant upon enrollment and on an annual basis thereafter. It can be provided with other materials that are distributed to employees, such as an election form, an SPD or enrollment materials, as long as it is "prominently positioned" among the other documents.

5. Notice of Health Information Privacy Practices (HIPAA Privacy Notice). This Notice is required by the HIPAA Health Information Privacy Regulations. A Privacy Notice should have been distributed before the initial compliance date for the Employer's health plans (which would have been in 2003 or 2004, or, if later, the date the Plan became effective) to all employees who participate in any non-insured health plan (including, if applicable, medical, dental, vision, health care flexible spending account, health reimbursement arrangement and long term care benefits). A health plan is not required to provide a separate copy of the Notice to an employee's covered spouse or dependent (except upon request) if a copy is provided to the employee. (Note that the distribution requirement does not apply to insured health plans because the insurance issuer is responsible for providing a Privacy Notice. If all health benefits under the Plan are insured, there is no need to distribute this Notice except upon request.) Also, if the Plan has already distributed a Privacy Notice that applies to all of its health benefits and which satisfies the Privacy Regulations, there is no need to distribute this one, unless Hood College wishes to use this Notice to replace the previous one. Please let us know if you would like us to review any other Privacy Notice used by the Plan.

After the initial distribution, the Notice should be provided to any employee who later enrolls in any non-insured health plan. Also, if the Notice is revised, the revised Notice must be provided to all employees who participate in any non-insured health plan, within 60 days of the effective date of the revised Notice. In addition, at least once every three years, the Plan must inform employees that the Notice is available and must explain how a participant may receive a copy.

The Notice may be provided electronically, but only to employees who consent in advance to receiving their copy electronically and employees may withdraw that consent at any time. Also, all covered persons have the right to receive a paper copy upon request. Finally, if the Employer maintains a website for employees that includes information about health benefits, the Notice must be prominently displayed on the website and must be available for download.

A copy of any Privacy Notice used by the Plan must be kept with the Plan records for at least six years after the Notice is no longer effective.

Note that health plans (other than certain insured health plans which have no more than minimal contact with protected health information) must also maintain a written document describing the Plan's policies and procedures for complying with the HIPAA Privacy Regulations. In addition, the Plan must have written policies and procedures for complying with the HIPAA Security Regulations. Health Plans are also required to comply with the HIPAA Electronic Transaction Regulations. For more information about any of these regulations, please contact Smith & Downey.

6. Medicare Part D Notice to Individuals. The employer must notify Medicare-eligible individuals (active and retired employees and their spouses and dependents) as to whether the employer-provided drug coverage is "creditable" (i.e., equivalent to or better than Part D) or "non-creditable".

Notices must be sent:

(a) within 12 months before each October 15;

(b) within 12 months before the date a Medicare eligible individual enrolls in the employer's drug plan (i.e., with enrollment materials),

(c) within 12 months before an individual's initial enrollment period for Part D (which begins three months before an individual turns 65),

(d) if the plan's coverage becomes or ceases to be creditable coverage, and

(e) upon a Medicare beneficiary's request.

One notice addressed to a covered employee or retiree and his or her spouse and dependents residing at the same address will satisfy the notice requirements with respect to all of those individuals. Because of the impracticality of employers being able to identify all individuals in categories (b) and (c) above, the Centers for Medicare and Medicaid Services (CMS) has stated that these notice requirements are satisfied if Part D notices are sent annually to all employees, retirees, spouses and dependents covered under the employer's prescription drug plan.

Model Part D notices are available online at: www.cms.hhs.gov/CreditableCoverage

7. Medicare Part D Notice to CMS. Employers are also required to notify CMS regarding whether prescription drug coverage is creditable. Notice must be provided through a link on the CMS website at: www.cms.gov/CreditableCoverage

At a minimum, disclosure to CMS must be made at the following times:

- Within 60 days after the first day of the plan year;
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status of the prescription drug plan.

8. CHIP Notice. A copy of this notice must be provided annually to each employee (including employees who are not eligible for health coverage) who resides in a state that maintains one of the premium assistance programs described in the notice. The regulators have developed a model notice for this purpose. This notice is expected to be updated annually and should be available each year through a Department of Labor website (currently at http://www.dol.gov/ebsa/chipmodelnotice.doc). The notice may be provided with other materials, such as initial enrollment materials, open enrollment materials or a summary plan description.

