SUMMARY PLAN DESCRIPTION

for the

Ardent Health Services Welfare Benefit Plan*

2022

Important COVID-19-related extensions to certain deadlines affecting your benefits are continuing in effect as of January 1, 2022, and are described in the Summary of Material Modifications (SMM) attached to the back of this booklet.

These extensions will end when the Outbreak Period ends—refer to the attached SMM for details.

This document, together with the benefit booklets from the benefit vendors listed in the section entitled **Benefit Programs and Vendors for the benefit programs in which you are enrolled, constitutes your complete Summary Plan Description for the Ardent Health Services Welfare Benefit Plan.*

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Introduction

AHS Management Company, Inc. ("Ardent Health Services") maintains the Ardent Health Services Welfare Benefit Plan (the "Plan") for the exclusive benefit of eligible employees and their eligible family members (and other Plan beneficiaries). This Summary Plan Description ("SPD") describes the benefits available under the Plan.

The Plan provides various welfare and related benefits through the benefit programs listed in the **Benefit Programs and Vendors** section of this SPD. That section also includes a listing of the insurance companies and third party administrators (collectively referred to throughout this document as "benefit vendors") insuring and/or administering the various benefit programs under the Plan.

You may not be eligible to choose from all of the benefit programs in the Plan. Eligibility to participate in a particular benefit program may depend on certain things, such as your employment classification, work location, the average number of hours you are expected to work per week, etc. You will be provided with information about which benefit programs you may be eligible to participate in when you first become eligible and during each annual open enrollment period. You may also contact the Plan Administrator, whose contact information appears below in **Important Information about the Plan**.

The benefit programs are summarized in certificate or evidence of coverage booklets issued by insurance companies, or other documents prepared by the benefit vendors or Ardent Health Services. These are collectively referred to throughout this document as "benefit booklets." A copy of each such benefit booklet is provided to you when you enroll during your initial enrollment opportunity and/or during the annual open enrollment period. A copy is also currently available on Ardent Health Services' benefits intranet site at www.getardentbenefits.com. A paper copy is also available to participants at no charge upon request from the Plan Administrator, whose contact information appears below in **Important Information about the Plan**.

The benefit booklets contain important information about the benefit programs. However, they do not contain all of the information required by a federal law called the Employee Retirement Income Security Act of 1974, as amended ("ERISA") to appear in a summary plan description. Therefore, this SPD, together with the benefit booklets for the welfare benefits in which you are enrolled, as well as any summaries of material modifications ("SMMs") to these documents, constitute your complete summary plan description for the Plan, as required by ERISA. *These documents should be read together and kept together, and shared with your covered family members*.

The Plan includes welfare benefit programs that are subject to ERISA and programs that are not subject to ERISA. Descriptions of the program(s) that are not subject to ERISA may be included in this SPD for convenience, but their inclusion in this SPD is not intended to subject those programs to the requirements of ERISA.

Many of the capitalized terms appearing in this SPD have special meanings and are defined in the **Definitions** section later in this SPD.

Important Information about the Plan

Plan Name

This Plan is named the **Ardent Health Services Welfare Benefit Plan**.

Type of Plan

This Plan is an employee welfare benefit plan providing the various benefit programs listed in the section of this SPD entitled **Benefit Programs and Vendors**. This Plan also includes a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code ("Code"), called the "Flexible Benefits Plan." The Flexible Benefits Plan (including the Flexible Spending Account(s)) is described in the Flexible Benefits Plan section later in this SPD.

Plan Year

The Plan's records are kept on a calendar year (January 1 to December 31) basis. (Note, however, that one or more of the benefit program(s) may be administered on a different policy or benefit year.)

Plan Number

The ERISA plan number assigned to this Plan by the Plan Sponsor is **501**.

Effective Date

The effective date of this updated Summary Plan Description is January 1, 2022. The Plan was originally effective July 1, 1993, and has been amended (and restated) from time to time since that original effective date, most recently as of January 1, 2021.

Plan Sponsor

The name and address of the sponsor of the Plan ("Plan Sponsor") are:

AHS Management Company, Inc.
One Burton Hills Blvd, Suite 250
Nashville, TN 37215

Plan Sponsor's Employer Identification Number (EIN)

The employer identification number assigned by the Internal Revenue Service to the Plan Sponsor is **62-1743438**.

