

HOPE COLLEGE
EMPLOYEE BENEFIT PLAN

Plan No. 501

PLAN DOCUMENT and SUMMARY PLAN DESCRIPTION

Amended and Restated as of July 1, 2020

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INTRODUCTION

Hope College (the "**Employer**") amends and restates the Hope College Benefit Plan (the "**Plan**") effective as of July 1, 2020. The Plan is sponsored and maintained for the benefit of the Employer's eligible employees and their eligible dependents.

The Plan allows eligible employees to choose benefits from among the following benefit programs (the "**Benefit Programs**"):

- A "**Medical/Rx Program**" that provides comprehensive major medical, and hospitalization benefits, along with a prescription drug program that provides comprehensive prescription drug benefits, under the "**Orange Plan**" (high deductible health plan) and "**Blue Plan**";
- A "**Dental Program**" that provides benefits including cleaning, maintenance and treatment services for teeth and gums;
- A "**Vision Program**" that provides benefits including eye examinations, lenses and/or frames;
- A "**Long-Term Disability Program**" that offers basic income replacement benefits for a period of time if you become totally disabled, as well as supplemental long-term disability benefits;
- A "**Life and Accidental Death & Dismemberment Insurance Program**" (the "**Life/AD&D Insurance Program**") that provides: (i) basic life insurance benefits for your beneficiary in the event of your death and provides you with the option to purchase supplemental life insurance for yourself and/or your Eligible Dependents; and (ii) basic insurance benefits in the event of your death, paralysis, and/or loss of limb;
- A "**Business Travel Accident Program**" that provides benefits for unexpected injuries or illnesses that you may incur while traveling on Employer business;
- An "**Employee Assistance Program**" (the "**EAP**") that provides you and your Eligible Dependents with counseling to help with work, family, and other personal matters;
- A "**Pre-Tax Payment Program**" that allows you to pay your share of the cost of certain Benefit Programs tax free;
- A "**Dependent Care Flexible Spending Account Program**" (the "**Dependent Care FSA Program**") that allows you to pay for certain dependent care expenses tax free, up to an annual maximum;
- A "**Health Care Flexible Spending Account Program**" (the "**Health Care FSA Program**") that allows you to pay for certain unreimbursed medical expenses tax free, up to an annual maximum; and

- A “**Health Savings Account Contributions Program**” (the “**HSA Contributions Program**”) allows you to make tax-free contributions to an HSA if you participate in an HDHP offered under this Plan’s Medical/Rx Program.

Some of the Benefit Programs are “**Insured**,” which means the Employer pays premiums to insurance companies that, in turn, pay for the benefits under insurance policies or contracts. Other Benefit Programs are “**Self-Insured**,” which means the benefits are paid from the Employer’s general assets and are not provided through an insurance contract. Appendix B (Benefit Program Information Chart) at the end of this document indicates the type of funding for each Benefit Program.

For each Insured Benefit Program:

- This document and the insurance contract or policy listed on the attached Appendix A (Plan Documents Chart) (“**Insurance Contract**”) serve as the official Plan document. If a conflict arises between the terms of this document and the Insurance Contract, the terms of the Insurance Contract will control.
- The insurer-prepared booklets, summaries, and/or certificates that describe the benefits available under the Benefit Program and that are listed on the attached Appendix A (Plan Documents Chart) (“**Booklets**”), together with this document, make up the summary plan description. If a conflict arises between the terms of this document and a Booklet, the terms of the Booklet will control. If a conflict arises between a Booklet and the Insurance Contract, the terms of the Insurance Contract will control.

For each Self-Insured Benefit Program, this document, along with applicable benefit certificates, booklets and/or summaries listed on the attached Appendix A (Plan Documents Chart) (“**Booklets**”), serve as the Plan document and summary plan description. If a conflict arises between the terms of this document and a Booklet, the Booklet will control.

The provisions of this Plan apply uniformly to all Participants, except as otherwise specifically stated herein. Please read these documents carefully and keep them with your personal records for future reference.

Where we define a term in this document, it also appears in bold print and in quotation marks. For your convenience, an Index of Defined Terms appears at the end of this document.

If you have any questions about a Benefit Program or the Plan in general, please contact the Human Resources Department at (616) 395-7811.

OBTAINING AND CHANGING COVERAGES

EMPLOYEE ELIGIBILITY

Full-Time Employee Eligibility

You may participate in all Benefit Programs under the Plan if you are a Full-Time Employee and you are not classified by the Employer in a position that is excluded from participation in the Plan in the section below titled "Ineligible Individuals."

You are a "**Full-Time Employee**" if you meet either of the following requirements:

- you are regularly scheduled to work at least 1,560 hours per year; or
- you are regularly scheduled to work fewer than 1,560 hours per year, but you are a "grandfathered" employee who was eligible to receive benefits under the Plan prior to August 1, 2013.

You will become eligible to participate in all Benefit Programs as of the date you become a Full-Time Employee.

Visiting Faculty, Resident Life Coordinator, and Non-Tenured Faculty on First Year of Assignment Eligibility

You may participate in all Benefit Programs except the Life/AD&D and Long-Term Disability Programs under the Plan if you are classified by the Employer as a (i) Visiting Faculty Member, (ii) Resident Life Coordinator, or (iii) Non-Tenured Faculty Member on first year of assignment.

You will become eligible to participate in the applicable Benefit Programs as of the date you become a Visiting Faculty Member, Resident Life Coordinator, or Non-Tenured Faculty Member on first year of assignment.

Resident Director Eligibility

You may participate in the Medical/Rx, Dental, Vision, the EAP and the Health FSA Programs under the Plan if you are classified by the Employer as a Resident Director or "Visiting Faculty Member".

You will become eligible to participate in those Benefit Programs as of the date you become a Resident Director.

Retiree Eligibility

Eligible employees who retire from the Employer may be eligible for retiree health benefits. See the Hope College Retiree Health Benefit Plan for details.

Ineligible Individuals

You are not eligible to participate in the Plan if you are classified by the Employer as one of the following, even if it is later determined that the classification is incorrect:

- An employee who normally works six months or less per year.
- An individual considered by the Employer to be providing services as an independent contractor.

- A leased employee.
- A student employee.
- An employee who performs services for the Employer pursuant to a written agreement that does not provide for participation in the Plan.
- An employee in a grant-funded position unless the terms of the grant provide for Plan participation.
- An adjunct faculty member.
- A faculty member on sabbatical leave except to the extent that the faculty member continues to receive compensation from the Employer while on sabbatical leave.

Change in Eligibility Based on Reclassification of Employment

If you have been working in a position that is ineligible for a Benefit Program and you are moved to a position that is eligible, you will be eligible to participate in that Benefit Program on the first day of your employment in the eligible position.

If you have been participating in a Benefit Program but you are moved to a position that is ineligible for that Benefit Program, your participation will end on the date you move to the ineligible position. To the extent it is available, you may elect COBRA Continuation Coverage.

Additional Eligibility Rules for Medical/Rx Program

If you are classified by the Employer as an employee but you do not meet the eligibility requirements for coverage under the Medical/Rx Program, the Employer will determine your eligibility to participate in the Orange Plan under Medical/Rx Program using the criteria described below. The Plan Administrator will at all times administer these eligibility rules in compliance with the requirements of the Affordable Care Act.

If you are a newly-hired employee, your eligibility for the Orange Plan under the Medical/Rx Program will be determined during a 12-month initial measurement period that begins on the first day of the month that begins on or after your first day of employment with the Employer. If you average at least 30 Hours of Service per week over the course of the entire initial measurement period, you will be eligible for the Orange Plan under the Medical/Rx Program during the 12-month period that begins on the first day of the month that begins on or after the date that is 13 months from your first day of employment. If you average less than 30 Hours of Service per week during your initial measurement period, you will not be eligible for the Orange Plan under the Medical/Rx Program and your eligibility for the Medical/Rx Program in future Plan Years will be determined under the rules below for On-Going Employees.

If you are an On-Going Employee and you average 30 Hours of Service per week during the standard measurement period that is the 12-month period ending on April 30th, you will be eligible for the Orange Plan under the Medical/Rx Program for the 12-month coverage period beginning on the next July 1st.

An **"On-Going Employee"** is an employee who has been employed by the Employer for at least one full standard measurement period.

For purposes of eligibility for the Orange Plan under the Medical/Rx Program, **"Hours of Service"** generally include all hours for which you are paid by the Employer for performance of duties and all hours for which you are paid by the Employer but no duties are performed due to

vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Hours of Service do not include: (1) hours paid under the Employer’s worker’s compensation program and (2) Hours of Service when compensation for those hours constitutes income from sources outside the United States. When calculating average Hours of Service, the Employer will disregard unpaid leaves for FMLA, military and jury duty.

If you meet the eligibility criteria under the rules in this section, you may enroll yourself and your Children in the Orange Plan under the Medical/Rx Program at the ACA premium share costs. You are not eligible to enroll your Spouse.

Additional Rules for Health Care FSA Program

Because the Health Care FSA Program is considered disqualifying medical coverage for purposes of HSA eligibility, if you elect the Orange Plan, you may only elect to make contribution to the Limited-Purpose Option under the Health Care FSA Program.

Additional Rules for HSA Contributions Program

To be eligible for the HSA Contributions Program, you must elect to participate in the Orange Plan option under the Medical/Rx Program.

Additional Rules for Fully Insured Benefit Programs

Each Insurer is responsible for determining eligibility for, and the amount of, any benefits payable under its Insurance Contract.

DEPENDENT ELIGIBILITY

Your Spouse and your Children (as defined below) are eligible for coverage under some of the Benefit Programs as shown in the chart below. They are “**Eligible Dependents**” with respect to those Benefit Programs.

Benefit Program	Eligible Dependents You May Cover
Medical/Rx Program	Your Children Your Spouse.
Dental Program	Your Spouse and your Children
Vision Program	Your Spouse and your Children
EAP Program (Family Member Coverage Options)	Your Spouse, your Children, and others living in your household
Life/AD&D Insurance Program (Dependent Coverage Options)	Your Spouse and your Children
Business Travel Accident	Spouse and Children of executives of the Employer

All other Benefit Programs under the Plan are available to you as an eligible employee of the Employer and do not apply to your family. However, you may be eligible to receive

reimbursement under the Health Care FSA Program for health care expenses incurred by your family members (see "Health Care FSA Program" beginning on page 22) and you may be eligible to receive reimbursement under the Dependent Care FSA Program for expenses incurred for the care of a family member (see "Dependent Care FSA Program" beginning on page 18).

The Plan Administrator may require you to show proof that a dependent meets the eligibility criteria. You must notify the Plan Administrator, in writing, of any change in status that results in a dependent no longer being an Eligible Dependent (e.g., your Spouse in the event of a divorce). The Plan has a right to recover from you any payments made by the Plan on behalf of an individual who is not an Eligible Dependent (see "Overpayments" beginning on page 71).

Definitions

"Spouse" means your legally married spouse, except as otherwise defined in an Insurance Contract. For purposes of the Medical/Rx Program, if your Spouse is offered coverage under his or her employer's health insurance plan, but you choose to enroll your Spouse in the Medical/Rx Program, coverage under the Medical/Rx Program will be secondary to the health insurance coverage of your Spouse's employer's health insurance plan. You will also be subject to an additional premium surcharge for the Medical/Rx Program if your Spouse declines coverage under his or her employer's health insurance plan and you enroll your Spouse in the Medical/Rx Program. Further, if you are eligible to enroll in the Orange Plan under the Medical/Rx Program because you meet the criteria described above in the section titled "Additional Eligibility Rules for the Medical/Rx Program" beginning on page 4, you are not eligible to enroll your Spouse.

"Child" means:

- For purposes of the Medical/Rx, Dental, and Vision Programs, your child; your legally adopted child; a child placed with you in anticipation of the child's being adopted; your step-child; a child placed with you through a state agency (i.e., a foster child); a child placed with you by court order (i.e., legal guardianship).

A child described above will be eligible for coverage even if the child is born out of wedlock, is not claimed by you as a dependent for federal income tax purposes, does not reside with you, or is married. In connection with any adoption or placement for adoption, child means an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

For the Medical/Rx, Dental and Vision Programs, your Child will be eligible for coverage through the end of the month in which he or she reaches age 26.

- For purposes of the Medical/Rx, Dental, and Vision Programs, an unmarried child who meets the requirements above may be covered beyond the age at which coverage would otherwise end (as described above) if the child is a disabled child. A child is a "disabled child" if all of the following criteria are met:
 - The child has a medically determined physical or mental condition that is expected to last indefinitely and prevents the child from being self-supporting;
 - The child is dependent on you for support and care;
 - The child is disabled before attaining age 19;

- You have notified the Plan Administrator in writing of the condition before the time your child attains the age at which coverage would otherwise end (as described above);
 - You have timely provided documentation of continued disability upon the Plan Administrator's request.
- For purposes of all other Benefit Programs providing coverage for your children, the definition of a "Child" is set forth in the Booklets describing the applicable Benefit Program.

Special Rule Regarding Double Eligibility

Your dependent cannot be your Eligible Dependent under a Benefit Program if he or she is eligible for coverage under that Benefit Program as an employee of the Employer.

If you and your Spouse are both employees of the Employer who are eligible for, and elect to participate in a Benefit Program, you will generally each be enrolled in the single coverage option under a particular Benefit Program (in other words, you cannot enroll your Spouse as a dependent). Also, if you and your Spouse are both Participants in a Benefit Program, your Child cannot be enrolled by both of you. If you elect coverage for a dependent Child, the Plan Administrator will enroll you in family coverage, with the Child and the Spouse with the lower annual compensation as Dependents of the employee with the higher annual compensation.

EMPLOYEE ENROLLMENT AND PARTICIPATION

Initial Enrollment

The Plan Administrator will enroll you in the Plan as soon as administratively practicable upon your completion of the enrollment process. You must complete the enrollment process within the time-period specified in your enrollment materials ("**Initial Enrollment Period**").

Your enrollment materials will describe the amount of any Employee Contributions required for the available options under each Benefit Program. By electing benefits under a Benefit Program that require Employee Contributions, you are agreeing to pay the required Employee Contributions through salary adjustments for pre-tax benefits or through salary deductions for after-tax benefits.

Your elections will be effective from the date you begin participating in the Plan, but Employee Contributions will be taken only from income you have not yet received. Elections during your Initial Enrollment Period are irrevocable for the remainder of the Plan Year, unless you become eligible to change elections under a Special Enrollment Period or a Change Event occurs. You may, however, change your election under the HSA Contributions Program on a prospective basis at any time.

If you are not receiving a paycheck from the Employer, you agree to timely pay your Employee Contributions as directed by the Plan Administrator.

If you enroll in the Medical/Rx, Dental, Vision, Dependent Care FSA, Health Care FSA, or HSA Contributions Program, you will be automatically enrolled in the Pre-Tax Payment Program.

Only you, and not your Eligible Dependents, may make Benefit Program elections. If you have properly enrolled in any Benefit Program, you are a "**Participant**" in the Plan. Any Eligible Dependents properly enrolled in the Plan are "**Covered Dependents**."

Unless otherwise specified in the enrollment materials, an applicable Insurance Contract or in the applicable Booklets, you must enroll yourself in a Benefit Program in order to also enroll your Eligible Dependents in that Benefit Program.

Open Enrollment

Each year the Employer establishes an "**Open Enrollment Period**" during which you can make new benefit elections for the upcoming Plan Year. To make your elections, you must complete the enrollment process as directed by the Plan Administrator prior to the end of the Open Enrollment Period.

The choices you make during the Open Enrollment Period will be effective on the first day of the upcoming Plan Year. Once the Plan Year begins, your choices are irrevocable and will remain in effect without any changes permitted through the remainder of the Plan Year, unless you are entitled to a Special Enrollment Period or a Change Event occurs. You may, however, change your Employee Contributions under the HSA Contributions Program on a prospective basis at any time.

If the Open Enrollment Period occurs while you are on an Employer-approved leave during which your benefits continue, you will be contacted and allowed to make an election during the Open Enrollment Period. If the Open Enrollment Period occurs while you are on an Employer-approved leave during which your benefits do not continue, you will be allowed to make an election for the new Plan Year when you return from your leave as long as you are eligible to participate upon your return.

If you enroll in the Medical/Rx, Dental, Vision, Dependent Care FSA, Health Care FSA, or HSA Contributions Programs, you will be automatically enrolled in the Pre-Tax Payment Program. However, if you are enrolled in the Orange Plan under the Medical/Rx Program because you met the eligibility criteria described in the section titled "Additional Eligibility Rules for the Medical/Rx Program" beginning on page 4, you are not eligible to pay for that coverage through the Pre-Tax Payment Program, and you must pay for your coverage on an after-tax basis.

Failure to Timely Enroll

Initial Enrollment Period

If you fail to properly enroll during your Initial Enrollment Period, you will be deemed to have elected coverage under, and you will be automatically enrolled in, "**Basic Coverage**" under Benefit Programs for which there are no Employee Contributions. Basic Coverage includes coverage under the Life/A&D Program, basic coverage under the Long-Term Disability Program, the Group Travel Accident Program, and the EAP. You will be deemed to have declined coverage under all other Benefit Programs for the remainder of the Plan Year.

Your elections (including your deemed election to decline coverage) will be irrevocable for the remainder of the Plan Year unless you become eligible to change elections under a Special Enrollment Period or a Change Event occurs.