This notice requirement applies to all health plans that provide benefits to any participant or dependent who resides in any state that has implemented a Medicaid or CHIP program to provide for premium assistance under employer plans or that reimburses any provider in any of those States. Those states (currently 38 states) are listed on the notice. Failure to comply with the notice and reporting requirements subjects an employer to fines of up to $100 per day for each employee or beneficiary affected by the failure.

9. Notice of Marketplace Coverage Options. This notice must be provided to new employees at the time they start work (or no later than 14 days later). If you have any question about whether Hood College is subject to the FLSA, please let us know. A copy of the notice was required to be provided on or before October 1, 2013 to all current employees at that time. The notice should be provided to all current employees as soon as possible if this deadline was not met.

This notice is based on a model notice issued by the Employee Benefits Security Administration (EBSA), which may be updated annually or on some other schedule. Any new version of the notice should be available from the EBSA's website at http://www.dol.gov/ebsa/healthreform/. The current model notice is three pages long but the third page, which includes specific questions about an individual employee's eligibility for medical coverage, is optional.

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

To: {NAME(S) OF EMPLOYEE AND/OR COVERED SPOUSE}
From: Plan Administrator
Date: {DATE OF NOTICE}

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you are covered 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. (Both you and, if you are married and your spouse is covered by the plan, your spouse should take the time to carefully read this notice.)

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 review the Plan's Summary Plan Description or 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 known as 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)

You must give notice of some qualifying events

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 later of (1) the date the qualifying event occurs or (2) the date that coverage would otherwise end because of the qualifying event. You must provide this notice, along with any required documentation to:

Hood College
c/o Human Resources Department
401 Rosemont Avenue
Frederick, MD 21701-8575

Your notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- Your name, address, phone number and health plan ID number.
- The name, address, phone number and health plan ID number for any dependent or spouse whose eligibility is affected by the qualifying event.
- A description of the qualifying event and the date on which it occurred.
- The following statement: "By signing this letter, I certify that the qualifying event described in this letter occurred on the date described in this letter."
- Your signature.

You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided in this notice.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, you may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

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. (NOTE: The rest of this paragraph applies to health plans other than the health care flexible spending account plan. For the rules that apply to the health care flexible spending account, see the "Special Rules for Health Care Flexible Spending Accounts" section below.) COBRA coverage generally lasts for 18 months if the qualifying event is 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 two 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 the Social Security Administration 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 total 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. To notify the Plan Administrator of a disability determination, you should follow the same procedures described above under "You Must Give Notice of Some Qualifying Events". Your notice must include documentation of the Social Security Administration's decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event. However, regardless of the deadline described in the previous sentence, your notice must be provided no later than the date your COBRA coverage would terminate without a disability extension.

Second qualifying event extension of 18-month period of COBRA 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 (following the same procedures described above under "*You Must Give Notice of Some Qualifying Events*"). 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), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but this extension is available only 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.

Special rules for health care flexible spending accounts

For a health care flexible spending account (Health FSA), COBRA continuation coverage is available **only if** the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs (plus any grace period that applies after the end of that Plan Year (as described in the Plan's SPD), but only if the qualified beneficiary keeps COBRA coverage in effect through the last day of the Plan Year). COBRA coverage under the Health FSA cannot be extended beyond that time for any reason.

EXAMPLE: Assume that an employee elected to contribute a total of $1,200 to her Health FSA

account for a Plan Year and then her employment terminates six months after the beginning of the Plan Year. By that time, she has contributed $600 to her FSA account through payroll deductions. Assume that she has already received $800 in reimbursements from her account for expenses incurred before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is $400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of $588 or less before her termination date, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay ($612).

Any deadlines or other rules for filing a request for reimbursement under the Health FSA will continue to apply if you elect continuation coverage under the Health FSA. See your Summary Plan Description for more details.

Additional continuation coverage rights for employees on military leave

If you take a leave of absence from employment with the Employer because of military service and your coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in this COBRA notice and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the last day of the 24-month period beginning on the date your military leave of absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer.

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 Program (CHIP), 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

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

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 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.

Plan Contact Information

For additional information about COBRA continuation rights or to report any address changes, please contact:

Hood College
c/o Human Resources Department
401 Rosemont Avenue
Frederick, MD 21701-8575
(301)696-3590

COBRA Continuation Coverage Election Notice

Date: {ENTER DATE OF NOTICE}

To: {IDENTIFY EACH QUALIFIED BENEFICIARY(IES), BY NAME OR STATUS}
{ENTER ADDRESS—A SEPARATE NOTICE SHOULD BE SENT TO EACH ANY QB LIVING AT A SEPARATE ADDRESS THAT THE PLAN IS AWARE OF}

This notice has important information about your right to continue your health care coverage in the Hood College Health and Welfare Benefits Plan (the Plan), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace at www.HealthCare.gov (or by calling 1-800-318-2596). You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision.