Insurance Companies, Third Party Administrators, and Other Benefit Vendors

The names of, and contact information for, the insurance companies, third party administrators, and other benefit vendors insuring and/or administering the benefit programs of the Plan are listed in the **Benefit Programs and Vendors** section of this SPD.

Plan Administrator

The name, business address, and business telephone number of the Plan Administrator are:

Ardent Health Services Benefits Committee
AHS Management Company, Inc.
One Burton Hills Blvd, Suite 250
Nashville, TN 37215

Telephone: (615) 296-3000

If you have any general questions about the Plan, you may contact Ardent Health Services at the above phone number, or in writing.

Funding Medium and Type of Plan Administration

Some of the benefit programs under the Plan are self-funded and some are fully-insured. Benefits under the self-funded benefit programs are paid in part by Eligible Employees' payroll deductions (as applicable) and in part by the Employer out of its general assets.

The fully-insured benefit programs under the Plan are insured under group contracts or policies entered into between Ardent Health Services and insurance companies. The insurance companies, not Ardent Health Services, are responsible for paying claims under these benefit programs. Insurance premiums for the fully-insured benefit programs are paid in part by Eligible Employees' payroll deductions (as applicable) and in part by the Employer out of its general assets.

Ardent Health Services provides a schedule of the applicable premium contributions during the initial enrollment and subsequent annual open enrollment periods, and at any time on request, for each of the benefit programs, as applicable. Ardent Health Services provides Eligible Employees the opportunity to pay for certain benefit programs on a pre-tax basis through the Flexible Benefits Plan. The benefit programs currently available for pre-tax premium payment under the Flexible Benefits Plan are listed in the **Benefit Programs and Vendors** section of this SPD (refer also to the **Flexible Benefits Plan** section of this SPD for information).

Ardent Health Services shares responsibility with the benefit vendors for administering the benefit programs, as described under **How the Plan is Administered** below. More information is also available in the benefit booklets.

Treatment of Insurance Distributions Received by Ardent Health Services as Policyholder

If Ardent Health Services, as the policyholder of any insurance policy under the Plan, receives a distribution from an insurer (for example, a dividend or a Medical Loss Ratio (MLR) rebate), the Plan Administrator will allocate the distribution in a manner consistent with the applicable fiduciary obligations under ERISA. For example, in its discretion, the Plan Administrator may (a) calculate the applicable portion, if any, of such rebate proceeds as is attributable to participant contributions and (b) determine in its discretion how to use that portion (if any) for the benefit of applicable participants, which may include applying the rebate toward future participant premiums or toward future benefit enhancements. Except as determined in (a) above, no other portion of any such rebate will be considered (or will be deemed to constitute) Plan assets.

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

AHS Management Company, Inc.
Attention: General Counsel
One Burton Hills Blvd, Suite 250
Nashville, TN 37215

Service of legal process may also be made on the Plan Administrator (contact information is provided above).

Conflicting Provisions

If the terms of this Summary Plan Description conflict with the terms of the Plan Document (including any insurance contract or policy), then the terms of the Plan Document, rather than this Summary Plan Description, will control, except as required by ERISA or other applicable law.

Except as otherwise specifically provided in the Plan Document or as required by law, any statement or representation, whether oral, written, electronic, or otherwise, made by the Plan Administrator, a benefit vendor (e.g., insurance company or third party administrator), or any other individual or entity that alters, modifies, amends, or is inconsistent with the written terms of the official Plan Document shall be invalid and unenforceable and may not be relied upon by any Employee, participant, beneficiary, benefit vendor, or other individual or entity.

Amendment and Termination

The Plan may be amended or terminated at any time, in the sole and unlimited discretion of Ardent Health Services as sponsor of the Plan, without advance notice to any person (except as required by law). The policies and contracts may also be amended or terminated at any time in accordance with their terms. No participant or beneficiary shall have any right to continuing benefits except to the extent required by law.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement for employment between you and any Employer.

Participating Employers

In addition to Ardent Health Services, other Employers may from time to time participate in the Plan. Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer is participating in the Plan.