Open Enrollment Period

If you are an eligible Full-Time Employee and you fail to properly enroll during an Open Enrollment Period, you will be deemed to have elected, and will be automatically enrolled in, Basic Coverage as well as the same level of coverage under the Medical/Rx, Dental, and Vision Programs, and any voluntary coverage under the Life/AD&D Insurance and Long-Term Disability Programs, as you have for the current Plan Year. You will be deemed to have declined coverage under all other Benefit Programs for the upcoming Plan Year.

Your elections (including your deemed election to decline coverage) for the upcoming Plan Year will be irrevocable unless you become eligible to change elections under a Special Enrollment Period or a Change Event occurs.

Special Enrollment Period

A "**Special Enrollment Period**" is an additional period during which you may enroll in the Plan's Medical/Rx Program. You may enroll yourself and your Eligible Dependents during a Special Enrollment Period as described below.

Enrollment of Newly Acquired Eligible Dependents

If you gain an Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll that new Eligible Dependent in coverage under the Medical/Rx Program. If you are not already enrolled in coverage, you must also enroll. You may also elect at that time to enroll your Spouse and any other Eligible Dependents. You must notify the Plan Administrator and request enrollment within 30 days after the date of the marriage, birth, adoption, or placement for adoption. Coverage will begin on the date of the marriage, birth, adoption, or placement for adoption.

Loss of Other Coverage

If you previously declined enrollment in the Medical/Rx Program for yourself or an Eligible Dependent because of other health insurance coverage, and eligibility for that other coverage is lost, you may enroll in the Medical/Rx Program during a Special Enrollment Period if the other coverage was:

- COBRA continuation coverage and the entire COBRA coverage period was exhausted; or
- not COBRA continuation coverage and ended because of:
 - loss of eligibility as a result of divorce, legal separation, loss of dependent status, your death, termination, or reduction in hours of employment, or because you no longer live or work in the other coverage's service area;
 - a discontinuation of coverage to a class of similarly situated individuals; or
 - termination of employer contributions to the other coverage.

If you (the Employee) lose other coverage, you may enroll yourself and any of your Eligible Dependents. If one of your Eligible Dependents loses other coverage, you may only enroll yourself (if you are not already covered) and that Eligible Dependent.

You must request enrollment within 30 days of the date the other coverage ends.

The Special Enrollment Period will not be available if the loss of other coverage is due to:

- failure to pay premiums on a timely basis;
- a choice to drop coverage for any reason, including an increase in premium or change in benefits, unless the reason is consistent with a Change Event described in the section titled "Mid-Year Election Changes" on page 10; or
- termination of coverage for cause, such as a fraudulent claim or intentional misrepresentation of a material fact.

Enrollment due to loss of other coverage will be effective as of the date the other coverage was lost.

Medicaid/Children's Health Insurance Program Changes

If you or an Eligible Dependent are eligible for but not enrolled in the Medical/Rx Program, you are entitled to a Special Enrollment Period to elect coverage under the Medical/Rx Program if:

- your coverage or the coverage of your Eligible Dependent under a Medicaid plan or state Children's Health Insurance Program ("**CHIP**") is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- you or an Eligible Dependent become eligible for a premium assistance subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 days after the date you or the Eligible Dependent are determined to be eligible for such assistance.

Mid-Year Election Changes

You may change your elections under the HSA Contributions Program (including your contributions amounts) prospectively at any time. For example, you may choose to revoke your election to make HSA contributions if you are no longer eligible to contribute to an HSA.

Under all other Benefit Programs, changes to your elections during the Plan Year cannot be made unless a Change Event occurs and your requested election change is consistent with that event. Each of the following is a "**Change Event**" if it causes you or a dependent to become eligible or ineligible for coverage:

- A change in your legal marital status (e.g., because of marriage, divorce, legal separation, annulment);
- A change in the number of your dependents (e.g., because of birth, death, adoption, placement for adoption);
- A change in your employment status or that of your dependent that affects eligibility under either the underlying benefit or the cafeteria plan (e.g., because of strike or lock-out, commencement or termination of employment, commencement or termination of an unpaid leave of absence, or a change in worksite);

- A change in your work schedule or that of your dependent (e.g., from full-time to part-time);
- A change in your residence or that of your dependent that limits network access; or
- A dependent satisfying, or ceasing to satisfy, requirements for dependent status under a Benefit Program (e.g., because of age or marriage).

Except with respect to the Health Care FSA Program, the following are also Change Events, regardless of whether or not the change causes you or a dependent to become eligible or ineligible for coverage:

- A change in the availability of benefit options or coverage under any of the Benefit Programs (e.g., a medical option is added to or deleted from the Medical/Rx Program);
- A change in coverage under another employer's plan resulting from either: (i) an election made during an open enrollment period under the other employer's plan that relates to a period of coverage that is different from the Plan Year for this Plan (e.g., your Spouse's open enrollment period is in January and your Spouse changes coverage), or (ii) a mid-year election change permitted under the other employer's plan;
- A significant increase or decrease in the cost of coverage during the Plan Year; and
- A loss of coverage under a group health plan sponsored by a governmental or educational institution.

In the event of an insignificant increase or decrease in the cost of coverage that occurs mid-Plan Year, the Employer will make automatic adjustments to any required Employee Contributions.

Additional Change Events for Health Care Options

In addition to the above Change Events, you may also change elections for the Medical/Rx, Dental, Vision, and Health Care FSA Programs if:

- a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) is entered by a court of competent jurisdiction that requires accident or health coverage for your Child; or
- you or your Covered Dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines).

Additional Change Events for Medical/Rx Program

In addition to the above Change Events, you may also change your elections under the Medical/Rx Program:

- if (i) you have a change in employment status that results in a change in work schedule from one in which you were reasonably expected to average 30 Hours of Service per week to a schedule in which you will be reasonably expected to average fewer than 30 Hours of Service per week without losing eligibility to participate in this Plan and (ii) you intend to enroll in another plan that provides minimum essential coverage that will become effective no later than the first day of the second month following the month in which your coverage under this Plan is revoked; or
- if (i) you become eligible to enroll in a health plan offered through a Health Insurance Marketplace established under the Affordable Care Act ("**Marketplace**") either because of a special enrollment right or during the Marketplace's annual open enrollment period and (ii) your new coverage under that plan will become effective no later than the day after your coverage under this Plan ends.

In either instance, you will be required to certify your intent to enroll in other coverage.

Additional Change Event for Dependent Care FSA Program

In addition to the above Change Events, you may also change your elections under the Dependent Care FSA Program if there is a change in your dependent care provider or a significant increase or decrease in the cost of dependent care.

Consistency Rule

Your election change must be consistent with the Change Event that affects your coverage under a Benefit Program. For example:

- If one of your Covered Dependents no longer meets the requirements for coverage, you can cancel coverage for that Covered Dependent, but you could **not** cancel coverage for your other Covered Dependents.
- If you have single coverage and you marry, you can elect family coverage.
- If your Spouse enrolls in coverage under his or her employer's plan, you can drop coverage for your Spouse under this Plan.
- If your dependent care provider changes, you can change your elections relating to the Dependent Care FSA Program but you could **not** change your Medical/Rx Program elections.

Contact Human Resources if you have questions about whether your requested change is consistent with your Change Event.

Procedures for Changing Elections Mid-Year Due to a Change Event

To make a mid-year election change as a result of a Change Event, you must submit a request as directed by the Plan Administrator and identify the Change Event. You will be required to

provide additional documentation for certain Change Events (e.g., a marriage certificate if you wish to add a new Spouse to your benefits coverage). The change request must be filed on or before the date that is 30 days after the date of the Change Event. The change in coverage generally will be effective as of the first payroll period following notification, or as soon as administratively possible thereafter. However, if the Change Event is birth or adoption of an Eligible Dependent Child, the change in coverage will be retroactively effective to the date of that Change Event. If one or more payroll periods have passed since the birth or adoption, additional Employee Contributions will be withheld from subsequent paychecks to pay for the retroactive coverage.

If you file a request for a change in coverage more than 30 days after the date of the Change Event, you will have to wait until the next Open Enrollment Period, a Special Enrollment Period, or until you experience another consistent Change Event to make the change.

Participation During Leave of Absence

As described in the Employer's handbooks, employees and their families may be allowed to continue coverage under the Plan's Benefit Programs during Family and Medical Leave Act of 1993 ("**FMLA**") leave, an Employer-approved disability leave of absence or an Employer-approved non-FMLA leave of absence.

All coverage under the Plan will continue while you are on an Employer-approved short-term disability leave (generally up to six months). Any continuation of benefits to which you may be entitled to under FMLA will run concurrently with this Employer-provided extension. Thereafter, your coverage under the Medical/Rx Program will continue for an additional 12 months, provided that you continue to pay for coverage. At the end of this 12-month period, coverage under the Medical/Rx Program will terminate and you will be eligible for COBRA continuation coverage.

For an Employer-approved non-FMLA leave of absence, your coverage under the Medical/Rx, Dental, Vision, Life/AD&D and LTD Programs will continue for up to one year. The cost to continue your coverage will be determined at the time the Employer approves your non-FMLA leave of absence.

Further, as described in the Employer's handbooks, coverage under the Medical/Rx, Dental, and Vision Programs may be extended for your Spouse and Children for one year if you die. Thereafter, your Spouse and Children may election COBRA continuation coverage.

Special Rules for the Dependent Care FSA Program

Unless your leave of absence is considered short-term or temporary, dependent care expenses incurred during the leave may not be reimbursable as Eligible Dependent Care Expenses because they are not considered to be incurred to enable you to work or to look for work. So, you may revoke your participation in the Dependent Care FSA Program. If you revoke your participation, the balance in your Dependent Care FSA will remain available for reimbursement of qualifying expenses incurred through the end of the Plan Year.

Participation Upon Return From Leave

If your benefits under a Benefit Program end while you are on a leave and you return to a position eligible for benefits, you may participate again immediately upon return from leave. The following rules apply:

- Subject to the special rules for the Health Care FSA and Dependent Care FSA Programs described below, if you return from leave before the end of the Plan Year in which your leave began, your benefits will be reinstated automatically with the same elections in effect at the time your leave began; and
- If you return from leave in a Plan Year other than the Plan Year in which your leave began, you will be required to make new elections. If you fail to complete the enrollment process within the time required by the Plan Administrator, the rules set forth above in "Failure to Timely Enroll" (beginning on page 8) will apply.

Special Rule for Health Care FSA Program

If your participation in the Health Care FSA Program ends during your leave and you return from your leave during the same Plan Year, you will resume participation and your Health Care FSA will be reinstated. When you begin again to participate in the Program, you may either:

- Resume coverage at the level in effect before your leave started and increase your Employee Contributions from each paycheck for the remaining portion of the Plan Year to make up for the unpaid Employee Contributions; or
- Resume coverage at a reduced level (pro-rated for the period during which no Employee Contributions were made) and keep your Employee Contributions from each paycheck the same as prior to your leave.

In both cases, the coverage level is reduced by prior reimbursements.

Special Rule for Dependent Care FSA Program

If your participation in the Dependent Care FSA Program ends during your leave and you return from your leave during the same Plan Year, you will resume participation in the Dependent Care FSA Program and your Dependent Care Account will be reinstated. When you begin again to participate in the Dependent Care FSA Program, you will make a new election for Employee Contributions for the remainder of the Plan Year.

End of Participation

Employee Coverage

Your coverage under a Benefit Program will end at the end of the day that any of the following events occurs:

- Your employment terminates;
- You revoke your existing election due to a Change Event (as defined below) that permits you to revoke your existing election;

- You fail to meet the eligibility requirements or conditions of the Benefit Program;
- For an Insured Benefit Program, the effective date for termination of coverage when the group Insurance Contract terminates;
- You commit, or attempt to commit, fraud against the Plan or have been dishonest about a material matter affecting eligibility for benefits. In the case of fraud or intentional misrepresentation of a material fact, **coverage may be retroactively terminated**;
- The Employer terminates the Benefit Program.

Also, if you fail to timely make any required Employee Contributions, the Plan may terminate your coverage retroactive to the last day of the coverage period for which you have paid.

If you are eligible for COBRA or USERRA Continuation Coverage, you may elect to continue your health coverage. Special rules apply to the timing of any required payments for COBRA or USERRA Continuation Coverage. (See "COBRA Continuation Coverage" and "Military Leave Continuation Coverage" beginning on page 54 for more information.)

Dependent Coverage

A Covered Dependent's coverage under a Benefit Program will end at the end of the day that any of the following events occurs:

- Your employment terminates;
- You revoke your existing election for the dependent's coverage due to a Change Event (as defined above) that permits you to revoke the election;
- The dependent fails to meet the Benefit Program's eligibility requirements or conditions;
- A Qualified Medical Child Support Order specifies termination of coverage;
- You or the dependent commits, or attempts to commit, fraud against the Plan or has been dishonest about a material matter affecting eligibility for benefits. In the case of fraud or intentional misrepresentation of a material fact, **coverage may be retroactively terminated**;
- For an Insured Benefit Program, the effective date for termination of coverage when the group Insurance Contract terminates; or
- The Employer terminates the Benefit Program.

Also, if you fail to timely make any required Employee Contributions, the Plan may terminate coverage retroactive to the last day of the coverage period for which you have paid.

If your dependent is eligible for COBRA Continuation Coverage, he or she may elect to continue health coverage. Special rules apply to the timing of any required payments for COBRA

Continuation Coverage. (See "COBRA Continuation Coverage" beginning on page 54 for more information.)

Participation upon Rehire

If you are participating in the Plan when your employment terminates and you are subsequently rehired in a position eligible for benefits, the following rules apply:

- If you are rehired in a subsequent Plan Year, you will immediately re-enter the Plan and make new elections for the remainder of that Plan Year.
- If you are rehired within the same Plan Year and within 30 days of the date your employment terminated, you will generally be reinstated in the Plan with the same elections in effect when your employment was terminated.
- If you are rehired within the same Plan Year but more than 30 days from the date your employment terminated, you will generally be allowed to immediately re-enter the Plan and be required to make new benefit elections for the remainder of the Plan Year.

If your participation in the Plan is reinstated upon rehire, your benefits will resume as soon as administratively practicable. If you are required to make new elections, you must complete the election process within the time frame required by the Plan Administrator. If you fail to complete the enrollment process within the time required by the Plan Administrator, then the rules set forth above in "Failure to Timely Enroll" (beginning on page 8) will apply.

Special Rule for Health Care FSA and Dependent Care FSA Programs

If you are participating in the Health Care FSA or Dependent Care FSA Program when your employment terminates and you are rehired in a position eligible for benefits less than 30 days later and in the same Plan Year, you will be re-enrolled, your prior elections will be reinstated, and the Plan Administrator will adjust your Employee Contributions as necessary for the remainder of the Plan Year.

If you are rehired at least 30 days after your date of termination or in the following Plan Year, you will be treated as a new employee.

BENEFIT PROGRAMS

MEDICAL/RX PROGRAM

For a description of the Medical/Rx Program benefits, please refer to the Booklets provided by the Claims Administrator listed in [Appendix B](#) (Benefit Program Information Chart).

DENTAL PROGRAM

For a description of the Dental Program benefits, please refer to the Booklets provided by the Claims Administrator listed in [Appendix B](#) (Benefit Program Information Chart).

VISION PROGRAM

For a description of the Vision Program benefits, please refer to the Booklets provided by the Claims Administrator listed in [Appendix B](#) (Benefit Program Information Chart).

LONG-TERM DISABILITY PROGRAM

For a description of the Long-Term Disability Program benefits, including optional benefits available for purchase under the Program, please refer to the Booklet provided by the Claims Administrator listed in [Appendix B](#) (Benefit Program Information Chart).

LIFE/AD&D INSURANCE PROGRAM

For a description of the Life/AD&D Insurance Program benefits, including optional benefits available for purchase under the Program, please refer to the applicable Booklet provided by the Claims Administrator listed in [Appendix B](#) (Benefit Program Information Chart).

GROUP TRAVEL ACCIDENT PROGRAM

For a description of the Group Travel Accident Program benefits, please refer to the Booklet provided by the Claims Administrator listed in [Appendix B](#) (Benefit Program Information Chart).

EAP

For a description of the EAP benefits, please refer to the Booklet provided by the Claims Administrator listed in [Appendix B](#) (Benefit Program Information Chart).

PRE-TAX PAYMENT PROGRAM

The Pre-Tax Payment Program allows you to pay for benefits under the following Benefit Programs on a tax-free basis: Medical/Rx Program coverage obtain other than by reason of meeting the eligibility criteria described in the section titled "Additional Eligibility Rules for Medical/Rx Program" beginning on page 4, and Dental, Vision, Health Care FSA, and Dependent Care FSA Programs. Employee Contributions for all other coverage will be paid on an after-tax basis.

To the extent Employee Contributions are required for benefits you elect under the Benefit Programs subject to the Pre-Tax Payment Program, you agree to have the Employer reduce your compensation to cover the cost of those benefits. Because your compensation is reduced, the amount of your federal payroll and Social Security taxes, as well as most state and municipal taxes, will also be reduced.

The Pre-Tax Payment Program may not be used to purchase individual health plan coverage or coverage obtained through the Marketplace.

COBRA Premiums

For so long as you continue to earn compensation from the Employer, you may also pay any COBRA or USERRA Continuation Coverage premiums for coverage provided under this Plan tax free.