If you choose to elect COBRA continuation coverage, follow the instructions on the enclosed Election Form to complete the Election Form and submit it to us.

Why am I getting this notice?

You're getting this notice because, if you do not elect COBRA continuation coverage, your coverage under the Plan will end on {ENTER DATE} due to {CHECK APPROPRIATE BOX}:

☐ End of employment
☐ Death of employee
☐ Entitlement to Medicare
☐ Reduction in hours of employment
☐ Divorce or legal separation
☐ Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in any category checked below can elect COBRA continuation coverage:

{INSERT NAMES OF CHILDREN, IF AVAILABLE}
☐ Employee or former employee

☐ Spouse or former spouse

☐ Any dependent child covered under the Plan on the day before the event that caused the loss of coverage: _____

☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan: _____

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for

you and your family through the Health Insurance Marketplace, Medicaid, 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 should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin on {ENTER DATE} and can last until {ENTER LAST DAY OF 18-MONTH OR 36-MONTH PERIOD}. {IF THE EMPLOYEE BECAME ENTITLED TO MEDICARE LESS THAN 18 MONTHS BEFORE AN 18-MONTH QUALIFYING EVENT AND THIS NOTICE APPLIES TO ANY QUALIFIED BENEFICIARY IN ADDITION TO THE EMPLOYEE, REPLACE THE LAST PART OF THIS SENTENCE WITH "and can last until {ENTER LAST DAY OF 18 MONTH PERIOD} for the employee or former employee and, for any other qualified beneficiary, until {ENTER DATE THAT IS 36 MONTHS FROM THE DATE THE EMPLOYEE BECAME ENTITLED TO MEDICARE}"}

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on medical plans imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may end before the date noted above for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage, including for failure to pay premiums or fraud. Coverage may also end earlier for any individual who becomes covered under another group health plan after electing COBRA.

How can I elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children who are qualified beneficiaries. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify the Plan (using the procedures described below) of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit http://www.dol.gov/ebsa/publications/cobraemployee.html.

If the maximum coverage period identified on the first page of this notice is less than 29 months and you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If the maximum coverage period identified on the first page of this notice is less than 36 months, an extension of the maximum period of coverage may be available if a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

Your notice of disability (or of a determination that a qualified beneficiary is no longer disabled) or a second qualifying event must be provided, along with any required documentation to:

Hood College
c/o Human Resources Department
401 Rosemont Avenue
Frederick, MD 21701-8575

The Plan may provide a form that may be used for this purpose. If no form is available, your notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- Your name, address, phone number and health plan ID number.
- The name, address, phone number and health plan ID number for any dependent or spouse whose eligibility is affected by the qualifying event.
- A description of the qualifying event and the date on which it occurred.
- The following statement: "By signing this letter, I certify that the qualifying event described in this letter occurred on the date described in this letter."
- Your signature.

You also should provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began or a copy of the Social Security Administration determination of disability. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided in this notice.

Disability

If the maximum COBRA period described in this notice is less than 29 months, the maximum COBRA period may be extended to 29 months if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the original period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination. To notify the Plan Administrator of a disability determination, you should follow the same procedures described above under "Can I extend the length of COBRA continuation coverage?". Your notice must include documentation of the Social Security Administration's decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event. However, regardless of the deadline described in the previous sentence, your notice must be provided no later than 18 months after your COBRA coverage began.

Second Qualifying Event

If the maximum coverage period identified on the first page of this notice is less than 36 months, the maximum

coverage period can be extended to 36 months for spouses (or former spouses) and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months (including the original 18 months). Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How much does COBRA continuation coverage cost?

The cost of COBRA continuation coverage is shown on the enclosed Election Form. See the "Important Information About Payment" section of this notice for details on payment procedures.

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful -- if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait until the next open enrollment period to enroll in Marketplace coverage, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your COBRA election period ends.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage under the Plan.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

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 initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period[1] to sign up, 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 Part B 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 then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation 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 will pay second. Certain COBRA continuation coverage 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.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your

1 https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods. These rules are different for people with End Stage Renal Disease (ESRD).

former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact the Plan Administrator at the following address or phone number:

Hood College
Human Resources
401 Rosemont Avenue
Frederick, MD 21701-8575
(301)696-3590.