Benefit Programs and Vendors

The following benefit programs and their benefit vendors are effective as of January 1, 2022:

BENEFIT VENDOR	BENEFIT PROGRAM/ COVERAGE TYPE	ELIGIBLE FOR PRE-TAX CONTRIBUTION VIA FLEXIBLE BENEFITS PLAN?	POLICY OR GROUP #	CONTACT INFORMATION
UMR	**Medical (including Prescription Drug)**	yes	76412605	UMR Telephone: (800) 675-1610 (or the number on the back of your ID card) Website: www.umr.com Prescription Drug – OptumRX Telephone: 844-783-1405 Website: www.optumrx.com
HealthFIRST	**Medical – offered in the UTHET market only**	yes	78-800197	HealthFIRST Telephone: (866) 220-0126 Website: www.hfbenefits.com Prescription Drug – OptumRX Telephone: 844-783-1405 Website: www.optumrx.com
ViaBenefits	**Health Savings Account (HSA)— available to participants in a High Deductible Health Plan offered under the Medical coverage above[1]**	yes		ViaBenefits Telephone: (800) 953-5395 Website: www.viabenefitsaccounts.com

[1] While HSA contributions are permitted through the Flexible Benefits Plan for Eligible Employees enrolled in an eligible medical plan under the Plan, the HSA is not a part of the Plan and is not subject to ERISA.

BENEFIT VENDOR	BENEFIT PROGRAM/ COVERAGE TYPE	ELIGIBLE FOR PRE-TAX CONTRIBUTION VIA FLEXIBLE BENEFITS PLAN?	POLICY OR GROUP #	CONTACT INFORMATION
Delta Dental of Tennessee	**Dental**	yes	4086	Delta Dental of Tennessee Telephone: (800) 223-3104 Website: www.deltadentaltn.com Email: information@deltadentaltn.com
VSP	**Vision**	yes		VSP Telephone: (800) 877-7195 Website: www.vsp.com
ViaBenefits	**Flexible Benefits Plan[2]—including the Flexible Spending Accounts[2]**	yes		ViaBenefits Telephone: (800) 953-5395 Website: www.viabenefitsaccounts.com
ComPsych	**Employee Assistance Program (EAP)**	n/a (employer-provided)		ComPsych Telephone: (833) 475-0997 Website: www.guidanceresources.com
New York Life	**Short-Term Disability (STD) Insurance**	no	VDT80179 SHD985379 VDT980206	NewYork Life Telephone: (888) 842-4462
New York Life	**Long-Term Disability (LTD) Insurance**	no	FLK980223 FLK980329	NewYork Life Telephone: (888) 842-4462
New York Life	**Life and Accidental Death and Dismemberment (AD&D) Insurance**	no	OK980420 OK980449	NewYork Life Telephone: (888) 842-4462
New York Life	**Business Travel Accident**	n/a (employer-provided)		Contact the Plan Administrator for information.
New York Life	**Critical Illness - Voluntary Benefit**	no	CI961234C01	NewYork Life Telephone: (888) 842-4462
MetLife	**Legal Plan – Voluntary Benefit**	no		MetLife Legal Plans Telephone: (800) 821-6400 Website: www.info.legalplans.com
ID Watchdog	**Identity Theft Protection – Voluntary Benefit**	no	4086	ID Watchdog Telephone: (866) 513-1518 Website: www.idwatchdog.com
Ardent Health Services	**Severance Plan**	n/a (employer-provided)		Contact the Plan Administrator for information.

[2] The Flexible Benefits Plan (other than the Health Care Flexible Spending Account offered thereunder) is not subject to ERISA.

Eligibility and Participation

Eligibility

Eligible Employees
An Eligible Employee under the Plan is an Employee who meets the general eligibility requirements of the Plan, summarized below and in the enrollment materials, and who also meets the eligibility requirements described in the benefit booklet for the particular benefit(s).

- To be eligible under the Plan, you must generally be classified by the Employer as an active Employee who meets the eligibility requirements described in the applicable Coverage Documents.

Eligible Dependents
An eligible dependent under the Plan is one who meets the general eligibility requirements of the Plan, summarized below and in the enrollment materials, and who also meets the eligibility requirements described in the benefit booklet for the particular benefit(s).