If you and your Spouse divorce, COBRA premiums to continue coverage for your former Spouse may not be paid on a pre-tax basis under this Pre-Tax Payment Program.

DEPENDENT CARE FSA PROGRAM

The Dependent Care FSA Program is designed to help you make tax-free payments for Eligible Dependent Care Expenses. Because the contributions you make under the Dependent Care FSA Program are made on a pre-tax basis, your taxable income will be reduced and, therefore, your federal payroll and Social Security taxes, as well as most state and municipal taxes, will be reduced. Because you will pay fewer taxes, your net take-home pay will be increased.

Example:

You are married and you and your Spouse each earn \$30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Dependent Care Expenses will be \$3,000. So, you choose to contribute \$3,000 to your Dependent Care FSA.

	Using Dependent Care FSA Program	Not Using Dependent Care FSA Program
Your Gross Pay (You and Your Spouse)	\$60,000	\$60,000
Your Pre Tax Dependent Care Expenses	<u>3,000</u>	<u>N/A</u>
Your Taxable Income	57,000	60,000
Your Income Taxes (25%)	14,250	15,000
Your Post Tax Dependent Care Expenses	<u>0</u>	<u>3,000</u>
Your Net Take Home Pay	\$42,750	\$42,000
Your Tax Savings	\$750	N/A

Dependent Care Flexible Spending Account

If you enroll in the Dependent Care FSA Program for a Plan Year, the Plan Administrator will establish a dependent care flexible spending account ("**Dependent Care FSA**") for you for the Plan Year. Your Dependent Care FSA will be credited each pay period with the Employee Contribution amount you authorized.

Your Dependent Care FSA is for bookkeeping purposes only. The amounts credited to your Dependent Care FSA are not assets that belong to you.

Annual Contribution Amount

The maximum amount you may contribute to your Dependent Care FSA each Plan Year is the least of:

- Your earned income from employment,

- Your Spouse's earned income from employment, or
- \$5,000 annually (\$2,500 if married filing separately).

If your Spouse has not earned any income from employment, but is a Full-Time Student or disabled and unable to care for himself or herself, your Spouse will be assumed to have earned \$250 a month if you claim reimbursement for the care of one Qualifying Individual, or \$500 a month if you claim reimbursement for the care of two or more Qualifying Individuals. A "**Full-Time Student**" means an individual who is considered a full-time student by a school during at least five calendar months during the taxable year. For this purpose, a school includes a high school; college; university; or technical, trade and mechanical school. It does not include an on-the-job training course, correspondence school, or school offering courses only on the Internet.

If the amount of your or your Spouse's earned income changes during the Plan Year so that your authorized contribution amount exceeds the maximum amount as stated above, you should immediately notify the Plan Administrator so that your authorized contribution amount can be reduced.

Amount That Can Be Reimbursed to Participants

You will only be reimbursed for Eligible Dependent Care Expenses you incur during the Plan Year for which you elected to be covered under the Dependent Care FSA Program.

Unlike the Health Care FSA Program, the Dependent Care FSA Program reimburses you for a Claim only to the extent that you have a balance in your Dependent Care FSA. If the balance in your Dependent Care FSA is insufficient to pay a Claim in full, the remainder of the Claim will be carried over and paid when the balance in your Dependent Care FSA is sufficient. No reimbursement is available before the Eligible Dependent Care Expense is incurred.

An expense is considered incurred on the date the services are performed and not when you are billed or make a payment.

Eligible Dependent Care Expenses

The amount credited to your Dependent Care FSA may only be used to pay for the Eligible Dependent Care Expenses of a Qualifying Individual.

A "**Qualifying Individual**" is defined as:

- Your child under the age of 13 who is considered your dependent for federal income tax purposes; or
- Your Spouse or dependent for federal income tax purposes (regardless of age) who is physically or mentally incapable of self-care, resides with you for at least one-half of your tax year, and regularly spends at least eight hours a day in your home. This rule also applies to a person who otherwise meets these requirements but who is not your tax dependent only because: he or she received gross income of \$4,000 or more; he or

she filed a joint return; or you, or your Spouse if filing jointly, could be claimed as a dependent on someone else's tax return.

If you are a parent who is divorced, legally separated, or separated under a written separation agreement, or if you lived apart from your Spouse at all times during the last six months of the calendar year, your child will be considered a Qualifying Individual if:

- the child is under the age of 13 or is physically or mentally incapable of self-care;
- the child is in your, the child's other parent's, or both of your custody for more than one-half of the calendar year;
- the child received over one-half of his or her support during the calendar year from you, the child's other parent, or both of you; and
- you have custody of the child for more of the calendar year than your Spouse or former Spouse, as the case may be. If the child was with you and your Spouse or former Spouse, as the case may be, for an equal number of nights, then you must have a higher adjusted gross income than your Spouse or former Spouse.

"Eligible Dependent Care Expenses" are expenses you incur for household services or care of a Qualifying Individual necessary to enable you to work or look for work. Eligible Dependent Care Expenses include:

- Expenses for the care of a Qualifying Individual inside your home provided the primary function of the care is to assure the well-being and protection of the Qualifying Individual;
- Costs of household services performed in and about your home that are ordinary and necessary to the maintenance of a household and that are attributable in part to the care of a Qualifying Individual;
- Educational expenses below the level of kindergarten and fees for before- or after-school care;
- Expenses for services provided outside your home for the care of a tax dependent under the age of 13 or any other Qualifying Individual who regularly spends at least eight hours each day in your home so long as, with respect to care provided at a dependent care center, the center complies with all applicable state and local laws and regulations, provides care for more than six individuals not residing at the facility, and receives payment or a grant for providing those services;
- Expenses for transportation to or from a caregiver if the transportation is provided by the caregiver;
- Cost of providing room and board to a caregiver;
- Employment taxes and similar payroll taxes paid with respect to a caregiver; and

- Related expenses that are not directly for the care of an Eligible Dependent, such as application fees, agency fees and deposits required to obtain care.

Ineligible Dependent Care Expenses

Not all dependent care expenses qualify as Eligible Dependent Care Expenses, such as:

- Expenses you pay on behalf of an individual who is not a Qualifying Individual;
- Expenses you pay to your Spouse, a parent of a Qualifying Individual child, your or your Spouse's tax dependent, or your Child under age 19, to care for a Qualifying Individual;
- Expenses for which you have received or will receive federal dependent care tax credits;
- Expenses in excess of your annual elected Employee Contributions or the maximum amount under the Dependent Care FSA Program;
- Expenses you pay to an ineligible provider (e.g., an overnight camp);
- Expenses you incur during a period of time you were not covered by the Dependent Care FSA Program;
- Expenses you incur for food, clothing, or education, unless incidental to and inseparable from the care provided (e.g., lunch and some educational services included in nursery school expenses);
- Educational expenses you incur for a child in kindergarten or a higher grade level, including summer school or tutoring programs;
- Generally, expenses you incur for transportation between your home and the place where the dependent care is provided, except that transportation to a day camp or an after-school program not on school premises furnished by a dependent care provider may be reimbursable if the expenses are otherwise Eligible Dependent Care Expenses;
- Expenses for which you have not provided satisfactory proof of payment (e.g., third-party substantiation as to the nature of the expense and the amount of your payment);
- Expenses for which you have not provided the Claims Administrator with the name, address, and Social Security number or EIN of the dependent care provider; and
- Expenses you submit later than the deadline described for the Dependent Care FSA Program in "Claims Under Dependent Care FSA" beginning on page 45.

Any reimbursement made for an expense that is not an Eligible Dependent Care Expense will be subject to applicable income taxes.

Amounts in your Dependent Care FSA can only be used to pay for Eligible Dependent Care Expenses and not for Eligible Health Care Expenses.

Federal Dependent Care Tax Credit

You are not eligible to receive both the federal dependent care tax credit and reimbursement under the Dependent Care FSA Program for the same expense. Before enrolling in the Dependent Care FSA Program, you should consider whether reimbursement under the Dependent Care FSA Program is more advantageous to you than the maximum federal dependent care tax credit. See IRS Publication 503 for more information.

Provider Information

When you submit your first Claim each year, you must provide the Claims Administrator with information about the dependent care provider including the provider's name, address, and Social Security number or employer identification number. If this information changes at any time, you are required to provide the new information with your next Claim. You may obtain this information from your dependent care provider on IRS Form W-10 (Dependent Care Provider's Identification and Certification).

You must also report your provider information to the IRS on your income tax return using IRS Form 2441. See IRS Publication 503 for additional information regarding your tax reporting obligations.

Expenses Eligible Under More than One Dependent Care Spending Account Program

If a dependent care benefit is payable under two or more dependent care spending account programs, you may submit a Claim for the expense to either program, but not to both. This Dependent Care FSA Program will not pay an expense paid by another program. At the Claims Administrator's request, you must supply information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments.

Forfeiture of Amounts in Your Dependent Care FSA

Because of Code requirements, if you do not use the total amount in your Dependent Care FSA for reimbursement of Eligible Dependent Care Expenses you incur during a Plan Year, the amount remaining will be forfeited and will not be returned to you. For this reason, you should carefully consider the amount you elect to contribute each Plan Year. Overestimating your expenses and contributing too much may cause you to forfeit unused amounts.

An expense is considered incurred on the date the service or product that gives rise to the expense is provided, not when billed or paid.

Use of Plan Forfeitures

The Plan Administrator will use forfeited amounts to pay the administrative expenses of the Dependent Care FSA Program, or otherwise apply the forfeitures as permitted under applicable law.

HEALTH CARE FSA PROGRAM

The Health Care FSA Program is designed to help you make tax-free payments for Eligible Health Care Expenses. Because the contributions you make under the Health Care FSA Program are made on a pre-tax basis, your taxable income will be reduced and, therefore, your federal payroll and Social Security taxes, as well as most state and municipal taxes, will be reduced. Because you will pay fewer taxes, your net take-home pay will be increased.

Example:

You earn \$30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Health Care Expenses will be \$1,500. So, you choose to contribute \$1,500 to your Health Care FSA.

	Using Health Care FSA Program	Not Using Health Care FSA Program
Your Gross Pay	\$30,000	\$30,000
Your Pre Tax Health Care Expenses	<u>1,500</u>	<u>N/A</u>
Your Taxable Income	28,500	30,000
Your Income Taxes (25%)	7,125	7,500
Your Post-tax Health Care Expenses	<u>0</u>	<u>1,500</u>
Your Net Take-Home Pay	\$21,375	\$21,000
Your Tax Savings	\$375	N/A

Flexible Spending Account

If you enroll in the Health Care FSA Program for a Plan Year, the Plan Administrator will establish a health care flexible spending account (“**Health Care FSA**”) for you for that Plan Year. Your Health Care FSA will be credited each pay period with the Employee Contribution amount you authorize. Your Health Care FSA is for bookkeeping purposes only. The amounts credited to your Health Care FSA are not assets that belong to you.

Because coverage under a health care FSA can adversely affect eligibility to contribute to an HSA (see “Effect on HSA Eligibility” beginning on page 26), the Health Care FSA Program offers two kinds of Health Care FSAs: (1) a general-purpose Health Care FSA that is considered disqualifying medical coverage for purposes of HSA eligibility (“**General Purpose Health Care FSA**”) and (2) a limited-purpose Health Care FSA that is designed to preserve the HSA eligibility of you and your Qualified Dependents (“**Limited Purpose Health Care FSA**”). The difference is the expenses that are reimbursable under each. (See the definition of Eligible Health Care Expenses in “Eligible Health Care Expenses” beginning on page 24.)

If you elect to participate in the Health Care FSA Program and you choose the Orange Plan under the Medical/Rx Program, you will be enrolled in a Limited Purpose Health Care FSA. If you elect to participate in the Health Care FSA Program and choose an option under the Medical/Rx Program other than the Orange Plan, you will be enrolled in a General Purpose Health Care FSA. As described in “Effect on HSA Eligibility” beginning on page 26, electing the General Purpose Health Care FSA will make you and your Qualified Dependents ineligible to make HSA contributions for any month during which you are covered by the General Purpose Health FSA. For example, even if your Spouse enrolls in HDHP medical coverage through his or her employer, your participation in the General Purpose Health FSA under this Plan will disqualify your Spouse from contributing to an HSA.

Contributions to Your Health Care FSA

You may contribute up to the contribution limit to your Health Care FSA each Plan Year. At its sole discretion, the Employer may adjust this maximum amount annually for inflation as permitted by law. Your enrollment materials will include the contribution limit for the upcoming Plan Year.

Amount Available for Reimbursement

Unlike the Dependent Care FSA Program, the Health Care FSA Program reimburses you for a Claim even if the balance in your Health Care FSA is insufficient to pay the Claim, as long as the Claim does not exceed the total amount of your elected Employee Contributions to the Health Care FSA Program for the Plan Year, less any previously paid Claims. For example, if you have elected to contribute \$1,000 under the Health Care FSA Program, you could be reimbursed in full for a \$1,000 Claim incurred on your first day of participation in the new Plan Year.

A special rule applies if your Health Care FSA includes a Carry-Over Amount (see "Carry-Over Amounts" beginning on page 26). Because Carry-Over Amounts are not determined until the end of the Claims run-out period for the prior Plan Year, your balance for purposes of reimbursing Claims submitted in the first 90 days of the Plan Year will not include Carry-Over Amounts. This means that, if you submit a Claim in the first 90 days of the Plan Year and your account (without the Carry-Over Amount) is insufficient to reimburse the Claim, the Claims Administrator will pay the Claim to the extent it can based on your balance, and then pay the rest of the Claim.

Expenses Eligible for Reimbursement

The amount credited to your Health Care FSA can only be used to pay for Eligible Health Care Expenses incurred for the benefit of you or a Qualified Dependent while you were covered under the Health Care FSA Program.

Qualified Dependent

A "Qualified Dependent" is:

- Your Spouse;
- Your child through the end of the year in which he or she turns age 26; or
- Any individual whom you can claim as a dependent on your federal income tax return under Code Section 105(b).

For this purpose, "child" means "**Child**" as that term is defined for the Medical/Rx, Dental, and Vision Programs in "Dependent Eligibility" beginning on page 5.

Eligible Health Care Expenses

"Eligible Health Care Expenses" are expenses that: (i) qualify as medical care under Sections 213(d)(1)(A) and (B) of the Code, and (ii) are not excluded under "Ineligible Health Care Expenses" beginning on page 25.

Expenses that qualify as medical care under Sections 213(d)(1)(A) and (B) of the Code generally include expenses incurred for diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation essential to obtaining related services. Common examples include amounts paid for:

- Hospital expenses;

- Medical/Rx, dental, or vision expenses;
- Prescription drugs;
- Over-the-counter medications obtained with a doctor's prescription (e.g., antacids, allergy medication, pain relievers, cold medications);
- Insulin; and
- Insurance deductibles and copayments that are not reimbursed by another insurance plan or reimbursement account.

If you have a Limited Purpose, Eligible Health Care Expenses are limited to dental and vision expenses.

Ineligible Health Care Expenses

The following are not Eligible Health Care Expenses even if they are incurred while you are covered by the Health Care FSA Program and are for the benefit of you or your Qualified Dependent:

- Expenses that are payable under any other insurance plan or group health plan (including one offered by the Employer) or that were paid under another employer's health care spending account program (at the Claims Administrator's request, you are obligated to supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments);
- Expenses for which you have received, or will receive, an itemized deduction on your federal tax return;
- Expenses you incur for premiums for insurance or health coverage;
- Expenses you incur in excess of the annualized elected amount, plus any Carry-Over Amount;
- Expenses you incur during a time you were not covered by the Health Care FSA Program;
- Over-the-counter medications or drugs for which you do not have a doctor's prescription, except insulin;
- Medications or drugs that are merely beneficial to general health (e.g., vitamins and dietary supplements);
- Expenses for which you have not provided satisfactory proof of payment;
- Payment for long-term care services or insurance premiums; and

- Expenses submitted after the applicable Claims deadline described in “Claims Under Group Health Plans: Medical/Rx, Dental, Vision, EAP, and Health Care FSA Programs” beginning on page 30.

Amounts in your Health Care FSA can only be used to pay for Eligible Health Care Expenses and not for Eligible Dependent Care Expenses.

Any reimbursement paid for an expense that is not an Eligible Health Care Expense will be subject to income taxes as applicable.

Carry-Over Amounts

You are permitted to carry over into the following Plan Year unspent funds, up to a maximum amount (“**Carry-Over Amount**”) as long as you remain eligible to participate in the Health Care FSA Program and you elect to contribute to the Health Care FSA Program for that following Plan Year. The maximum Carry-Over Amount will be automatically increased to an amount equal to 20 percent of the Code’s maximum health FSA salary reduction contribution amount for the Plan Year from which the amounts are carried over. Thus, the maximum unused amount that can be carried over from the Plan Year beginning in 2020 to the Plan Year beginning in 2021 is \$550. Unused Carry-Over Amounts attributable to one Plan Year will be forfeited at the end of the following Plan Year.

Forfeiture of Amounts in Your Health Care FSA

Except for amounts you are allowed to carry over to the next Plan Year (see “Carry-Over Amounts” above), if you do not use the total amount in your Health Care FSA for reimbursement of Eligible Health Care Expenses you incur during a Plan Year, the amount remaining will be forfeited and will not be returned to you. For this reason, you should carefully consider the amount you elect to contribute each Plan Year. Overestimating your expenses and contributing too much may cause you to forfeit unused amounts.