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Military leave continuation coverage rights

In addition to the rights that apply under COBRA (as described in this Notice), if you take (or an employee for whom you are a covered spouse or dependent takes) a leave of absence from employment with the employer because of military service and your coverage would otherwise terminate, you have the right to elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You elect this coverage in the same way you elect COBRA coverage (and it counts as COBRA coverage as well). The same election deadlines that apply for electing COBRA coverage also apply for elections of USERRA continuation coverage. However, the amount you pay for the coverage is determined under USERRA. If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage. If your leave lasts longer than 30 days, you will be required to pay the same amount that applies under COBRA. This continuation coverage is otherwise identical to the continuation coverage described in this notice and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the last day of the 24-month period beginning on the date your military leave of absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the employer. Please contact the Plan Administrator if you have questions about coverage during periods of military service.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and

the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

Important Information About Payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator using the address or phone number provided in this notice to confirm the correct amount of your first payment.

Monthly payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make monthly payments for each monthly coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. Under the Plan, each of these monthly payments for continuation coverage is due on the first day of that month. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send monthly notices of payments due for each month.

Grace periods for monthly payments

Although monthly payments are due on the first day of each month as described above, you'll be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. You'll get continuation coverage for each monthly coverage period as long as payment for that month is made before the end of the grace period. If you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you don't make a monthly payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to the Plan Administrator at the address provided in this notice.

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: **Hood College**
Human Resources
401 Rosemont Avenue
Frederick, MD 21701-8575

This Election Form must be completed and returned by mail {*OR DESCRIBE OTHER MEANS OF SUBMISSION AND DUE DATE*}. If mailed, it must be post-marked no later than {*ENTER DATE*}.

If you don't submit a completed Election Form by the due date shown above, you'll lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages provided with this Election Form.

The following table shows the monthly premium for each coverage option available under the Plan.

CHECK ANY COVERAGE OPTIONS YOU WISH TO ELECT TO CONTINUE. ANY COVERAGE THAT YOU DO NOT ELECT TO CONTINUE WILL TERMINATE AND YOU WILL LOSE YOUR RIGHT TO ELECT THAT COVERAGE ON THE DUE DATE INDICATED ABOVE. (Check no more than one box for each column; if a monthly premium is not listed, coverage is not available.)

	MONTHLY PREMIUM				
	Medical/drug	Dental	Vision	EAP	Health Care FSA*
Individual coverage	☐	☐	☐	☐	☐
Employee & spouse	☐	☐	☐	☐	
Employee or spouse & one child	☐	☐	☐	☐	
Family coverage	☐	☐	☐	☐	

* FSA coverage is available only for the remainder of the health care flexible spending account Plan Year (expenses may be incurred through the end of any grace period that applies after the end of the Plan Year (as described in your SPD), but the grace period will be available only if you continue your COBRA coverage through the last day of the Plan Year). Amount currently available: $_____.

If you do not return this Election Form by the date described above, you will lose your right to elect coverage. **If you do return this Form, then, within 45 days after your election, you must pay a premium for the period of coverage from the date your coverage would otherwise terminate to the date of this election, in addition to any future monthly premium that becomes due during the 45-day period.** If you fail to pay this premium by that deadline your coverage will terminate. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator using the address or phone number provided in this Notice to confirm the correct amount of your first payment.

Other than the initial premium, premium payments are due on the first day of each month of coverage and must be paid no later than 30 days after the first day of each month of coverage. If any premium payment is not received by

the Plan Administrator on time, coverage will terminate and may not be reinstated. Premium amounts change from time to time. You will be notified of any change in this premium amount.

The maximum period of coverage that applies is explained on the accompanying notice of COBRA rights. The date when continuation health care coverage would be first effective is also indicated in the accompanying notice of COBRA rights. Coverage is provided subject to each person's eligibility. The Plan Administrator reserves the right to terminate COBRA coverage retroactively if an individual is determined to be ineligible for coverage

CHECK ONE (Note: Continuation coverage is available only for individuals who were covered under the Plan at the time of the event.)

_____ I elect continuation coverage, as indicated on page 1 of this Form, for the following individuals:

	Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

_____ I elect continuation coverage under the Plan, as indicated on Page 1 of this Form, only for myself.

_____ I waive my right to continuation coverage under the Plan.

I HAVE READ THIS FORM AND THE NOTICE OF RIGHTS ACCOMPANYING THIS FORM AND I UNDERSTAND MY RIGHTS TO ELECT CONTINUATION COVERAGE. I also agree to inform the Plan Administrator at the address provided on this Form, if I become covered or a member of my family becomes covered under another group health plan or if I become or a member of my family becomes entitled to Medicare.