- Eligible child* – to be eligible under the Plan, the child must be your child ("child" includes your natural child, stepchild, legally adopted child or child placed with you for adoption, or child for whom you are a legal guardian; "child" also includes any child who is recognized as an alternate recipient in a Qualified Medical Child Support Order ("QMCSO")—refer to **Qualified Medical Child Support Orders** later in this SPD for more information) who has not yet attained age 26. Coverage may also be available under certain benefit program(s) beyond this maximum age for an unmarried disabled dependent child. Refer to the benefit booklet(s) for information.
- Eligible spouse* – to be eligible under the Plan, the spouse must be legally married to you (and must be considered your "spouse" for federal income tax purposes).
- Eligible domestic partner* – for your domestic partner to be eligible as your dependent under the Plan, you and your domestic partner must meet the following criteria:
  - Domestic partners are two adults of the same or opposite sex who are not married or related by blood, but who have lived together continuously for at least twelve (12) months and plan to do so indefinitely. In addition, domestic partners are jointly responsible for each other's basic living expenses during the domestic partnership, reside at the same primary address, and maintain no other domestic partner relationship or marriage.
  - The Employee and domestic partner must also meet, and each will be required to affirm in writing that they meet, all the requirements set forth in the Plan's *Affidavit of Domestic Partnership* form. Proof of financial interdependence will also be required at the time of initial enrollment, and it also may be required from time to time thereafter.
  - Please complete the *Affidavit of Domestic Partnership*, available from the Ardent Health Benefits Service Center (or via the web at www.getardentbenefits.com/enroll) and return the completed form in accordance with the form's instructions.

At initial enrollment, and at any time thereafter, the Employer and the Plan Administrator (or its delegate) reserve the right to request and require proof of dependent status as a condition of initial and/or continued enrollment in the Plan. Specifically, the Plan reserves the right to:

(a) Remove dependents from coverage if they are found to be ineligible during an audit or if they do not comply with audit requests for information and/or verification documents;

(b) Seek repayment of premiums and claims incurred for dependents who have been found, during an audit, to be ineligible or who are non-compliant with the audit; and/or

(c) Terminate the employment of an Employee in the case of benefit eligibility fraud.

The Plan, in its discretion, may or may not offer COBRA coverage to dependents who are found to be ineligible or non-compliant during the audit.

***IMPORTANT NOTE: No one may be double-covered under the Plan; for example, if both you and your spouse or domestic partner are Eligible Employees, only one of you may cover your eligible child(ren); and you and your spouse or domestic partner each may be covered either as an Employee or as a dependent, but not both. If both you and your child(ren) are Eligible Employees under the Plan, then your child(ren) may be covered either as an Employee or as a dependent, but not both.**

Participation

Certain benefit programs require that you make a timely election to enroll for coverage. Information about enrollment procedures is provided in the enrollment materials you receive when you first become eligible and during the annual open enrollment period. Information about when various benefit programs' coverage begins is described in the applicable benefit booklets and is summarized in the enrollment materials. Information about when various benefit programs end is also found in the applicable benefit booklets, and below, under **Termination of Participation**.

For any benefit program(s) requiring Evidence of Insurability ("EOI"), coverage (or any increase in coverage you have requested, as applicable) will not become effective unless and until underwriting approval has been confirmed by the applicable insurance company. Refer to the applicable benefit booklet(s) for details.

You must generally enroll for coverage under the benefit programs *by the date described in the enrollment materials*. If you fail to timely enroll, you may have to wait until the next annual open enrollment period to enroll. *Under certain circumstances, however, you and your dependents may be able to enroll in certain benefit programs without waiting for the next annual open enrollment period, as described in the applicable benefit booklet(s) and below:*

Life Events

HIPAA Special Enrollment Rights—Loss of Other Group Health Plan Coverage or Acquisition of a New Dependent

Under HIPAA, a special enrollment period for group health plan coverage may be available if you lose coverage under certain conditions or when you acquire a new dependent by marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your other dependents' other coverage). However, you must request enrollment and provide supporting documentation within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment and provide supporting documentation within **30 days** after the marriage, birth, adoption, or placement for adoption.

To request HIPAA special enrollment or obtain more information, contact the Plan Administrator (whose contact information appears under **Important Information about the Plan** above). You must make a timely enrollment request and provide supporting documentation by the applicable deadlines described above when requesting HIPAA special enrollment. If you timely request enrollment and provide supporting documentation, coverage will be effective for those enrolled as of the date of the event.