An expense is considered incurred on the date the service or product that gives rise to the expense is provided, not when billed or paid.

Forfeiture Due to End of Participation

If you terminate your employment or you lose your eligibility to participate in the Health Care FSA Program, the amount in your Health Care FSA, including any Carry-Over Amount, will be forfeited unless you elect to continue coverage in the Health Care FSA Program under COBRA or USERRA, if available.

Use of Plan Forfeitures

The Plan Administrator will use forfeited amounts to pay the administrative expenses for the Health Care FSA Program, or otherwise apply the forfeitures as permitted under applicable law.

Effect on HSA Eligibility

Coverage under the Limited Purpose Health FSA will not affect your HSA eligibility or that of your Qualified Dependents. However, coverage under a General-Purpose Health FSA is considered disqualifying medical coverage and will make you and your Qualified Dependents ineligible to make contributions to an HSA for each month during which you are covered by the Health Care FSA Program.

Also, if you have a General Purpose Health FSA with amounts remaining at the end of the Plan Year that are carried over to the next Plan Year, and you elect the Orange Plan under the Medical/Rx Program for that next Plan Year, your Carry-Over Amount automatically will be carried over to a Limited Purpose Health FSA.

Federal Itemized Deduction

You are not entitled to receive both a federal itemized deduction for medical expenses and a reimbursement under the Health Care FSA Program for the same expense. Before enrolling in the Health Care FSA Program, you should determine whether reimbursement of Eligible Health Care Expenses under the Health Care FSA Program is more advantageous than the federal itemized deduction.

Expenses Eligible Under More than One Health Care Spending Account Program

If a health care benefit is payable under two or more health care spending account programs, you may submit a Claim for the expense to either program, but not to both. This Health Care FSA Program will not pay an expense paid by another program. At the Claims Administrator's request, you must supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments.

HSA CONTRIBUTIONS PROGRAM

The HSA Contributions Program allows you to reduce your taxable compensation by making tax-free Employee Contributions to an HSA established on your behalf with the HSA custodian selected by the Employer.

Your HSA is a personal account that you own, not an employee benefit program sponsored by the Employer. You are the owner of your HSA, and the Employer generally has no authority or control over the funds deposited in your HSA. As described in "Distributions From Your HSA" beginning on page 29, you are solely responsible for complying with federal tax rules regarding distributions from your HSA and any tax consequences associated with those distributions.

Eligibility for HSA Contributions Program

In addition to the requirements described in the "Eligibility" section beginning on page 3, in order to participate in the HSA Contributions Program, you: (1) must be eligible for and participating in the HDHP with HSA option offered under this Plan's Medical/Rx Program; (2) may not be claimed as a dependent on anyone else's tax return; and (3) may not be covered by a disqualifying medical plan that provides coverage below the deductible threshold established under the federal tax code. See the most current version of IRS Publication 969 for the current deductible threshold.

Disqualifying medical plans include: this Plan's Health Care FSA Program; Medicare Parts A, B, or D; a Medicare Advantage plan; coverage under a Spouse's medical plan that is not an HDHP; coverage under a Spouse's or other family member's health care FSA, unless it is a limited-purpose or post-deductible FSA; Veterans Administration medical benefits received during the preceding three months, unless you have been determined to have a service-related disability; coverage under the TRICARE program; Indian Health Service medical benefits received during

the preceding three months; and any other coverage that covers all or even a portion of medical expenses that you incur before you have satisfied the deductible threshold.

You are responsible for determining your eligibility to make contributions to an HSA, or have contributions made on your behalf. The Employer may require certification or other representation of your HSA eligibility.

Establishing and Maintaining Your HSA

If you are a Participant in the HSA Contributions Program, your Employer will establish an HSA on your behalf with an HSA custodian of its choosing. Your HSA is subject to the terms and conditions of the custodial agreement and you are solely responsible for any fees assessed under that agreement.

You may, at any time, transfer funds from your Employer-selected HSA custodian to another HSA with the custodian of your choice. The Employer, however, will only contribute funds to an HSA with its selected custodian. If you transfer funds to another HSA, you must keep your HSA with the Employer-selected HSA custodian open and active to ensure that the Employer can deposit contributions to the HSA.

Contributions to Your HSA

Limits on HSA Contributions

The amount that may be contributed to your HSA must not exceed the limits established under the federal tax code, which are adjusted annually. If you are age 55 or older, you may also elect to make an additional "catch-up" contribution.

If you are married and both you and your Spouse have an HSA, the IRS limits your joint contributions for the year to the contributions limit for family coverage. If both you and your Spouse are above age 55 and each of you establish an HSA, then you may both also make an additional \$ "catch-up" contribution to each account. If only you have an HSA, then only you can make a "catch-up" contribution. For more information about the rules that apply to a married couple, you should read IRS Special Publication 969.

If the total deposits to your HSA for the year exceed the applicable maximum contribution limit, the excess amounts will be deemed an excess contribution for federal tax purposes. You will be taxed on this excess contribution. Additionally, if you do not promptly withdraw this excess contribution, including any interest earned on the excess contribution, you will pay a 6% excise tax each year that the excess contribution, including its earned interest, remains in your HSA.

Limits for Those Not Eligible to Contribute to HSA for Full Year

If you are not eligible to contribute to an HSA for the entire year, your maximum contribution amount may have to be prorated for the number of months of the year that you are eligible to contribute (see "Eligibility For HSA Contributions Program" beginning on page 27). For example, if you terminate employment with the Employer on June 15 and are no longer covered under a high deductible health plan for the rest of the calendar year, you will only be eligible to contribute to an HSA for the first six months of the year and your maximum contribution amount will be reduced to half of the annual limit. This pro-rata contribution rule also applies to the catch-up contribution during the year in which you turn age 55.

If you join the Plan after the start of the year and have not been previously covered under a high deductible health plan, the amount you may contribute without restriction is also prorated for the number of months you are covered by the HDHP option (and are otherwise eligible to contribute to an HSA). However, the IRS has a special rule that allows you to fund your HSA up to the annual contribution limit for the calendar year if you are covered by an HDHP in December of that calendar year. To take advantage of this rule, you are required to remain covered under a high deductible health plan (and not otherwise be disqualified from contributing to an HSA) until the end of the *following* calendar year. If you fail to remain HSA-eligible throughout the following calendar year, you would have to pay income taxes, plus an additional 10% penalty tax, on the contributions above your prorated contribution limit, unless you lose your HSA eligibility based on disability or death.

You are responsible for determining whether you are eligible to contribute to an HSA each month and for adjusting your HSA contributions accordingly. For more information, you should read IRS Publication 969.

Changing HSA Contributions

You can elect to begin or end contributions, or increase or decrease contributions, to your HSA at any time. These changes will not affect your prior contributions, but only contributions you make going forward. Your change will go into effect with the next payroll period that begins after you have successfully submitted your election change, or as soon thereafter as administratively feasible.

Recording Contributions

Because you are the owner of your HSA, you are responsible for keeping track of how much has been deposited into your account. The Employer will keep track of HSA contributions made through this Plan; however, you will be responsible for keeping track of contributions made outside of the Plan, including amounts that your Spouse may contribute to an HSA. As noted above, you are also responsible for determining your eligibility to make contributions to an HSA, or have contributions made on your behalf, throughout the year.

Distributions From Your HSA

This Plan does not govern distributions from your HSA. Distributions and all other matters relating to maintenance of your HSA are subject to the custodial agreement governing your HSA account. You are solely responsible for complying with federal tax rules regarding distributions from your HSA and any tax consequences associated with those distributions. For more information about HSA distribution rules, you should read IRS Publication 969.

IMPORTANT INFORMATION ABOUT THE PLAN

FILING AND PROCESSING CLAIMS

For the claims procedures under each Benefit Program, **first consult the applicable Booklets provided by the insurer or Claims Administrator. The procedures described in this section are intended to supplement the information provided in those Booklets.** If there is an inconsistency in the claims procedures described in this section and

those described in the Booklets, the Booklets will control. If the Booklets for a Benefit Program do not contain claims procedures, the procedures described in this section for that Benefit Program will apply.

General Rules

A “**Claim**” is any request for a Plan benefit made in accordance with the Plan’s procedures, or a claim or allegation by a claimant that the Plan Administrator, a Plan fiduciary, or the Employer has violated ERISA or the Code.

A Claim may be filed, and an appeal of a denied Claim may be sought, by any Participant or Covered Dependent. A claimant may appoint an authorized representative to file a Claim on his or her behalf and to communicate with the Plan with respect to any Claim or appeal. To appoint an authorized representative, request the appropriate forms from Human Resources. The Plan Administrator will consider the claimant’s most recent appointment of an authorized representative to supersede any appointments made previously. The Claims Administrator will communicate directly with the authorized representative and may send a copy of those communications to the claimant. If no representative is appointed, the Claims Administrator will communicate with the claimant directly. For the Medical/Rx, Dental, and Vision Programs, health care providers with knowledge of the claimant’s condition will also be treated as authorized representatives. The Plan Administrator will also recognize as an authorized representative a person legally appointed to represent a claimant (e.g., a court-appointed representative in the case of a claimant’s incapacitation), provided that Claims under the applicable Benefit Program fall within the scope of that representation.

The entity or individual that is responsible for determining a Claim under a particular Benefit Program is referred to as the “**Claims Administrator.**” Refer to [Appendix B](#) (Benefit Program Information Chart) for the Claims Administrator for each Benefit Program. The Claims Administrator who reviews a denied Claim may be different than the Claims Administrator who reviews the initial Claim.

No Claim for a benefit will be paid or reimbursed prior to the date on which the expense was incurred. **An expense is considered incurred on the date the services are performed and not when you are billed or make a payment; except that for purposes of the Health Care FSA Program, if your dental provider requires advanced payment for orthodontia procedures, those orthodontia procedures will be considered incurred on the date you make the advanced payment.**

Claims Under Group Health Plans: Medical/Rx, Dental, Vision, EAP, and Health Care FSA Programs

This section describes the procedures for filing and processing most Claims under the Plan’s group health plans which include the Medical/Rx, Dental, Vision, EAP, and Health Care FSA Programs. If your Claim is for a benefit conditioned upon the Claims Administrator’s determination of a disability, see “Claims Under the Long-Term Disability Programs and Claims Under Other Benefit Programs for Benefits Conditioned Upon the Claims Administrator’s Determination of Disability” beginning on page 41 for additional requirements that may apply.

The rules pertaining to the processing of Claims under the Plan's group health plans vary based on whether a Claim is a Pre-Service Claim, a Post-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim.

A "**Pre-Service Claim**" is a Claim for health care that is conditioned, in whole or in part, on your obtaining approval before receiving the care (e.g., pre-authorization or pre-certification).

An "**Urgent Care Claim**" is a Pre-Service Claim where applying the standard time frames for a Pre-Service Claim:

- could seriously jeopardize your life or health or your ability to regain maximum function; or
- would, in the opinion of a physician with knowledge of your medical condition, cause you severe pain that cannot be managed adequately without the care or treatment that is the subject of the Claim.

If your physician does not identify your Claim as an Urgent Care Claim, the Plan will determine whether the Claim is an Urgent Care Claim using the judgment of a prudent layperson with average knowledge of health and medicine.

A "**Concurrent Care Claim**" is a Claim related to: (i) the reduction or termination of a previously approved course of treatment; or (ii) the extension of a previously approved course of treatment.

A "**Post-Service Claim**" is a Claim for health care that is not conditioned, in whole or in part, on your obtaining approval before receiving the care (e.g., pre-authorization or pre-certification).

Filing a Claim

Pre-Service Claims

If you are required to obtain approval before receiving care, your health care provider will typically submit your Pre-Service Claim for you. Pre-Service Claims may be submitted by mail, telephone, or electronic media to the Claims Administrator. The Claims Administrator may require substantiation by a third party that is independent of you, your Spouse or your dependents (e.g., your health care provider) including, but not limited to, a statement of: (1) the anticipated service, treatment, or procedure; (2) the anticipated date of the service, treatment, or procedure; and (3) an estimate of the cost of the service, treatment, or procedure.

If you or your health care provider are seeking pre-approval and you do not properly submit the Pre-Service Claim, the Claims Administrator will notify you within five days and explain what steps you must take to properly file your Claim. The Claims Administrator may provide the notification orally unless you request written notification.

Approval of your Pre-Service Claim serves only to meet the Plan's pre-approval requirement so that you will not be penalized. Pre-approval is not a guarantee that the Claim will be paid in

full, as there may be other reasons to deny your Claim. Once the treatment is provided, the provider's bill will be processed as a Post-Service Claim.

Urgent Care Claims

If you need urgent health care that requires pre-approval, your health care provider will typically submit your Urgent Care Claim. Urgent Care Claims may be submitted to the Claims Administrator orally or in writing, and all necessary information may be provided by telephone, facsimile, or any other similarly expeditious method. The Claims Administrator may require substantiation by a third party that is independent of you, your Spouse or your dependents (e.g., your health care provider) including, but not limited to, a statement of: (1) the service, treatment, or procedure; (2) the date of the service, treatment, or procedure; and (3) the cost of the service, treatment, or procedure.

If you or your health care provider have not properly submitted an Urgent Care Claim under the Plan's Claims procedures, the Claims Administrator will notify you within 24 hours and explain what steps you must take to properly file your Claim. The Claims Administrator may provide the notification orally unless you request written notification.

Concurrent Care Claims

If you have been approved for a course of treatment under the Medical/Rx Program and you wish to extend the course of treatment beyond what was initially authorized, you may file a Concurrent Care Claim to request the extension. You must submit all information in support of your Concurrent Care Claim to the Claims Administrator at least 24 hours prior to the scheduled expiration of the course of treatment. The Claims Administrator may require substantiation by a third party that is independent of you, your Spouse or your dependents (e.g., your health care provider) including, but not limited to, a statement of: (1) the service, treatment, or procedure to be extended; (2) the duration of the extension of the service, treatment, or procedure; and (3) the cost of the extended service, treatment, or procedure.

Post-Service Claims

Once you have received care, your health care provider will typically submit your Post-Service Claim for you. If you have paid for services out of your own pocket, or the provider has sent a bill directly to you for payment, you should obtain a Claim form from Human Resources or the Claims Administrator. Post-Service Claims may be submitted to the Claims Administrator in writing or by any reasonably available electronic media.

The Claims Administrator may require substantiation by a third party that is independent of you, your Spouse or your dependents (e.g., your health care provider) including, but not limited to, a statement of: (1) the service, treatment, procedure, or product; (2) the date on which you received or underwent the service, treatment, or procedure, or the date on which you purchased the product; and (3) the amount charged. The Claims Administrator may also require your Claim to include a completed Claim form (including any documentation required by the Claim form) and, if you have already paid for the service, treatment, procedure or product, evidence of payment (e.g., a cancelled check, receipt, an invoice marked "paid," etc.). For Claims under the Health Care FSA Program, you will also be required to certify that you have not been reimbursed for, and will not seek reimbursement of, the expense under any other plan.

Deadline for Post-Service Claims Under Medical/Rx, Dental, Vision, and EAP Programs

You are encouraged to submit your Post-Service Claims under the Medical/Rx, Dental, Vision, and EAP Programs as soon as possible after you incur the expense. Unless otherwise specified in the applicable Insurance Contracts or Booklets, Post-Service Claims under these Programs must be submitted within 12 months of the date the expense was incurred.

Deadline for Post-Service Claims Under Health Care FSA Program

Generally, to obtain reimbursement of Eligible Health Care Expenses incurred during a Plan Year, you must submit a Claim to the Claims Administrator within 91 days after the end of the Plan Year. However, if your participation in the Health Care FSA Program ends before the end of the Plan Year (e.g., because your employment terminates), final Claims for Eligible Health Care Expenses incurred prior to the date your participation ends must be submitted within 91 days of the date your participation ends.

Notice of Initial Claim Determination

Timing of Notice of Initial Claim Determination

Pre-Service Claim

If your Claim is a Pre-Service Claim, the Claims Administrator will notify you of its determination (whether adverse or not) within a reasonable period of time considering the medical circumstances, but not later than 15 days after receipt of the Claim, or 30 days if the Claims Administrator determines an extension is necessary due to matters beyond the control of the Plan and notifies you within the original 15-day period of the reason for the extension and date by which the determination is intended to be made. If the extension is necessary because you failed to submit a complete Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Urgent Care Claim

If your Claim is an Urgent Care Claim, the Claims Administrator will notify you of its determination (whether adverse or not) as soon as possible taking into account the medical circumstances, but no later than 72 hours after receipt of the Claim, unless your Claim is incomplete. If your Urgent Care Claim is incomplete, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the Claim, of the information necessary to complete the Claim. You will be given a reasonable period of time, but not less than 48 hours, to provide the necessary information; and the Claims Administrator will notify you of its determination within 48 hours of receipt of that information. If you fail to provide the information in a timely manner, the Claims Administrator will make its determination based on the information it has and will notify you of its determination within 48 hours of the deadline for providing the necessary information.

Concurrent Care Claim

The reduction or termination of a previously approved course of treatment is considered a denial of a Concurrent Care Claim. In this circumstance, the Claims Administrator will issue a Notice of Initial Claim Denial sufficiently in advance of the reduction or termination to allow you to exercise your right of appeal and obtain a determination before the benefit is reduced or terminated.