SIGNATURE: _____ DATE: _____

PLEASE PRINT, USING INK:

Name: _____ _____
Relationship to individual listed above

Address: _____

Telephone: _____

If the COBRA qualifying event is an employee's or former employee's termination of employment or reduction in hours, answer the following question (for eligible individuals other than the employee or former employee, this date is important in determining if COBRA coverage must be offered for 18 months or for a longer period):

Is the former employee entitled to Medicare (Part A, Part B or both)? ☐ No ☐ Yes. If yes, on what date did he or she first become covered under Medicare (the date is shown on the Medicare card)? _____

RECEIVED BY PLAN ADMINISTRATOR:

Date: _____ By: _____

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

NOTICE OF TERMINATION OF COBRA COVERAGE

To: {LIST EACH QUALIFIED BENEFICIARY COVERED BY THIS NOTICE}
Date: {INSERT DATE OF NOTICE}
From: Plan Administrator

On _____, COBRA coverage for the individual(s) listed above will terminate.

This COBRA coverage is being terminated for the reason checked below:

____ Coverage under another group health plan that does not impose a preexisting condition on the individual(s) commencing after the date of the COBRA election.

____ The end of the applicable maximum COBRA coverage period.

____ Failure to pay COBRA premiums when due.

____ Termination of all of the sponsor's group health plans.

____ Entitlement to Medicare after the date of the COBRA election.

____ Other: _____.

{INCLUDE IF APPLICABLE (REVISE AS APPROPRIATE TO DESCRIBE ANY CONVERSION RIGHTS OR ANY OTHER RIGHTS THAT ARE AVAILABLE UNDER THE PLAN OR APPLICABLE LAW FOR ALTERNATIVE GROUP OR INDIVIDUAL COVERAGE): You have the right to convert your expiring group coverage to an individual insurance policy offered by the Plan's insurance carrier. Application forms and additional information about any available conversion coverage is available from the Plan Administrator.}

Questions and Further Information

If you believe the information above contains an error, or if you have questions about this Notice, contact the Plan Administrator at:

Hood College
Human Resources
401 Rosemont Avenue
Frederick, MD 21701-8575
(301)696-3590

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

To: {Name of Qualified Beneficiary}
Date: {DATE}
From: Plan Administrator

This Notice is being provided to you as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The Plan Administrator has received a notice relating to possible health care continuation coverage for you under COBRA. That notice was {DESCRIBE THE NOTICE OR INFORMATION RECEIVED BY THE PLAN}.

The Plan Administrator has reviewed the notice the Plan received and has determined that you are not eligible for {INCLUDE IF APPLICABLE: an extension of your rights to} health care continuation coverage under COBRA because of the circumstances described in that notice.

This determination is based on: {EXPLAIN WHY COBRA COVERAGE (OR, IF APPLICABLE, AN EXTENSION OF COBRA COVERAGE) IS NOT AVAILABLE}.

Questions and Further Information

If you believe the information above is not correct, or if you have questions about this Notice, contact the Plan Administrator at:

Hood College
Human Resources
401 Rosemont Avenue
Frederick, MD 21701-8575
(301)696-3590

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Hood College Health and Welfare Benefits Plan's health coverage options 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 the Plan's health coverage features 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 30 days after your or your dependents' other 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 and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Also, if you or your eligible dependent are covered under Medicaid or a State Children's Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and any affected dependent in this Plan's medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. If you or your eligible dependent become eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days after the date a government agency determines that you are eligible for that financial assistance.

To request special enrollment or obtain more information, contact:

Hood College
401 Rosemont Avenue
Frederick, MD 21701-8575
(301)696-3590

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

SUBROGATION AGREEMENT

I am covered (or my dependent is covered) under the Plan noted above, pursuant to the terms thereof. I agree that if I incur or have incurred (or my dependent incurs or has incurred) an injury or illness caused by a third party, I assign to the Plan (individually, on behalf of my dependent, or both) all of my rights, based on whatever theories or damages, to recover expenses paid by the Plan, including, but not limited to, the right to make a claim, sue and recover damages when the injury or illness giving rise to the expenses occurs through the act or omission of another person. In addition, I agree to reimburse the Plan in full, in first priority, for any such expenses paid by it out of any funds payable to me or on my behalf from any source whatsoever, such as, but not limited to, third-party insurance, uninsured or underinsured motorist coverage, medical payments, no fault or school insurance coverage, etc., regardless of whether I (or my dependent) have been fully compensated for my (or my dependent's) damages. The amounts assigned to the Plan and which I agree to reimburse to the Plan hereunder shall be unreduced by any fees of any attorney retained by me or any other person or any other fees, costs or expenses.