CHIPRA Special Enrollment Rights—Medicaid- or CHIP-Related Events

Under CHIPRA, a special enrollment period for group health plan coverage may be available if you or your dependent(s) lose coverage under a Medicaid plan under Title XIX of the Social Security Act ("Medicaid") or under a state Children's Health Insurance Program ("CHIP"), if that coverage is terminated due to loss of eligibility, or if you or your dependent(s) become eligible for financial assistance under Medicaid or CHIP with respect to coverage under this Plan. However, you must request enrollment and provide supporting documentation within **60 days** of the occurrence of either of these events.

To request CHIPRA special enrollment or obtain more information, contact the Plan Administrator (whose contact information appears above under **Important Information about the Plan**). You must make a timely enrollment request and provide supporting documentation by the deadline described above when requesting CHIPRA special enrollment. If you timely request enrollment and provide supporting documentation, coverage will be effective for those enrolled as of the date of the event.

Qualified Medical Child Support Orders

With respect to benefit programs that are group health plans, the Plan will also provide for enrollment and benefits as required by any "qualified medical child support order" (as defined in ERISA) or "QMCSO."

The Plan has in place procedures for determining whether an order (which may be in the form of either a medical child support order or a National Medical Support Notice ("NMSN")) qualifies as a QMCSO. Participants and beneficiaries can obtain a copy of the Plan's QMCSO procedures on request, without charge, from the Plan Administrator whose contact information appears under **Important Information about the Plan** above.

The Plan Administrator will determine if the order or NMSN properly meets the standards for a QMCSO, thus permitting coverage under the Plan. A properly completed NMSN will be treated as a QMCSO and will have the same force and effect.

Enrollment and benefits will be provided as soon as reasonably practicable after a determination is made by the Plan Administrator that the order or notice it receives is a QMCSO, and the applicable child(ren) shall become "alternate recipient(s)" of the applicable group health plan benefits under this Plan, generally subject to the same limitations, restrictions, provisions and procedures as any other dependent. As required by federal law, the Plan Administrator will permit an alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient.

Other Election Changes during the Year for Life Events

You may experience certain other life events during the Plan Year that will allow you to make certain corresponding Plan election changes during the year, provided you timely notify the Plan and provide supporting documentation, generally within **30 days** after the event. These are discussed in the **Flexible Benefits Plan** section of this SPD, in the enrollment materials, and in the applicable benefit booklet(s). To request midyear election changes, contact the Plan Administrator (whose contact information appears under **Important Information about the Plan** above).

You must make a timely enrollment request and provide supporting documentation when requesting midyear election changes. If you timely request enrollment and provide supporting documentation, coverage will be effective for those enrolled as of the date of the event.

Coverage during Certain Leaves of Absence

The Plan will provide benefit continuation rights as required during a period of qualifying leave under the FMLA and USERRA. Contact the Plan Administrator and/or refer to the benefit booklets and the Employer's applicable leave of absence policy(ies) for information.

Termination of Participation

Your participation (and the participant of your eligible family members) in the Plan will generally end on the date on which your eligibility or your employment with the Employer ends, unless the specific benefit program provides for coverage through the end of the month. Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours of service drop below the required hours threshold for the particular benefit, if you make a false representation or commit fraud with respect to the Plan (discussed immediately below), or for any other reason described in this SPD or the benefit booklet(s). Coverage will also end if the Plan is terminated. You should review the benefit booklet(s) for other termination events and additional information.

Termination of Coverage for False Representations or Fraud

If any individual makes a false representation to, or commits any fraud under or with respect to, the Plan, the Plan Administrator has the right to permanently terminate coverage for the individual and his or her dependents, to the extent permitted by law. This may include, for example, submitting falsified claims or covering an individual who is not eligible to participate in the Plan (e.g., adding a spouse before the date of marriage, continuing to cover a domestic partner after the dissolution of the relationship, or covering a child who does not meet the Plan's definition of an eligible dependent, etc.). To the extent permitted by law, the Plan Administrator may seek reimbursement for all claims or expenses paid by the Plan as a result of the false representation or fraud, and may reduce future benefits under the Plan as an offset for amounts that should be reimbursed, or pursue legal action against the individual.

With respect to medical coverage under the Plan, any termination of coverage under this provision will generally be effective on a prospective basis. However, in the case of fraud or an intentional misrepresentation of material fact, coverage may be terminated retroactively (generally called a "Rescission" of coverage), in which case the affected individual(s) will receive notice and will be provided the opportunity to appeal the Rescission, if required by law (refer to **Appendix A** of this SPD for information).