If your Concurrent Care Claim is for the extension of a previously approved course of treatment, the Claims Administrator will notify you of its determination (whether adverse or not) within 24 hours after receipt of the Claim.

Post-Service Claim

The Claims Administrator is not required to notify you of its determination for a Post-Service Claim unless the Claim is denied. If a Post-Service Claim is denied, the Claims Administrator will provide you with a Notice of Initial Claim Denial within a reasonable period of time, but not later than 30 days after receipt of the Claim, or 45 days if the Claims Administrator determines an extension is necessary due to matters beyond the control of the Plan and notifies you within the original 30-day period of the reason for the extension and date by which the determination is intended to be made. If the extension is necessary because you failed to submit a complete Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Initial Claim Denial

Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, or any rescission of coverage, is a Claim denial. This includes any determination based on the eligibility of the person on whose behalf the expense was incurred or whether the expense itself is eligible for reimbursement.

If your initial Claim is denied in whole or in part, or if your coverage is rescinded, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its determination in a culturally and linguistically appropriate manner. The notice of initial claim denial will:

- provide information to help you identify the Claim including, upon request and when applicable, the diagnosis and treatment codes and the meanings of those codes;
- inform you of the specific reasons for the denial of your initial Claim and any denial code and its corresponding meaning;
- inform you of the pertinent Plan provisions on which the denial is based;
- describe any rule, standard, guideline, protocol, or similar document or criteria relied on in making the initial determination; or include a statement that the rule, standard, guideline, protocol, or similar document or criteria was relied on and that a copy of it may be obtained at no charge upon request;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgment for the denial, or include a statement that an explanation will be provided free of charge upon request;
- describe any additional materials necessary to perfect your Claim, and explain why this material is necessary;

- include an explanation of the Plan's internal and external appeal procedures, including information about how to initiate an appeal and the applicable time limits; and a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures;
- provide contact information for an office of health insurance consumer assistance or a health insurance ombudsman program, if such a service has been established in your state.

Special Rules for Urgent Care Claims

The notice of initial claim denial for an Urgent Care Claim may be provided orally, with a written or electronic notice to follow within three days. In addition to the information listed above, the notice of initial claim denial for an Urgent Care Claim will include an explanation of the expedited review process available for such claims.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 180 days of receipt of the notice of initial claim denial. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

Review of Appeal

The persons reviewing your appeal will grant no deference to the original Claim denial but will assess the information you provide as if they were looking at the Claim for the first time. Also, the persons reviewing your appeal will not be the same persons who made the initial decision, nor will they be subordinates of those individuals. Upon request and free of charge, you will also be provided reasonable access to and copies of, all documents, records, and other information relevant to your Claim.

If the initial Claim denial is based on medical judgment (e.g., it was based on an assessment that your treatment was experimental or was not medically necessary), the Claims Administrator must consult with an expert in the appropriate field when reviewing the Claim. The expert will not be someone who was consulted in the initial review of your Claim or a subordinate of anyone consulted in that review. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

Expedited Review for Urgent Care Claims

You may request an expedited review for an Urgent Care Claim. Your request may be made orally or in writing and all necessary information, including the Claims Administrator's determination on review, will be transmitted by telephone, facsimile, email, or other similarly expeditious methods.

Notice of Determination on Appeal

Timing of Notice of Determination on Appeal

Pre-Service Claim

If you appeal the initial denial of a Pre-Service Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time considering the medical circumstances, but not later than 30 days after receipt of the appeal.

Urgent Care Claim

If you appeal the initial denial of an Urgent Care Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) as soon as possible taking into account the medical circumstances, but no later than 72 hours after receipt of the appeal.

Post-Service Claim

If you appeal the initial denial of a Post-Service Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 60 days after receipt of the appeal.

If your Claim is for benefits conditioned upon a determination of disability, you will be notified of the determination on review (whether adverse or not) within a reasonable period of time, but not later than 45 days after receipt of the appeal.

Form and Content of Notice of Denial on Appeal

If your Claim is denied upon appeal, in whole or in part, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its determination in a culturally and linguistically appropriate manner. The notice of denial on appeal will:

- provide information to help you identify the Claim including, upon request and when applicable, the diagnosis and treatment codes and the meanings of those codes;
- inform you of the specific reasons for the denial and include any denial code and its corresponding meaning;
- provide you with a description of the Plan's standard, if any, used in denying the Claim;
- inform you of the specific Plan provisions on which the denial is based;
- provide an explanation of additional internal levels of appeal and external review that the Plan makes available, if any, including information about how to initiate an appeal and the applicable time limits;
- contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);
- describe any rule, standard, guideline, protocol, or similar document or criteria relied on in denying the Claim on appeal; or include a statement that the rule, standard,

guideline, protocol, or similar document or criteria was relied on and that a copy of it may be obtained at no charge upon request;

- contain a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgement for the denial, or include a statement that an explanation will be provided free of charge upon request;
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- provide contact information for an office of health insurance consumer assistance or a health insurance ombudsman program, if such a service has been established in your state.

The decision of the Claims Administrator on appeal is final, subject to the external review (as described immediately below) or the order of a federal court in a civil action.

External Review

Under certain circumstances described below, your Claim under the Medical/Rx, Dental, or Vision Program may be eligible for external review by an independent reviewing organization ("**IRO**"). This external review procedure is voluntary and you are not required to use it before filing a civil action in court.

The IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. After reviewing all of the information available to you and the Plan, the IRO will recommend whether the Plan should uphold or reverse the Claim Administrator's final determination of the Claim. The IRO's decision is binding on the Plan and you, except to the extent that other remedies are available under state or federal law.

Standard Procedures for External Review

If you have exhausted the Benefit Program's required appeal procedures and your Claim under the Medical/Rx, Dental, or Vision Program was denied because of a medical judgment or a rescission of coverage, you have the right to request an external review. Specifically, external review applies to a Claim that is denied based on: (i) the Benefit Programs requirements about medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; (ii) whether a treatment is experimental or investigational; (iii) whether the Benefit Program complies with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques; and (iv) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time).

Claims regarding plan eligibility and contractual or legal interpretations of the Plan are not eligible for external review.

Request for External Review

If you decide to request an external review, you must submit a written request to the Claims Administrator within four months of the date of your final notice of denial on appeal. The final notice of denial on appeal will contain an explanation of how to make this request.

Preliminary Review

Upon receipt of your request, the Claims Administrator will have five business days to perform a preliminary review and determine whether your Claim is eligible for external review. If your request is incomplete, you will be permitted to submit the missing information within the original 4-month filing period or, if that time period has already expired, 48 hours from your receipt of the notice that your request is incomplete.

External Review

If the Claims Administrator determines that your Claim is eligible for external review, it will be assigned to an IRO and all documents and information considered in making the benefit determination will be forwarded to the IRO within five business days. You will receive a notice that your Claim has been accepted for external review and you will be given 10 days to submit any additional information relevant to your Claim. You will receive the IRO's final decision within 45 days of receipt of your request for external review.

Expedited External Review

You can request an expedited external review of your Claim if you have:

- filed a request for expedited internal appeal but your Claim involves a medical condition for which the timeframe for completion of that appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or
- exhausted the required internal appeal procedures and the Claim involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or if the Claim concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services, and you have not been discharged from the facility.

A request for an expedited external appeal may be submitted orally or in writing, and all necessary information may be provided by telephone, facsimile, or any other similarly expeditious method. The process is substantially the same as the standard procedures described above except that the Claims Administrator's preliminary review will be performed immediately, all documentation and information considered in making the benefit determination will be transmitted to the IRO electronically or by telephone or facsimile or other available expeditious method, and the IRO's notice of final determination will be issued as expeditiously as the circumstances require, but no later than 72 hours after the IRO receives your request for expedited external review. If the notice is given orally, you will receive a written confirmation of the determination within 48 hours of the date of the oral notice.

If the Claim involves experimental or investigational treatments, the IRO will ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

Filing Civil Action

If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the claim you file in court will be subject to dismissal. Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures

If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat the Benefit Program's claims procedures as having been completed and immediately seek an external review or file a civil action in court.

Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims Under Life/AD&D Insurance Program

This section describes the procedures for filing and processing most Claims under the Life/AD&D Insurance Program. If your Claim is for a benefit conditioned upon the Claims Administrator's determination of a disability, see "Claims Under the Long-Term Disability Program and Claims Under Other Benefit Programs for Benefits Conditioned Upon the Claims Administrator's Determination of Disability" beginning on page 41 for additional requirement that may apply.

Filing a Claim

To file a Claim under the Life/AD&D Insurance Program, you must send a completed Claim form, and any materials or documentation required by the form, to the Claims Administrator at the address found in [Appendix B](#) (Benefit Program Information Chart). You may obtain a Claim form from Human Resources or the Claims Administrator.

See the Insurance Contracts or Booklets for each Benefit Program for the applicable deadlines for the submission of Claims.

Notice of Initial Claim Denial

Timing of Notice of Initial Claim Denial

If your Claim is denied, in whole or in part, the Claims Administrator will notify you within a reasonable period of time (but not later than 90 days) after receipt of your Claim. An extension of up to 90 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will

describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Initial Claim Denial

Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, or any rescission of coverage, is a Claim denial. This includes any determination based on eligibility.

If your initial Claim is denied in whole or in part, or if your coverage is rescinded or terminated for cause, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its determination. This notice of claim denial will:

- inform you of the specific reasons for the denial of your initial Claim;
- inform you of the pertinent Plan provisions on which the denial is based;
- describe any additional materials necessary to perfect your Claim, and explain why this material is necessary; and
- include an explanation of the Plan's appeal procedures, including information about how to initiate an appeal and the applicable time limits; and a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 60 days of receipt of the notice. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

Notice of Determination on Appeal

Timing of Notice of Determination on Appeal

If you appeal the initial denial of your Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 60 days after receipt of the appeal. An extension of up to 60 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Denial on Appeal

If your Claim is denied upon appeal, in whole or in part, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its denial in a culturally and linguistically appropriate manner. This notice of denial on appeal will:

- inform you of the specific reasons for the denial;
- inform you of the specific Plan provisions on which the denial is based;
- provide an explanation of additional levels of appeal that the Plan makes available, if any, including information about how to initiate an appeal and the applicable time limits;
- contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);
- contain a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures.

The decision of the Claims Administrator on appeal is final, subject to the order of a federal court in a civil action.

Filing Civil Action

If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the claim you file in court will be subject to dismissal. Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures

If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat a Benefit Program's claims procedures as having been completed and immediately file a civil action in court.

Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims Under the Long-Term Disability Program and Claims Under Other Benefit Programs for Benefits Conditioned Upon the Claims Administrator's Determination of Disability

This section describes the procedures for filing and processing Claims under the Long-Term Disability Program. These rules also apply to Claims under other Benefit Programs if the Claim is for benefits that are conditioned upon the Claims Administrator's determination of disability.

Filing a Claim

To file a Claim for benefits under the Long-Term Disability Program, you must send a completed Claim form, and any materials or documentation required by the form, to the Claims

Administrator at the address found in Appendix B (Benefit Program Information Chart). You may obtain a Claim form from Human Resources or the Claims Administrator. Unless otherwise specified in the applicable Insurance Contracts or Booklets, Claims under the Long-Term Disability Program must be submitted within 12 months of the date of the event giving rise to the Claim.

To file a Claim for benefits conditioned upon a determination of disability under any other Benefit Program, follow the procedures described above for the applicable Program.

Notice of Initial Claim Denial

Timing of Notice of Initial Claim Denial

If your Claim is denied, the Claims Administrator will notify you within a reasonable period of time (but not later than 45 days) after receipt of your Claim. The determination period may be extended by 30 days if the Claims Administrator decides it is necessary due to matters beyond its control. If an extension is required, you will receive notice prior to the end of the initial determination period. A second 30-day extension may be taken by the Claims Administrator so long as you are again notified before the end of the first 30-day extension period. The notice of extension will:

- explain the standards on which entitlement to a benefit is based;
- indicate the unresolved issues that prevent a decision on the Claim;
- describe the additional information that is needed to resolve those issues;
- include the date by which the Claims Administrator expects to make its decision.

If the Claims Administrator requests additional information, you will be allowed a reasonable period of time (at least 45 days) to submit that information before the Claims Administrator proceeds to make its decision.

Form and Content of Notice of Initial Claim Denial

Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, or any rescission of coverage, is a Claim denial. This includes any determination based on eligibility.

If your initial Claim is denied in whole or in part, or if your coverage is rescinded or terminated for cause, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its determination in a culturally and linguistically appropriate manner. The notice of initial claim denial will:

- inform you of the specific reasons for the denial of your initial Claim;
- inform you of the pertinent Plan provisions on which the denial is based;

- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgment for the denial, or include a statement that an explanation will be provided free of charge upon request;
- describe any additional materials necessary to perfect your Claim, and explain why this material is necessary;
- include an explanation of the Plan's appeal procedures, including information about how to initiate an appeal and the applicable time limits; and a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures;
- include an explanation of the basis for disagreeing with, or not following: the views presented by you of health care professionals treating you or vocational professionals evaluating your Claim; the views of medical or vocational experts obtained by the plan even if the views were not relied upon in making the decision to deny your Claim; a disability determination made by the Social Security Administration;
- describe any rule, standard, guideline, protocol, or similar document or criteria relied on in making the initial determination; or include a statement that one does not exist; and
- include a statement that you are entitled to receive, free of charge and on request, reasonable access to, and copies of, all document, records, and other information relevant to your Claim.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 180 days of receipt of the notice of initial claim denial. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

Review of Appeal

The persons reviewing your appeal will grant no deference to the original Claim denial but will assess the information you provide as if they were looking at the Claim for the first time. Also, the persons reviewing your appeal will not be the same persons who made the initial decision, nor will they be subordinates of those individuals. Upon request and free of charge, you will also be provided reasonable access to and copies of, all documents, records, and other information relevant to your Claim.

If the initial Claim denial is based on medical judgment, the Claims Administrator must consult with an expert in the appropriate field when reviewing the Claim. The expert will not be someone who was consulted in the initial review of your Claim or a subordinate of anyone consulted in that review. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

Notice of Determination on Appeal

Timing of Notice of Determination on Appeal

If you appeal the initial denial of your Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 45 days after receipt of the appeal. An extension of up to 45 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Denial on Appeal

If your Claim is denied upon appeal, in whole or in part, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its denial in a culturally and linguistically appropriate manner. The notice of denial on appeal will:

- inform you of the specific reasons for the denial;
- provide you with a description of the Plan's standard, if any, used in denying the Claim;
- inform you of the specific Plan provisions on which the denial is based;
- provide an explanation of additional levels of appeal that the Plan makes available, if any, including information about how to initiate an appeal and the applicable time limits;
- contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);
- contain a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures and a description of any time limitations that apply to that right, including the calendar date on which the limitations expire;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgement for the denial, or include a statement that an explanation will be provided free of charge upon request;
- an explanation of the basis for disagreeing with, or not following: the views presented by you of health care professionals treating you or vocational professionals evaluating your Claim; the views of medical or vocational experts obtained by the plan even if the views were not relied upon in making the decision to deny your Claim; a disability determination made by the Social Security Administration; and

- a description of any rule, standard, guideline, protocol, or similar document or criteria relied on in making the initial determination; or a statement that one does not exist.

Before the Claims Administrator makes its decision, the Plan will notify you of any additional grounds for denying your Claim and provide you with an opportunity to present additional evidence in response. This evidence will be provided as soon as possible and sufficiently in advance of the date the Plan must provide notice of its decision on appeal.

The decision of the Claims Administrator on appeal is final, subject to the order of a federal court in a civil action.

Filing Civil Action

If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the claim you file in court will be subject to dismissal. Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures

If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat a Benefit Program's claims procedures as having been completed and immediately file a civil action in court.

Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims Under Dependent Care FSA Program

Filing a Claim

Claims for reimbursement of Eligible Dependent Care Expenses under the Dependent Care FSA Program must be submitted on Claim forms available from the Claims Administrator. All Claims must:

- Be for a paid expense incurred during the Plan Year; and
- Include:
 - Amount, date, and nature of the expense;
 - Name, address, and the federal taxpayer identification number or employer identification number of the person, organization, or entity to which the expense was or is to be paid;
 - Name of the person for whom the expense was incurred, and the relationship of that person to you;

- Amount recovered or recoverable from any other source with respect to the expense;
- Written evidence from an independent third party stating that the expense has been incurred, the amount of the expense (e.g., bills, invoices, receipts, or other writings showing the amount of the expense); and
- Any other information deemed necessary by the Claims Administrator in order to make a reasonable determination that the expense is reimbursable.

Generally, to obtain reimbursement of Eligible Dependent Care Expenses incurred during a Plan Year, you must submit a Claim to the Claims Administrator within 91 days after the end of the Plan Year. However, if your participation in the Dependent Care FSA Program ends before the end of the Plan Year (e.g., because your employment terminates), final Claims for Eligible Dependent Care Expenses incurred prior to the date your participation ends must be submitted within 91 days of the date your participation ends.

Small claims may be held until they reach a reasonable threshold amount to be established by the Claims Administrator.