I also agree, as a condition for and consequence of receiving medical, disability or any other benefits under the Plan as follows:

(1) I (or my attorney or other authorized representative) will promptly inform the Plan of any settlement agreement and provide reasonable advance notice of any plans for the disbursement of any settlement funds to me or my covered dependent (or to any other person on behalf of any covered person);

(2) I (or my attorney or other authorized representative) will hold any settlement funds received with respect to a claim that is subject to the Plan's subrogation rights in trust for the benefit of the Plan until all obligations to the Plan are satisfied (or to disburse such funds to the Plan to satisfy any obligations to the Plan under the Plan's subrogation provisions);

(3) I (or my attorney or other authorized representative) will maintain and treat any settlement funds received by or on my behalf (or on behalf of any other person covered under my coverage), as Plan assets, to the full extent of any benefits paid by the Plan and to I agree to act as a trustee of Plan assets with respect to such amounts until the covered person's obligations under the Plan's subrogation provisions are satisfied; and

(4) I (or my attorney or other authorized representative) agree that the Plan has an equitable lien on any settlement funds payable to me or any other person covered under my Plan coverage or on behalf of any person covered under my coverage to the full extent of any benefits paid by the Plan amounts until the covered person's obligations under the Plan's subrogation provisions are satisfied in full.

_____
SIGNATURE OF PARTICIPANT

_____
PRINT NAME OF PARTICIPANT

_____
NAME(S) OF DEPENDENT(S)

Date: _____

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES

As required by §609 of ERISA, the following are the procedures used by the Plan to determine whether a medical child support order is a "Qualified Medical Child Support Order" which is to be honored by the Plan as described in §609 of ERISA.

I. Determination of an Order's status as a Qualified Medical Child Support Order.

The Plan will honor the terms of a medical child support order if the order is determined by the Plan Administrator to be a Qualified Medical Child Support Order (QMCSO). An order will be determined by the Plan Administrator to be a QMCSO only if the answer to each of the following questions is "Yes":

Yes	**No**	
		(1) Is the order a judgment, decree or order by a court or by an administrative process having the force and effect of state law (including an approval of a property settlement agreement) which:
☐	☐	(a) provides for child support with respect to a child of a Plan Participant or provides for health benefit coverage to such a child (such a child referred to herein as an "alternate recipient");
☐	☐	(b) is made pursuant to a state domestic relations law (including a community property law); and
☐	☐	(c) relates to benefits under the Plan or enforces a law related to medical child support described in §1908 of the Social Security Act with respect to the Plan?
☐	☐	(2) Does the order create or recognize the existence of an alternate recipient's right to, or assign to an alternate recipient the right to, receive benefits for which a Participant or dependent is eligible under the Plan?
		(3) Does the order clearly specify the following:
☐	☐	(a) The name and the last known mailing address (if any) of the Participant covered by the order?
☐	☐	(b) The name and mailing address of each alternate recipient covered by the order?
☐	☐	(c) A reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which the type of coverage is to be determined?
☐	☐	(d) The period to which the order applies?
☐	☐	(e) Each plan to which the order applies?

Yes **No**

☐ ☐ (4) Does the order require the Plan to provide only a type or form of benefit, or an option, which currently is provided under the Plan (except to the extent necessary to meet the requirements of a law relating to medical child support described in §1908 of the Social Security Act). (Answer this question "No" if the order (i) requires the Plan to provide a type or form of benefit, or an option, which currently is not provided under the Plan and (ii) does not purport to provide a type or form of benefit, or an option, which is necessary to meet the requirements of a law relating to medical child support described in §1908 of the Social Security Act.)

If any question above is answered "No", the Plan Administrator will instruct legal counsel to take appropriate action to resist the order, or to take the steps necessary to ensure that the order is amended to be a QMCSO.

II. QMCSO Procedures.

Upon receipt of an order, the Plan Administrator promptly will notify the Plan Participant and each alternate recipient of the Plan Administrator's receipt of the order and the Plan Administrator's procedures for determining if the order is a QMCSO. Within a reasonable period of time after receipt of the order (e.g., 30 days), the Plan Administrator will make its determination concerning whether the order is a QMCSO and will notify the Participant and each alternate recipient of the Plan Administrator's determination. The Plan Administrator will notify the alternate recipient(s) of the Plan Administrator's determination by written notice mailed to the address specified in the order. Alternate recipients may designate a representative to receive copies of the notice that is required to be sent to alternate recipients.