Notice of Initial Claim Denial

If your Claim is denied, the Claims Administrator will notify you within a reasonable period of time, but not later than 30 days after receipt of the Claim, or 45 days if the Claims Administrator determines an extension is necessary due to matters beyond the control of the Plan and notifies you within the original 30-day period of the reason for the extension and date by which the determination is intended to be made. If the extension is necessary because you failed to submit a complete Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 60 days of receipt of the notice. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

Notice of Determination on Appeal

Timing of Notice of Determination on Appeal

If you appeal the initial denial of your Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 60 days after receipt of the appeal. An extension of up to 60 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an

explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Denial on Appeal

If your Claim is denied upon appeal, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its denial, including the specific reasons for the denial on appeal.

Filing Civil Action

If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the claim you file in court may be subject to dismissal. Any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures

If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat the claims procedures as having been completed and immediately file a civil action in court.

Any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims Under HSA Contributions Program

Claims for payment or reimbursement of expenses under your HSA are governed by the terms and conditions of your custodial agreement. Refer to your custodial agreement or contact your HSA custodian for applicable claims procedures.

For Claims related to your eligibility for the HSA Contributions Program, see "Claims Based Solely on Eligibility to Participate in Plan or Benefit Program and Claims of ERISA or Code Violations" below.

Claims Under Pre-Tax Payment Program

You are not required to file a Claim for benefits under the Pre-Tax Payment Program. Benefits are provided automatically once you are enrolled in the Program.

For Claims related to your eligibility for the Pre-Tax Payment Program, see "Claims Based Solely on Eligibility to Participate in Plan or Benefit Program and Claims of ERISA or Code Violations" below.

Claims Based Solely on Eligibility to Participate in Plan or Benefit Program and Claims of ERISA or Code Violations

Filing a Claim

If for any reason you believe you have been improperly excluded from the Plan or from any of the Plan's Benefit Programs, or if you believe that the Plan Administrator, a Plan fiduciary, or the Employer has violated ERISA or the Code, you may file a formal Claim in writing to the Plan Administrator. Be sure to include:

- For Claims related to eligibility, the reason you think you should be entitled to participate in the applicable Benefit Program and the reason you think you have not been permitted to participate;
- For Claims of ERISA or Code violations, a description of the alleged violation; and
- Your name and Social Security number.

This procedure only applies to a Claim that deals solely with eligibility to participate in the Plan or a particular Benefit Program, and to Claims of ERISA or Code violations. It will not apply to eligibility determinations that are linked to a Claim for a specific benefit under a particular Benefit Program. In those instances, your Claim will be decided under the procedures that apply to the specific benefit you are seeking.

Initial Claim Decision

Notice of the decision on your Claim will be issued within a reasonable period of time, but not later than 30 days after receipt of the Claim, or 45 days if the Plan Administrator determines an extension is necessary due to matters beyond the control of the Plan and notifies you within the original 30-day period of the reason for the extension and date by which the determination is intended to be made. If the extension is necessary because you failed to submit a complete Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Plan Administrator makes its determination.

Claim Review Procedures

If your Claim is denied, in whole or in part, and you disagree with this decision, you must make a written appeal to the Plan Administrator for a review of the denial of your Claim within 60 days of the notice of denial.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim to participate. You may also submit written comments, documents, records, and other information relating to your appeal to the Plan Administrator.

The review on your appeal will take into account all comments, documents, records, and other information submitted by you relating to your appeal, even if that information was not submitted or considered in the initial decision of your Claim. The Plan Administrator will make its decision on your appeal within a reasonable time, but no later than 60 days from receipt of the appeal. An extension of up to 60 days is permitted if the Claims Administrator decides that

special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Filing Civil Action

If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the claim you file in court will be subject to dismissal. Unless otherwise provided in an applicable Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures

If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat these claims procedures as having been completed and immediately file a civil action in court.

Unless otherwise provided in an applicable Booklet, any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

SPECIAL RULES FOR HEALTH BENEFIT PROGRAMS

General Exclusions

No benefits are payable for the following under the Medical/Rx, Dental or Vision Programs:

- Expenses due to an injury or illness arising out of or in the course of employment or in the course of any activity you undertake for wage or profit;
- Expenses where there is no legal obligation or financial liability to pay, or where charges would not be made if there were no coverage under a Benefit Program;
- Expenses for services, care or supplies that are rendered or received prior to or after any period of coverage under a Benefit Program, except as specifically provided under this Plan;
- Expenses applied toward satisfaction of any deductible or copayment required by a Benefit Program;
- Expenses for services or treatment given by an immediate family member (parent, grandparent, Spouse, Child, grandchild or sibling) or a person residing in the same household as the patient;
- Expenses that the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government;

- Expenses for benefits that are provided, or that would have been provided had the Participant enrolled for them, under Medicare, except as provided in "Coordination with Medicare" beginning on page 52; or
- For the Medical/Rx Program only, expenses for injuries received in an accident involving a Motor Vehicle (for this purpose, "**Motor Vehicle**" means a car or other vehicle, including a trailer, operated or designated for operation upon a public highway by power other than muscular power that has more than two wheels; it does not include a motorcycle, moped or any off road vehicle or all-terrain vehicle).

Coordination of Benefits

For purposes of the Medical/Rx, Dental, and Vision Programs, unless otherwise provided under an Insurance Contract, or under the Booklets of an insurer or a third-party administrator, the Plan will coordinate with:

- Another group health plan (including any employer-sponsored welfare benefit plan, whether or not insured, that provides medical or dental coverage, including prescription drugs), such as insurance provided by a Spouse's employer;
- Money you or your Covered Dependent could receive from another person or entity who caused the injuries on account of which a Claim was made.

When the Plan coordinates benefits, one source of benefits will be "primary," meaning it will pay before the other source. The other will be "secondary," meaning it will pay after the primary source of benefits.

When the Plan is primary, it will pay benefits as if there were no other source of benefits. But if the Plan is secondary, it will first calculate what it would pay in the absence of any other source of benefits. Then the Plan will subtract from that amount the amount that should be paid by the other source. The Plan will pay that difference, so that the Participant will receive the full amount of benefits payable under the Plan. (The amount payable by the other source will be subtracted even if you do not apply for benefits from that other source.) This Plan will not, however, pay more than it would have if it were the only source of benefits.

Coordination with Other Group Health Plans

If you or your Covered Dependent incur an expense that would be paid by two or more group health plans, the group health plan with the highest priority is primary and will pay first. The other group health plan is secondary and will pay next.

Unless otherwise provided under an Insurance Contract, or under the Booklets of an insurer or a third-party administrator, priority is determined by the first of the following rules that applies:

- First: A group health plan without a coordination of benefits provision will pay.
- Second: Then a group health plan covering the patient as an employee, rather than as a dependent, will pay.

Third: For a patient who is a dependent Child, unless there is a court order or judgment stating otherwise, the plan responsible for payment is determined as follows:

- If the dependent Child's parents are married or living together, whether or not they have ever been married, the group health plan of the parent whose birthday occurs earlier in the calendar year will pay. If both parents have the same birthday, the plan that has covered the parent the longest will pay.
- If the dependent Child's parents are divorced, legally separated, or not living together, whether or not they have ever been married:
 - if a court order or judgment makes one parent responsible for a Child's health expenses, that parent's group health plan (that also covers the Child) will pay;
 - if a court order or judgment makes both parents responsible or if it states that the parents have joint custody without specifying that one parent has responsibility for the Child's health expenses, then the parent whose birthday falls earlier in the calendar year will pay, and if both parents have the same birthdate, the plan that has covered the parent longest will pay;
 - if there is no court order or judgment addressing responsibility for the Child's health care coverage, the plan with priority is the first of the following that is applicable: (i) the plan covering the custodial parent; (ii) the plan covering the custodial parent's spouse; (iii) the plan covering the noncustodial parent; and (iv) the plan covering the noncustodial parent's spouse.
 - If the dependent Child is covered by more than one plan of individuals who are not the parents of the Child, the responsible plan will be determined in accordance with the above rules for dependent Children as if those individuals were the Child's parents.
 - If the dependent Child is covered under a parent's plan and is also covered under the Child's Spouse's plan, the plan that has covered the parent or Spouse for the longer period of time will be the primary plan.

Fourth: Then the group health plan that has covered the patient for the longer period of time will pay.

Fifth: Then any other group health plan will pay.

If two or more group health plans have the same priority, they will each pay pro-rata.

There are some special rules that have precedence over the above priorities:

- COBRA coverage is always secondary to any other group health plan; and

- Coverage provided by virtue of being a laid-off employee or an employee on a leave of absence is always secondary to coverage provided by virtue of that individual being an active employee.

The rules described in this section are intended to be, and will be interpreted to be, consistent with the state of Michigan's Coordination of Benefits Act.

Medical/Rx Program Coordination with Vehicle Accident Insurance

The Medical/Rx Program does not pay benefits for injuries received in an accident involving a Motor Vehicle. Any state insurance law that purports to require that the Medical/Rx Program be primary or that does not allow the Medical/Rx Program to subrogate or recover its payments is preempted by ERISA. This means that even if you are covered under a vehicle accident insurance policy that makes "other health coverage" primary, the Medical/Rx Program will still not pay for those benefits. You are considered covered under a vehicle accident insurance policy if you would be eligible for medical expense benefits under the policy if the Medical/Rx Program did not exist.

Coordination with Medicare

The general rule is that the Plan will be secondary to Medicare in all circumstances where federal law does not require the Plan to be primary. If you are covered under the Medical/Rx Program and you or your Spouse are over 65 years old and eligible for Medicare, you may reject coverage in this Plan and rely on Medicare as your sole source of coverage. If you do not reject coverage under this Plan, you will have coverage under both this Plan and Medicare. In this case, federal law requires that the Plan is primary and Medicare is secondary.

Medicare is also available for certain people who have not yet reached the age of 65, but who have received Social Security disability benefits for at least 24 months. When Medicare is available in those situations, the Plan will be primary for you and your Covered Dependents as long as you are in current employment status; otherwise the Plan will be secondary.

Medicare is also available to individuals who have been under treatment for end-stage renal disease. The Plan will be primary to Medicare for a covered individual who qualifies for Medicare benefits because of end-stage renal disease for the coordination period set forth in the Medicare secondary payer provisions of the Social Security Act. After the coordination period ends, the Plan will be secondary.

It is your responsibility to apply for Medicare benefits that are available. If Medicare is primary under these rules, the Plan will calculate the benefits it provides as if you were enrolled in Medicare, regardless of whether you have applied.

Coordination with CHIP Coverage

The Plan will be considered primary to any CHIP coverage that supplements this Plan.

Coordination with Third Parties

If a third party negligently or tortiously causes a health problem on account of which you have incurred medical expenses, the Plan is secondary to the third party's liability to you. If benefits

are available under any insurance policy as a result of this negligent or tortious conduct, the Plan is secondary to those benefits.

Facility of Payment

If an expense or benefit that should have been paid by the Plan is paid by another person or entity, the Plan may pay to that person or entity any amount that it considers necessary to satisfy the intent of the Plan's coordination provisions. The Plan will then have no further liability for those expenses or benefits.

The Plan will not pay any expense or benefit that has actually been paid by another source, even if that other source is secondary to the Plan, unless that source files a claim for reimbursement. If the other source files a claim for reimbursement, the Facility of Payment provision of this Plan applies.

Subrogation/Right of Recovery

Unless otherwise provided under an Insurance Contract, or under the Booklets of an insurer or third-party administrator, this section applies with respect to subrogation and the Plan's right of recovery.

If you or your Covered Dependents incur a loss for which another party may be responsible, the Plan has a right to recover benefits paid by the Plan for that loss. The Plan has an equitable right to seek reimbursement from any payments that you or your Covered Dependents receive from the party responsible for the loss, or the Plan may "step into the shoes" of yourself or your Covered Dependent, or your successors in interest, to bring a subrogation action against any third party that may be responsible for the loss. This right exists until the Plan has been reimbursed in full for the benefits it has paid and the expenses and attorney fees the Plan has incurred in enforcing its rights.

When you and your Covered Dependents accept benefits under a Benefit Program, you assign to the Plan, or transfer to the Plan, all rights of recovery from any other party, to the fullest extent permitted by law. The Plan will be subrogated to and may bring any claim you or your dependents may have against the other party (or its insurer). You may not assign your claims to any other person without permission of the Plan. The Plan will have a first priority lien on any recovery for the total amount it has paid, as well as for any expenses or attorneys' fees incurred in enforcing the Plan's rights. The Plan may withhold payment of benefits when it appears that another party may be liable for the loss until the liability is legally determined.

If you or your Covered Dependents receive any funds from any person who may have a responsibility for a loss covered by the Plan, the Plan has the right to be reimbursed from your total recovery before any amounts, including expenses or attorneys' fees, are deducted, whether or not the recovery is specifically for that loss, and regardless of how the proceeds are characterized or the source of the recovery. This is a right of first reimbursement, and the "make whole" rule or "common fund" rule will not apply.

Without limiting the Plan's right to reimbursement or subrogation, these rights apply to any judgment, settlement or payment made or to be made because of an accident or malpractice, including but not limited to payments made by other insurance of any kind. The Plan will not

pay, offset any recovery, or in any way be responsible for any fee or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

You and your Covered Dependents must cooperate fully with the Plan Administrator to protect the Plan's right of reduction, recovery, reimbursement or subrogation and must sign any reimbursement or subrogation agreement or other document that may be requested by the Plan Administrator, although the plan may exercise its rights under this section whether or not any such agreement is requested or signed by you. You and your Covered Dependents are responsible for notifying the plan in writing of any claim you may have against another party who may be responsible for benefits paid under this Plan. Your notice must be provided within 30 days of the date that any notice is given to any party, including an attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to any injury, illness, or condition for which the Plan has paid benefits.

If you, your agent, a trust, or any other person or entity receive any proceeds of settlement or judgment on behalf of you or your Covered Dependent, and if the plan has a right to any portion of those proceeds, you, your agent, or the third party must hold those proceeds in trust for the plan. The plan may recover any expenses it incurs because you or your Covered Dependents failed to cooperate in enforcing the plan's rights under this section. If you or your Covered Dependents do not comply with this section, your right to benefits under the plan may be forfeited.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("**COBRA**") provides Qualified Beneficiaries, upon the occurrence of a Qualifying Event, the right to continuation coverage under the Medical/Rx, Dental, Vision, EAP and Health Care FSA Programs beyond the time the coverage would normally end ("**COBRA Continuation Coverage**"). This section generally explains COBRA Continuation Coverage, when it may become available, and what you need to do to protect your right to receive it.

You may have other, more affordable 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 does not accept late enrollees. When deciding whether to elect COBRA Continuation Coverage, you should investigate these other options.

COBRA Continuation Coverage for the Plan is administered by the "**COBRA Administrator**," whose name, address, and phone number can be found in [Appendix B](#) (Benefit Program Information Chart). For more information about your COBRA rights under the Plan, please contact the COBRA Administrator.

Qualifying Events and Qualified Beneficiaries

COBRA Continuation Coverage is a continuation of coverage under the Medical/Rx, Dental, Vision, and Health Care FSA Programs when coverage would otherwise end on account of a life event known as a "**Qualifying Event**." After a Qualifying Event, COBRA Continuation

Coverage must be offered to each person who is a Qualified Beneficiary. A "**Qualified Beneficiary**" is someone who will lose coverage under the Plan because of a Qualifying Event.

You will become a Qualified Beneficiary if you will lose your coverage under the Plan because either of the following Qualifying Events happens:

- Your hours of work are reduced or you move to a position with the Employer where you are not eligible to participate in the Plan; or
- Your employment ends for any reason other than your gross misconduct.

Your Spouse will become a Qualified Beneficiary if coverage is lost because any one or more of the following Qualifying Events happens:

- You die;
- You are divorced or legally separated from your Spouse;
- Your hours of work are reduced or you move to a position with the Employer where you are not eligible to participate in the Plan;
- Your employment ends for any reason other than your gross misconduct; or
- You become entitled to Medicare benefits (under Part A, Part B, or both).

Your Covered Dependent Child will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

- You die;
- You are divorced or legally separated from your Spouse;
- Your hours of work are reduced or you move to a position with the Employer where you are not eligible to participate in the Plan;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- Your Child stops being eligible for coverage under the Plan as a dependent Child.

COBRA Following FMLA Leave

If you, your Spouse, and dependent Child are covered by the Medical Dental, Vision, or Health Care FSA Program on the day before you begin a leave of absence under FMLA, you will become Qualified Beneficiaries entitled to elect COBRA Continuation Coverage under the applicable Benefit Program on the last day of FMLA leave if you do not return to work at the end of your FMLA leave, whether or not coverage remained in force during the leave.

Notice of Qualifying Event Required

The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the COBRA Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the reduction of your hours or end of your employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

For the other Qualifying Events (e.g., your divorce or legal separation, or your Child's losing eligibility for coverage as a dependent Child), you must notify the COBRA Administrator within 60 days after the Qualifying Event occurs. You must provide written notice of the Qualifying Event to the COBRA Administrator. Emailed notices or notices sent by facsimile will be considered written notices. Oral or voice-mailed notices will not be accepted.

Your notice must include: the name and contact information of the person giving notice, the name and address of the employee or former employee who is or was a Plan Participant, a description of the Qualifying Event, the date of the Qualifying Event, any documents or materials relevant to the Qualifying Event (e.g., a copy of a judgment of divorce in the event of a divorce), and the names, addresses, and Social Security numbers of the Covered Dependents affected by the Qualifying Event. Failure to notify the COBRA Administrator in a timely manner will mean that neither you nor your Covered Dependents will be able to elect COBRA Continuation Coverage for these Qualifying Events.

Electing COBRA Continuation Coverage

Once the COBRA Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. To elect Continuation Coverage, you must complete the election form and send it in according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, your Spouse may elect coverage even if you do not. COBRA Continuation Coverage may be elected for only one, several, or for all dependent Children who are Qualified Beneficiaries. A parent may elect or reject Continuation Coverage for any minor Children. You and your Spouse may elect Continuation Coverage for each other, but cannot reject coverage for the other person. After you have submitted your election forms, if it is determined that you or a Covered Dependent is not entitled to Continuation Coverage, you will be provided with a written explanation of why the election of Continuation Coverage could not be honored.

In considering whether to elect COBRA Continuation Coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible, such as a plan sponsored by your Spouse's employer, within 30 days after your group health plan coverage ends because of the Qualifying Events listed above. You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you elect COBRA Continuation Coverage for the maximum time available to you.

Cost of COBRA Continuation Coverage

Generally, each Qualified Beneficiary must pay the entire cost of COBRA Continuation Coverage. The cost cannot exceed 102% (or in the case of an extension due to a disability, 150%) of the cost to the Plan for coverage of a similarly-situated Plan Participant and/or beneficiary who is not receiving COBRA Continuation Coverage. The cost for a similarly-situated Plan Participant or beneficiary includes both the Employer contributions and Employee Contributions for coverage. The required payment for each COBRA Continuation period for each option will be described in the notice sent to you.

Paying for COBRA Continuation Coverage

First Payment for COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment with the election form. You must, however, make your first payment no later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) If you miss this first payment date, you will lose all COBRA Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your payment.

Periodic Payments for COBRA Continuation Coverage

After your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent coverage period. Each monthly payment for COBRA Continuation Coverage is due on the dates stated in the COBRA election forms sent to you. If you make a monthly 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 is not legally obligated to send periodic notices of payments due for these coverage periods.

Grace Periods for Monthly Payments

Although monthly payments are due on the dates stated in the COBRA election forms, you will be given a grace period of 30 days after the first day of each coverage period to make each periodic payment. Your COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan retroactive to the date payment was due. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and either the amount paid will be deemed payment in full for that period or you will be asked to pay the shortfall. If the notice says the shortfall must be paid and you do not pay within 30 days after the date the notice is received, COBRA Continuation Coverage will end retroactive to the date the shortfall payment was due.

Duration of Coverage

COBRA Continuation Coverage for you and your Covered Dependents may continue:

- for 18 months when the Qualifying Event is the end of your employment or reduction in your hours of employment;

- 29 months when the Qualifying Event is your end of employment or reduction of your work hours and you or a Covered Dependent qualify for a disability extension (refer to "Disability" below) during the 18-month COBRA Continuation Coverage period;
- for your Covered Dependents for 36 months when the Qualifying Event is your divorce or legal separation, your death, your enrollment in Medicare (Part A or Part B) or a Child's loss of Eligible Dependent status; or
- for your Covered Dependents, when the Qualifying Event is your end of employment or reduction in your work hours, and you enrolled in Medicare fewer than 18 months before the Qualifying Event, for 36 months after the date you enrolled in Medicare. For example, if you enrolled in Medicare eight months before you terminated employment, Continuation Coverage for your Covered Dependents could last up to 36 months from the date you enrolled in Medicare, which is 28 months after the date of the Qualifying Event.

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

- any required premium payment is not paid in full on time; or
- after electing COBRA Continuation Coverage, a Qualified Beneficiary:
 - becomes covered under another employer's group health plan; or
 - becomes enrolled in Medicare benefits, under Part A or Part B, or both; or
- the Employer ceases to provide any group health plan for its employees.

COBRA Continuation Coverage also may be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Continuation Coverage, such as fraud. If your period of COBRA Continuation Coverage is terminated for any reason before the end of your maximum period, you will be notified of the termination and provided with an explanation of why it was terminated.

At the end of the 18-month or 36-month COBRA Continuation Coverage period, you must be allowed to enroll for individual conversion coverage, but only if this opportunity is provided under the specific Benefit Program for which you elected COBRA Continuation Coverage.

Extending Length of COBRA Continuation Coverage

There are two ways in which a COBRA Continuation Coverage period of less than 36 months may be extended: if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the COBRA Administrator in writing of a disability or second Qualifying Event in order to extend the period of COBRA Continuation Coverage. Your failure to provide notice of a disability or second Qualifying Event may affect the right to extend the period of COBRA Continuation Coverage.

Disability

If you or any Covered Dependent is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family

may be entitled to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. 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 18-month period of COBRA Continuation Coverage.

You or a Covered Dependent must notify the COBRA Administrator in writing on or before the 60th day after the latest of: (a) the date of the Social Security Administration's disability determination, (b) the date on which the employment-related Qualifying Event occurred, or (c) the date on which the Qualified Beneficiary lost Plan coverage but, in any event, before the end of the original 18-month COBRA Continuation Coverage period. This disability notice must include the name of the disabled person, the effective date of the Social Security Administration's disability determination, and any accompanying documentation.

Each Qualified Beneficiary who has elected COBRA Continuation Coverage on account of your employment-related Qualifying Event will be entitled to the 11-month disability extension as long as one of them qualifies for it. If the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact in writing on or before the 30th day following the Social Security Administration's determination. Coverage due to your initial employment-related Qualifying Event, or any subsequent Qualifying Event, may still be available if the maximum period for that COBRA Continuation Coverage has not expired as of the date a determination of "no longer disabled" is made.

Second Qualifying Event

If your Covered Dependents experience another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, your Covered Dependents can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the COBRA Administrator. This extension may be available to your Covered Dependents receiving COBRA Continuation Coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced or legally separated from your Spouse, or your dependent Child stops being eligible under the Plan as a dependent Child, but only if the event would have caused your Covered Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

You must notify the COBRA Administrator within 60 days after a second Qualifying Event occurs if you want to extend COBRA Continuation Coverage. Your notice must include: the name of the employee or former employee who is or was a Plan Participant; a description of the second Qualifying Event; and the names, addresses, and Social Security numbers of the Covered Dependents involved in the second Qualifying Event. Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.

Special Rule for Health Care FSA Program

The COBRA Continuation Coverage you may elect with respect to the Health Care FSA Program is different from the COBRA Continuation Coverage you may elect with respect to other COBRA-eligible Benefit Programs offered by the Employer.

First, COBRA Continuation Coverage for the Health Care FSA Program is only available until the end of the Plan Year in which the Qualifying Event occurs and may not be extended beyond that date.

Second, if you elect to receive COBRA Continuation Coverage under the Health Care FSA Program, you must pay the applicable premium, and the Employer is entitled to add a 2% administration charge. If you will not be receiving any compensation that can be reduced under the Health Care FSA Program, you will be paying 102% premium on an after-tax basis for only 100% coverage. Thus, even though COBRA Continuation Coverage is available, you must decide if it is a justifiable option for you based on its cost to you.

Third, the Plan does not have to offer you COBRA Continuation Coverage for the Health Care FSA Program if, at the time of the Qualifying Event, the contribution you must pay for this coverage exceeds the maximum coverage remaining available to you for the Plan Year under the Health Care FSA Program. For example, if you terminate employment in March after electing to contribute \$1,800 to the Health Care FSA Program and you have already submitted Claims totaling \$1,000, then your remaining coverage would be \$800, but your cost to keep this coverage would be \$1,377 ($\$1,800 \times 102\% = \$1,836/12 = \$153/\text{month} \times \text{the 9 months remaining in Plan Year}$). In this case, you would not be entitled to COBRA Continuation Coverage under the Health Care FSA Program.

Trade Preferences Extension Act of 2015

The Trade Preferences Extension Act of 2015 reinstated the Health Coverage Tax Credit for certain individuals who become eligible for Trade Adjustment Assistance ("**TAA**"). Eligible individuals can either take a tax credit or get advance payment of up to 72.5% of their premiums for qualified health insurance, including COBRA Continuation Coverage. If you are a TAA-eligible individual who did not initially elect COBRA Continuation Coverage, you have a second chance to make an election for COBRA Continuation Coverage during the 60-day period that begins on the first day of the month in which you become TAA-eligible if the election is made within six months after the date of the TAA-related loss of coverage. If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282 (TTD/TTY). More information about the Trade Act is also available at <http://www.doleta.gov/tradeact/>.

Questions About COBRA Continuation Coverage

If you have questions concerning the Plan or your COBRA Continuation Coverage rights, you should contact the COBRA Administrator. For more information about your rights under ERISA (including COBRA), HIPAA, 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Plan Informed of Any Changes of Address

In order to protect your family's rights to COBRA Continuation Coverage, you should keep the Plan Administrator and COBRA Administrator informed of any changes in the addresses of family members.

Military Leave Continuation Coverage

If you are called to active duty in the United States Armed Forces, the Coast Guard, the National Guard or the Public Health Service, you will be offered, under the Uniformed Services Employment and Reemployment Act of 1994, as amended ("**USERRA**"), up to 24 months of continuation coverage ("**USERRA Continuation Coverage**"). If your leave is less than 31 days, you will have to make the same contributions towards your coverage as do active employees, but you cannot be required to contribute more than that amount. If your leave is longer than 31 days, you may be charged 102% of the cost for the coverage, including both Employer contributions and Employee Contributions.

The maximum period for USERRA Continuation Coverage is the lesser of: (a) 24 months from the date your leave commences; or (b) the period from the date your leave begins to the day after you fail to return to employment within the time allowed following discharge. For leaves less than 31 days, one day is allowed; for leaves 31-180 days, 14 days is allowed; for leaves longer than 180 days, 90 days is allowed. USERRA Continuation Coverage is alternate coverage to that provided under COBRA, so the two coverage periods run concurrently, not consecutively. Eligibility for TRICARE (formerly CHAMPUS) or active duty military coverage will not terminate USERRA Continuation Coverage.

Except when compliance with COBRA procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances, the rules applicable to electing COBRA Continuation Coverage under the Plan (e.g., time periods for electing, effect of failure to make a timely election, etc.) apply to electing USERRA Continuation Coverage. To elect USERRA Continuation Coverage, or if you have questions about your rights under USERRA, contact Human Resources.

HIPAA Privacy Rule

The Health Insurance Portability and Accountability Act ("**HIPAA**") privacy regulations ("**Privacy Rules**") and security regulations ("**Security Rules**") apply to health information that the Plan Administrator handles in connection with the Medical/Rx, Dental, and Health Care FSA Programs. All definitions in the Privacy Rules and the Security Rules are incorporated by reference into the Plan. If a term is not defined in the Privacy Rules or Security Rules, the term will have its generally accepted meaning.

Hybrid Entity

To the extent the Plan provides any non-health benefits (e.g., dependent care, disability, life insurance), only the health care components of the Plan are subject to these provisions.

Protected Health Information

The Employer will have access to PHI only as permitted under this Plan or as otherwise required or permitted by the Privacy Rules. "**PHI**" means personal health information that is created or received by the Plan and relates to:

- Past, present, and future physical or mental health or condition of an individual;
- Provision of health care to an individual; or

- Past, present, or future payment for the provision of health care to an individual;

that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

Uses and Disclosures of PHI by Plan

The Plan may disclose PHI to the Employer only if the Privacy Rules specifically permit the use or disclosure, or if the individual authorizes the Plan to use or disclose PHI to the Employer.

Plan Administrative Functions

Once the Employer receives PHI from the Plan, it may use or disclose PHI only for Plan Administration Functions. “**Plan Administration Functions**” are administrative tasks performed by the Employer on behalf of the Plan and exclude employment-related functions and functions performed by the Employer in connection with any other benefit or benefit plan of the Employer. Plan Administration Functions include, but are not limited to:

- Enrollment and disenrollment activities;
- Verification of participation in the Plan;
- Obtaining premium contributions;
- Determining eligibility for benefits;
- Activities to coordinate benefits with other plans and coverages;
- Final adjudication of appeals of claim denials;
- Exercise of the Plan’s rights of reimbursement and subrogation;
- Assisting Participants in eligibility, benefit claims matters, inquiries, and appeals;
- Obtaining premium bids;
- Evaluation of health plan design;
- Activities relating to placement, renewal, or replacement of a contract of health insurance or health benefits (including stop-loss and excess loss insurance);
- Legal services and auditing functions (including fraud and abuse detection);
- Business planning, management and general administration;
- Making claims under stop-loss or excess loss insurance; and
- Activities in connection with the transfer, merger or consolidation of the Plan, including due diligence.

Privacy Obligations of Employer

With respect to PHI created by or received from the Plan, the Employer will:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual;
- report to the Plan any use or disclosure of PHI that is inconsistent with the Privacy Rules of which the Employer becomes aware;
- make PHI available to an individual in accordance with the access requirements of the Privacy Rules;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rules;
- make available the information required to provide an accounting of disclosures;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services Secretary for purposes of determining compliance with the Privacy Rules;
- if feasible, return or destroy all PHI received from the Plan and retain no copies of that PHI when no longer needed by the Employer for the purpose for which disclosure was made, (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible); and
- ensure that adequate separation between the Plan and the Employer is maintained as required by the Privacy Rules. For purposes of maintaining adequate separation between the Plan and the Employer, only the employees or classes of employees identified in the Employer's privacy policies and procedures ("**Authorized Employees**") will be given access to PHI. The section of the Employer's privacy policies and procedures that lists these employees is incorporated by reference into this Plan. The access to and use of PHI by Authorized Employees is restricted to the Plan Administration Functions that the Employer performs for the Plan. If an Authorized Employee uses or discloses PHI in ways other than those permitted by the Plan or the Privacy Rules, the Authorized Employee will be subject to the disciplinary procedures described in the Employer's employee handbook. The Employer may impose, at its discretion, reasonable sanctions as necessary to ensure that no further non-compliance with the Plan or the Privacy Rules occurs.

Electronic Data Security Obligations of Employer

To the extent the Employer maintains electronic PHI, the Employer will:

- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan as required by the HIPAA Security Rules;
- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that the required separation between the Plan and the Employer is supported by reasonable and appropriate security measures;
- ensure that any agents, including subcontractors, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and
- report to the Plan any security incident involving PHI of which it becomes aware.

Qualified Medical Child Support Orders

The Plan Administrator will honor an order that is a “qualified medical child support order” within the meaning of ERISA Section 609(a)(2)(A) (“**QMCSO**”). Provided it otherwise meets the requirements of a QMCSO as described below, an appropriately completed “national medical support notice” (“**NMSN**”) will be deemed a QMCSO. The Plan Administrator, or its delegate, has full discretionary authority within the meaning of the U.S. Supreme Court’s decision in Firestone Tire & Rubber v. Bruch (1989) to determine whether a medical child support order is “qualified” within the meaning of ERISA Section 609(a)(2)(A), and reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency.

To be a QMCSO, an order must clearly specify all of the following:

- Name of the plan required to provide coverage;
- Name and mailing address of the Participant;
- Name and mailing address of each Alternate Recipient;
- Reasonable description of the type of coverage to be provided; and
- When coverage will begin and end.

A QMCSO cannot require the Plan to provide any type or form of benefit or any benefit option that is not already offered, except as necessary to meet the requirements of a state medical support law enacted under the Social Security Act.

QMCSO Determination Procedures

Upon receipt of an order or NMSN requiring health plan coverage for the child of a Participant (“**Alternate Recipient**”), the Plan Administrator will notify the Participant and the Alternate Recipient in writing that the Plan has received the order and will provide a notice of these

procedures. Within a reasonable period of time after receipt of the order, the Plan Administrator will determine whether the order or NMSN is a QMCSO and notify the Participant and Alternate Recipient of its determination. If the order is an appropriately completed NMSN and it is deemed to be a QMCSO, the Plan Administrator will also, within 40 business days of receipt of the NMSN, notify the issuing court or agency and the custodial parent whether coverage is available to the child under the terms of the Plan and, if so, the steps to be taken to effectuate coverage.

If the Plan Administrator determines that an order or NMSN is not a QMCSO, the notice will include an explanation of the defective or missing provisions.

The Participant and each Alternate Recipient have the right to request in writing, within 30 days after being notified of the Plan Administrator's determination, that the Plan Administrator reconsider its determination of the order or NMSN. The Participant and each Alternate Recipient may present additional materials to the Plan Administrator for review. The Plan Administrator will provide sufficient information for the Participant and/or Alternate Recipient to understand available options and to assist in appropriately completing the order or NMSN. If the Plan Administrator requests additional information or material, you will be given a reasonable period of time to submit it. The Plan Administrator will provide notice of its final determination within a reasonable period of time after receipt of the requested information (typically within 30 days). If you fail to provide the requested information in a timely manner, the Plan Administrator will make its final determination based on the information it has, and will notify you within a reasonable period of time after the deadline for providing the missing information (typically within 30 days). If no request for reconsideration is filed within 30 days of the Plan Administrator's initial notice of determination, the determination will become final.

An Alternate Recipient may provide the Plan Administrator with a written designation for a representative to receive a copy of all notices required under these procedures.

Filing Civil Action

If you have exhausted the required appeal procedures described above and you are not satisfied with the determination, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the claim you file in court will be subject to dismissal. Any civil action must be filed within one year of the date on which you receive the final notice of determination.