If the Plan Administrator determines that an order is a QMCSO:

(A) The Administrator will notify the following people that the order is a QMCSO:
- N The Participant
- N All alternate recipients
- N Any representatives designated by the alternate recipients to receive copies of notices

(B) Alternate recipients will be considered dependents under the Plan.

(C) Alternate recipients will be considered participants under the Plan for purposes of the reporting and disclosure requirements of ERISA (e.g., Summary Plan Description delivery, annual reporting on Form 5500, etc.).

(D) Any payment made by the Plan pursuant to the QMCSO that is reimbursement for expenses paid by an alternate recipient or alternate recipient's custodial parent or legal guardian will be made to the alternate recipient or alternate recipient's custodial parent or legal guardian.

NOTICE OF REQUIRED COVERAGE FOLLOWING MASTECTOMIES

To: All Participants in the Hood College Health and Welfare Benefits Plan

From: Hood College

Date:

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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Please contact the Plan Administrator or refer to your Summary Plan Description for more detailed information regarding deductibles and coinsurance for these benefits under the Plan.

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

Hood College
401 Rosemont Avenue
Frederick, MD 21701-8575
(301)696-3590

Hood College

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Your Information. Your Rights. The Plan's Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask the Plan to limit the information the Plan shares
- Get a list of those with whom the Plan has shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

The Plan's Uses and Disclosures

The Plan may use and share your information to:

- Help manage the health care treatment you receive
- Help administer and review the operation of the Plan
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Privacy Contact for questions about the Plan's Health Information Privacy Practices:

Hood College
c/o Health Plan Privacy Official
401 Rosemont Avenue
Frederick, MD 21701-8575
(301)696-3590

Introduction

The health plans sponsored by Hood College (referred to in this Notice as the "**Health Plans**" or just the Plan) may use or disclose health information about participants and their covered dependents as required for purposes of administering the Health Plans. Some of these functions are handled directly by Hood College, while other functions are performed by other service providers under contract with the Health Plans or by insurance carriers.

This Notice applies to each Health Plan sponsored by Hood College, including plans that provide medical, vision, prescription drug, dental, long term care, health reimbursement arrangement and health care flexible spending account benefits. However, for benefits that are provided through insurance contracts, you will receive a separate notice, similar to this one, from the insurer and only that notice will apply to the insurer's uses or disclosures of your health information.

The Plan is required by law to maintain the privacy of certain health information about you and to provide you this Notice of the Plan's legal duties and privacy practices with respect to that protected health information. This Notice also provides details regarding certain rights you may have under federal law regarding medical information about you that is maintained by the Plan.

The Plan is required by law to abide by the terms of this Notice while it is in effect. **This Notice is effective beginning July 1, 2023** and will remain in effect until it is revised.

If the Plan's health information privacy policies and procedures are changed so that any part of this Notice is no longer accurate, the Plan will revise this Privacy Notice. A copy of any revised Privacy Notice will be available upon request to the Privacy Contact Person indicated later in this Notice. Also, if required under applicable law, the Plan will automatically provide a copy of any revised notice to employees who participate in the Plan. The Plan reserves the right to apply any changes in its health information policies retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies were revised.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- The Plan will provide a copy or a summary of your health and claims records, usually within 30 days of your request. The Plan may charge a reasonable, cost-based fee.

Ask the Plan to correct health and claims records

- You can ask the Plan to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask the Plan to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- The Plan will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask the Plan to limit what it uses or shares

- You can ask the Plan not to use or share certain health information for treatment, payment, or the Plan's operations.
- The Plan is not required to agree to your request, and may say "no" if it would negatively affect the administration of the Plan.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times the Plan has shared your health information for six years prior to the date you ask, who received it, and why.
- The Plan will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Plan to make). The Plan will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- The Plan will make sure the person has this authority and can act for you before taking any action.

File a complaint if you feel your rights are violated

- You can complain if you feel the Plan has violated your rights by contacting the Plan using the Privacy Contact information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- Hood College will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell the Plan your choices about what it may share. If you have a clear preference for how the Plan shares your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

You have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell the Plan your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases the Plan will *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

The Plan's Uses and Disclosures

How does the Plan typically use or share your health information?