Failure of Plan Administrator to Follow Procedures

If the Plan Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat the determination procedures as having been completed and immediately file a civil action in court.

Any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Medicaid Eligibility and Assignment of Rights

The Plan will not take into account that an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("**State Medicaid Plan**") either in enrolling that individual as a Participant

or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits in accordance with any assignment of rights made by or on behalf of that individual as required under a State Medicaid Plan pursuant to Section 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to the individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law that provides that the State has acquired the rights with respect to the individual to payment for those items and services under this Plan.

Maternity Benefits

Pursuant to federal law, the Plan, or any insurance issuer providing coverage for maternity benefits under the Plan, will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's treating physician, after consultation with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours, as the case may be). The Plan will not require a medical provider to obtain authorization from the Plan (or the insurance issuer) for prescribing a length of stay not in excess of the above periods. Nothing in this provision, however, requires that a woman covered under this Plan give birth in a hospital or stay in the hospital a fixed period of time following the birth of her Child.

Post-Mastectomy Benefits

To the extent the Plan (or any insurance issuer) provides benefits for mastectomies, it will also provide coverage for reconstructive surgery of either or both breasts following a mastectomy (including for the purpose of attaining a symmetrical appearance) and for the treatment of physical complications at all stages of the mastectomy and the recovery period, including lymphedemas.

Genetic Information Nondiscrimination Act

The Plan complies with the Genetic Information Nondiscrimination Act of 2008. Participants and Eligible Dependents are not required to undergo genetic testing, nor shall the Plan use genetic information related to any employee or family member to determine eligibility to participate in the plan or to determine any required Employee Contribution for any health benefit provided under the plan.

Mental Health Parity and Addiction Equity Act

The Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") to the extent MHPAEA is applicable to the Plan. Nothing in the Plan will be construed to require any Benefit Program to provide coverage for mental health and/or substance abuse disorder benefits. This section will not create any rights in excess of the minimum required by law.

Right to Choose Primary Care Provider

The Plan generally provides for the designation of a primary care provider. Participants have the right to designate any primary care provider who participates in the Plan's network and who is available to accept new patients. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator listed on Schedule A. For children, Participants may designate a pediatrician as the primary care

provider. A female Participant does not need prior authorization from the Plan or any other person (including a primary care provider) in order to obtain obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator listed on the Benefits Program Information Chart.

PLAN ADMINISTRATION

Plan Administrator

"**Plan Administrator**" means the Employer.

The Plan Administrator is the named fiduciary of the Plan and has sole responsibility for the administration of the Plan, including the responsibilities of administrator as defined by ERISA.

The Plan Administrator has full discretionary authority to: interpret the Plan; determine eligibility for and the amount of benefits; determine the status and rights of Participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms (including enrollment forms); exercise all of the power and authority contemplated by the Employee Retirement Income Security Act of 1974, as amended, ("**ERISA**") and the Internal Revenue Code of 1986, as amended (the "**Code**") with respect to the Plan; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the Plan. The discretionary authority of the Plan Administrator extends to its factual determinations, as well as its construction of Plan terms and its determination of benefit entitlements. The Plan Administrator has the necessary discretionary authority and control over the Plan to require deferential judicial review pursuant to the U.S. Supreme Court decision in Firestone Tire and Rubber Co. v. Bruch (1980).

The Plan may have other fiduciaries, advisors, and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. A person or persons to whom an allocation or delegation is made has the same amount of discretion as the Plan Administrator for matters covered by the allocation or delegation. The Claims Administrators are the fiduciaries with respect to Claims processing and benefit determinations. The insurer is the fiduciary for Claims processing for any Insured Benefit Program. Refer to Appendix B (Benefit Program Information Chart) for additional information relating to the Claims Administrators.

Each fiduciary is solely responsible for its own improper acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary.

Indemnification

The Employer will indemnify each employee to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act, except when it is judicially determined to be due to the gross negligence or willful misconduct of the employee. The Employer may choose, at its own expense, to purchase and keep in effect sufficient liability insurance to cover any claim, loss, damage, expense, or liability arising from any employee's action or failure to act.

Discretion

Wherever it is provided in the Plan that the Employer or Plan Administrator may perform or not perform any act, or permit or consent to any action, non-action, or procedure, or wherever they are given discretionary power or authority, they have exclusive discretion; provided, however, that they may not exercise their discretion so as to violate the Code or knowingly to discriminate either for or against any employee, Participant, or covered individual or any group of these persons.

OTHER IMPORTANT PROVISIONS**Plan Sponsor**

Hope College
100 East 8th Street, Suite 210
Holland, MI 49423
(616) 395-7811

Plan Sponsor Identification Number

38-1381271

Plan Administrator

The Employer

Agent for Service of Legal Process

Director of Human Resources
Hope College
100 East 8th Street, Suite 210
Holland, MI 49423
(616) 395-7811

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

Plan Name

Hope College Employee Benefit Plan

Plan Number

501

Plan Year

July 1 – June 30

Type of Plan

The Plan is a welfare benefit plan under ERISA. However, the following Benefit Programs are not subject to ERISA: Pre-Tax Payment, Dependent Care FSA, and HSA Contributions Programs.

The Plan also includes a cafeteria plan under Section 125 of the Code.

Funding

Except for amounts you pay to participate in each Benefit Program (including any required payments for COBRA or USERRA Continuation Coverage) ("**Employee Contributions**") and any copayments and deductibles and other out-of-pocket payments that are required, the Employer pays the cost of the Benefit Programs. You will be informed of the amount of any required Employee Contributions at the time of enrollment.

The benefits provided under the Plan will be paid, to the extent permitted by ERISA and the Code, from the general assets of the Employer and through insurance. Nothing in this Plan will be construed to require the Employer to maintain any fund for its own contributions or segregate any amount that it is obligated to contribute for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

Payment Obligations and Role of Claims Administrator

For those Benefit Programs that are Self-Insured, if you are covered by the Plan and either the Plan or the Employer does not ultimately pay the expenses that are eligible for payment under the Plan for any reason, you and your Covered Dependents may be liable for those expenses.

The Claims Administrators under the Self-Insured Benefit Programs merely process Claims and do not ensure that any of your medical expenses will be paid. Complete and proper Claims for benefits made by you will be promptly processed; but if there are delays in processing Claims, you will have no greater rights against the Claims Administrators than are otherwise afforded you by law.

Amendment or Termination of Plan

The Employer may amend, modify, or terminate the Plan at any time in any manner or with respect to any individual in its sole discretion. Any amendment may be made retroactively effective to the extent not prohibited by the Code or ERISA. If the Plan is terminated or partially terminated for any reason, the benefits to which you became entitled prior to the effective date for the Plan's termination will be covered. Termination of the Plan will not reduce or eliminate your right to receive your compensation earned before the date of termination.

The Employer may amend an Insured Benefit Program, including the benefits provided under the Benefit Program, by changing policies or insurance companies, or by agreeing with the insurance company to amend or modify the underlying policies or contracts that, with this document, constitute the Benefit Program.

Merger of Plan

This Plan may be merged or consolidated, or its assets and liabilities may be transferred, in whole or in part, to another plan (and trust qualified under Code Section 501(c)(9)) if: (i) each Participant's benefit under any merged or consolidated Benefit Program is equal to or greater than the benefit the Participant would have been entitled to receive if the Benefit Program had terminated immediately before the merger, consolidation, or transfer; and (ii) the Employer and any new or successor employer authorize the merger, consolidation, or transfer. No Plan assets shall revert to the Employer.

Nondiscrimination Rules

The Plan will operate in compliance with all applicable nondiscrimination requirements under the Code. If the Plan Administrator determines at any time that the Plan may not satisfy any applicable nondiscrimination rule, the Plan Administrator may take whatever action it deems appropriate to assure compliance with the rule. Any action will be taken uniformly with respect to similarly-situated Participants. The action may include, without limitation, the modification of your enrollment elections, and reduction of your elected benefits to the extent necessary to satisfy the nondiscrimination rule, with or without your consent. If your Plan benefits are affected, you will be notified of the action to be taken.

Compliance with Applicable Law

The Plan is intended to comply with all applicable law and will be considered amended to the extent necessary for compliance. The Plan is intended to provide benefits that are tax free to the extent allowed under the Code; however, neither the Plan, the Employer, the Plan Administrator, nor any Plan fiduciary represents or guarantees that this Plan, in fact, meets the requirements of any provision of the Code. Any other provision of this Plan notwithstanding, individuals who are not treated as employees under the Code for purposes of tax-free treatment of any contribution to any Benefit Program are not eligible to participate in the Pre-Tax Payment, Health Care FSA, Dependent Care FSA, or HSA Contributions Program.

The Plan cannot be operated so as to defer the receipt of compensation that you have earned in one Plan Year to the next. Under IRS rules, the following are not considered deferrals of compensation: (i) compensation reductions in the final month of a Plan Year that satisfy premium obligations for coverage in the first month of the immediately following Plan Year; (ii) reimbursement for advanced payments required for orthodontia procedures extending from one Plan Year to the next; (iii) payment or reimbursement for durable medical equipment with a useful life beyond a single Plan Year; and (iv) disability payments under a long-term disability policy.

If the Plan Administrator determines at any time that the Plan may not satisfy applicable law, the Plan Administrator may take whatever action it deems appropriate to assure compliance with the law. Any action will be taken uniformly with respect to similarly-situated Participants. The action may include, without limitation and without your consent, the modification of your enrollment elections and reduction of your elected benefits to the extent necessary to satisfy applicable law. If your Plan benefits are affected, you will be notified of the action to be taken.

Limitation of Rights

The Plan does not constitute a contract between you and the Employer. Nothing contained in the Plan gives you the right to be retained in the service of the Employer or to interfere with the

right of the Employer to discharge you at any time, with or without cause, regardless of the effect that the discharge will have upon you as a Participant in the Plan.

Overpayments

An "**Overpayment**" occurs if the Plan pays an amount not payable under the Plan, if the Plan pays an expense or benefit more than once, if an expense or benefit is paid by both the Plan and a third party, or if the Plan pays an expense or benefit based on fraud, misrepresentation, or failure to provide material information. An expense or benefit is considered paid if it is paid to you or to someone else (e.g., a health care provider) on your or your Covered Dependent's behalf.

If an Overpayment is made by the Plan, the Plan has the right to recover the Overpayment. If that Overpayment is made to a health care provider, the Plan may request a refund of the overpayment from either you or the provider. If the refund is not received from either you or the provider, the Overpayment will be deducted from future Plan benefits available to you or your Covered Dependents or from your wages, but the amounts withheld may not reduce your pay below the applicable state minimum wage law to the extent permitted by law.

Insurance Rebates

If the Employer or Plan receives an insurance rebate or other distribution from an insurance company, the portion of that rebate or distribution attributable to Participant contributions shall be utilized for any permissible plan purpose at the sole discretion of the Plan Administrator. Such purposes shall include, but not be limited to, the payment of future Participant premium payments, benefit enhancements, or any other use permitted by law.

Forfeitures

Failure to claim any amount or cash any check that becomes payable to you or is paid on your behalf under this Plan within two years after such amount first becomes payable, will result in such amount being forfeited. Such amounts shall cease to be a liability of the Plan, provided due and proper care has been exercised by the Plan Administrator in attempting to make such payment.

Entire Representation

This document and the Insurance Contracts and Booklets listed on the attached Appendix A (Plan Documents Chart) are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral).

Acceptance; Cooperation

If you accept benefits under this Plan, you are considered to have accepted its terms, and agree to perform any act and to execute any documents that may be necessary or desirable to carry out this Plan or any of its provisions.

Governing Law

The Plan is to be construed and enforced in accordance with the laws of the State of Michigan, to the extent not preempted by federal law.

Construction

Words used in the masculine apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural shall be read as the singular, and the singular as the plural.

Non-Assignability of Rights

No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest will be void. Direct payment of a benefit to a provider on your behalf shall not be considered an assignment of the benefit.

Errors

An error cannot give a benefit to you if you are not actually entitled to the benefit.

Severability

The enforceability of any provision of the Plan will not affect the enforceability of the remaining provisions of the Plan.

STATEMENT OF ERISA RIGHTS

Under the Medical/Rx, Dental, Vision, Health Care FSA, Life/AD&D Insurance, Long-Term Disability, and EAP Programs, ERISA entitles you to the following rights and protections:

Receive Information About Your Plan and Benefits

- Examine, without charge at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including Insurance Contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, if any, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Insurance Contracts, if any, copies of the latest annual report (Form 5500 Series), if any, and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your Spouse, or Covered Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Covered Dependents may have to pay for this coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the persons who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Plan Participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules described in "Filing and Processing Claims" beginning on page 29.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them in 30 days, you may file suit in a federal court. In that 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 that is denied, in whole or in part, you may file suit in a state or federal court, provided you first exhaust the claims and appeals procedures for the applicable Benefit Program as described under "Filing and Processing Claims" beginning on page 29.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court, provided you first exhaust the applicable claims and appeals procedures described in "Claims Based Solely on Eligibility to Participate in Plan or Benefit Program and Claims of ERISA or Code Violations" beginning on page 48.

In addition, if you disagree with the Plan's determination concerning a medical child support order or NMSN, you may file suit in federal court, provided you first request a reconsideration of the determination as described in "Qualified Medical Child Support Orders" beginning on page 64.

As described earlier in this document, if the Plan Administrator fails to follow the applicable claims and appeals procedures or ignores a medical child support order or NMSN, you may file suit in state or federal court even if you do not first exhaust the Plan's claims and appeals procedures.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator you should contact the nearest office of the EBSA, 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 EBSA.

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EXECUTION

IN WITNESS WHEREOF, Hope College has caused this amendment and restatement of the Plan to be executed by its duly authorized employee this 10th day of December, 2020.

HOPE COLLEGE

By:  _____

Its: Benefits Manager

APPENDIX A

PLAN DOCUMENTS CHART
Effective July 1, 2020

Benefit Program	Insurance Policy/Contract (if applicable)	Booklets
Medical/Rx	N/A	BCBS of Michigan Member Handbook for Orange Plan BCBS of Michigan Member Handbook for Blue Plan CVS Caremark and Prudent Rx booklets
Dental		BCBS of Michigan Dental Options Group Benefit Certificate Aflac Dental Certificate
Vision	EyeMed Policy No. VC-19	Certificate for EyeMed Policy No. VC-19
Long-Term Disability	Lincoln National Life Insurance Company Group Policy No. 000010189019	Certificate of Coverage for Lincoln National Life Insurance Company Group Policy No. 000010189019
Life/AD&D Insurance	Lincoln National Life Insurance Company Group Policy No. 000010189017	Certificate of Coverage for Lincoln National Life Insurance Company Group Policy No. 000010189017
Group Travel Accident	ACE American Insurance Company Policy #GLM N05660889	Certificate of Coverage - ACE American Insurance Company Policy #GLM N05660889
Employee Assistance Program (EAP)	N/A	Summary brochure
Pre-Tax Payment	N/A	N/A
Dependent Care FSA	N/A	N/A
Health Care FSA	N/A	N/A
Health Savings Account Contribution	N/A	N/A

APPENDIX B

BENEFIT PROGRAM INFORMATION CHART
Effective July 1, 2020

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Medical/Rx Program	Self-Funded	<p>Medical: Blue Cross Blue Shield of Michigan 86 Monroe Center, N.W. Grand Rapids, MI 49503 (888) 890-5712 www.bcbsm.com</p> <p>Prescription drug: CVS/Caremark (888) 321-4206 www.caremark.com</p> <p>For Paper Claims: P.O. Box 52136 Phoenix, AZ 85072</p> <p>For Mail Service Claims: P.O. Box 659541 San Antonio, TX 78265</p>
Dental Program	Insured	<p>Blue Cross Blue Shield of Michigan 600 E. Lafayette Blvd. Detroit, MI 48226-2998 (877) 671-2583 www.bcbsm.com</p>
Vision Program	Insured	<p>EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 (866) 939-3633 www.eyemedvisioncare.com</p>

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Long-Term Disability Program	Insured	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066 (800) 423-2765 www.lincolnfinancial.com
Life / AD&D Insurance Program	Insured	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066 (800) 423-2765 www.lincolnfinancial.com
Group Travel Accident	Insured	ACE American Insurance Company Chubb NA Accident & health P.O. Box 5124 Scranton, PA 18505-0556 (800) 366-0627 (inside the US) (302) 476-6794 (outside the US)
EAP	Self-Insured	Ulliance, Inc. 900 Tower Drive #600 Troy, MI 48098 (248) 680-4611
Pre-Tax Payment Program	N/A	Plan Administrator
Dependent Care FSA Program	N/A	PNC Benefit Plus P.O. Box 2865 Fargo, ND 58108 (844) 356-9993 www.participant.pncbenefitplus.com

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Health Care FSA Program	Self-Insured <u>Filing a Claim:</u>	PNC Benefit Plus P.O. Box 2865 Fargo, ND 58108 (844) 356-9993 www.participant.pncbenefitplus.com
HSA Contributions Program	N/A <u>Employer-designated HSA Custodian:</u>	PNC Benefit Plus P.O. Box 2865 Fargo, ND 58108 (844) 356-9993 www.participant.pncbenefitplus.com
COBRA Administrator	N/A	Plan Administrator