The Plan typically uses or shares your health information in the following ways.

Pay for your health services

The Plan can use and disclose your health information to pay for your health services.
Example: The Plan processes your health care claims to coordinate payment to providers or to reimburse you for eligible expenses you have paid.

Health care operations

- The Plan may use or disclose PHI for purposes that are related to the operation of the Plan including utilization review programs, quality assurance reviews, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan.
- The Plan is not allowed to use genetic information to decide whether to offer you coverage or the price of that coverage.

Example: We use health information about you to offer wellness program services for you.

Help manage the health care treatment you receive

The Plan may use your health information and share it with professionals who are treating you.
Example: A doctor sends the Plan information about your diagnosis and treatment plan so we can arrange additional services.

Administer your plan

The Plan may disclose your health information to the plan sponsor for plan administration.
Example: A business associate for the Plan may provide certain statistics to the Plan Sponsor to explain the costs of the Plan.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before

we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

The Plan can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

The Plan can use or share your information for health research.

Comply with the law

The Plan will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- The Plan can share health information about you with organ procurement organizations.
- The Plan can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

The Plan can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

The Plan can share health information about you in response to a court or administrative order, or in response to a subpoena.

The Plan's Responsibilities

- The Plan is required by law to maintain the privacy and security of your protected health information.
- The Plan will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The Plan must follow the duties and privacy practices described in this notice and give you a copy of it.
- The Plan will not use or share your information other than as described here unless authorize the Plan, in writing, to use or share your information for another purpose. If you tell us we can use information for some other purpose, you may change your mind at any time. Let the Plan know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Important Notice from Hood College About
Your Prescription Drug Coverage and Medicare

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

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

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

2. **Hood College has determined that the prescription drug coverage offered by the Hood College Health and Welfare Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Hood College coverage will not be affected. Details of the Plan's prescription drug benefits are included in the separate benefits booklet previously provided to you as part of (or along with) the Plan's Summary Plan Description. In addition, keep in mind that your current coverage pays for other health expenses for you and, if applicable, your eligible dependents, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits even if you choose to enroll in a Medicare prescription drug plan. If you are enrolled in both the Plan and a Medicare prescription drug plan, your prescription coverage under the Plan will be coordinated with the Medicare prescription drug benefit.

If you do decide to join a Medicare drug plan and drop your current Hood College coverage, be aware that you and your dependents may not be able to get this coverage back or you may have to wait for a later

enrollment period (see your Summary Plan Description for details on when eligible individuals may elect coverage under the Plan).

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Hood College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about this Notice or Your Current Prescription Drug Coverage

Contact the person or office listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Hood College changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	{Insert MM/DD/YY}
Name of Sender:	Hood College
Contact:	Human Resources
Address:	401 Rosemont Avenue, Frederick, MD 21701-8575
Phone:	(301)696-3590

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

Starting in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace is available each year for coverage starting as early as the next January 1. Please visit **HealthCare.gov** for more information.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage--is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Hood College, 401 Rosemont Avenue, Frederick, MD 21701-8575, (301)696-3590

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Hood College	4.Employer Identification Number (EIN) 52-0591608
5. Employer address: 401 Rosemont Avenue	6. Employer phone number (301)696-3590
7. City, 8. State, 9. ZIP code Frederick, MD 21701-8575	
10. Who can we contact about employee health coverage at this job? Human Resources	
11. Phone number (if different from above):	12. Email address

Here is some basic information about health coverage offered by your employer:

- As your employer, we offer a health plan to the following employees: FTE .5 or greater. Full details of employee eligibility rules are included in the Plan's Summary Plan Description, which is available from the Employer at the address of phone number described above.

- We also offer coverage for dependents. Eligible dependents include: spouses and children (up to age 26) and disabled children who are age 26 and older. Full details of dependent eligibility rules are included in the Plan's Summary Plan Description, which is available from the Employer at the address of phone number described above.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

{NOTE: THIS ENTIRE PAGE IS OPTIONAL AND MAY BE DELETED. IT REQUIRES INDIVIDUAL INFORMATION, SO IT MAY BE USEFUL FOR NOTICES PROVIDED TO NEW EMPLOYEES BUT PROBABLY WOULD NOT BE PRACTICAL TO USE FOR THE INITIAL DISTRIBUTION}

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (continue to 14)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue to 14)

☐ **No** (STOP and provide form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ **Yes** (Go to question 15) ☐ **No** (STOP and provide form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he or she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and provide form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)