If you disagree with an eligibility determination made under the Plan, you have the right to request a review of that determination—refer to the **Eligibility Determinations under the Plan** section at the end of **Appendix A** of this SPD for details.

COBRA or Other Continuation Rights

You may be eligible for continuation coverage under COBRA and/or for conversion or similar policies under state law (if applicable) when your coverage under this Plan terminates. Information about continuation coverage under COBRA is contained in the **COBRA Continuation Coverage** section later in this SPD. *Important notice requirements you must follow in order to preserve your rights under COBRA are described in that section.* If you have questions about any conversion or similar rights you may have under state law, refer to the applicable benefit booklet(s) or contact the benefit vendor.

Health and Other Welfare Benefits under the Plan

The Plan provides you with a choice among the benefit programs listed in the **Benefit Programs and Vendors** section of this SPD for which you are eligible. A description of the benefits provided under each benefit program of the Plan is set forth in each program's benefit booklet.

The benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime benefit maximums, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, or limited coverage for new or existing prescription drugs, medical tests, medical devices or medical procedures. These and other limitations are set forth and are explained in the particular benefit booklet(s). Where a benefit program has a network of providers, a provider list will be furnished (a list of network

providers is available on each benefit vendor's website—website information is provided in the **Benefit Programs and Vendors** section of this SPD).

Special protections apply to medical coverage under the Plan—for example, you have special rights related to childbirth under the Newborns' and Mothers' Health Protection Act of 1996, and related to mastectomy under the Women's Health and Cancer Rights Act of 1998. For details, refer to the applicable medical benefit booklet or contact the benefit vendor for your medical coverage. You may also contact the Plan Administrator (whose contact information appears under **Important Information about the Plan** above) for more information.

Flexible Benefits Plan

Introduction to the Flexible Benefits Plan (a Benefit Program under the Plan)

As part of the Plan, we maintain the Flexible Benefits Plan, a "cafeteria plan" within the meaning of Section 125 of the Code, for Eligible Employees. Under this Flexible Benefits Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this section of the SPD.

The Flexible Benefits Plan is designed to provide you with a choice between cash compensation (i.e., your normal paycheck without elective salary redirections) and certain benefits, as described in this section (called "Benefit Options"). One of the most important features of the Flexible Benefits Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under the Flexible Benefits Plan, these same expenses will be paid for with a portion of your pay before federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this section of the SPD carefully so that you understand the provisions of the Flexible Benefits Plan, the benefits you will receive, how it operates, and your rights under federal law. This section of the SPD also describes the Flexible Spending Accounts (also called "FSAs") that are components of the Flexible Benefits Plan. Remember that this is only a summary of the key parts of the Flexible Benefits Plan and the FSAs, and a brief description of your rights as a participant. This section of the SPD is not a part of the official Plan Documents. If there is a conflict between the Plan Document and this section of the SPD, the Plan Documents will control.

Below, we have attempted to answer most of the questions you may have regarding your benefits in the Flexible Benefits Plan. If this SPD does not answer all of your questions, please contact the Plan Administrator (or other Plan representative), whose contact information is in the **Important Information about the Plan** section of this SPD, or the FSA administrator, ViaBenefits, whose contact information can be found in the **Benefit Programs and Vendors** Section above.

Who can participate in the Flexible Benefits Plan?

Eligible Employees who are participating in a Benefit Option as of January 1, 2022, are eligible to participate in the Flexible Benefits Plan immediately. Otherwise, if you are or become an Eligible Employee, you will be eligible to begin participating in the Flexible Benefits Plan once you have satisfied the conditions for coverage as described in the enrollment materials. Those Eligible Employees who actually participate in the Flexible Benefits Plan are called "Participants."

What must I do to enroll in the Flexible Benefits Plan?

To become a Participant in the Flexible Benefits Plan, you must complete an enrollment form (which may be electronic) during the applicable election period (described below) to participate. The enrollment form includes your personal choices for each of the Benefit Options that are being offered under the Flexible

Benefits Plan. Through that process, you will also authorize us to set some of your earnings aside in order to pay for all or a portion (as applicable) of the Benefit Options you have selected.

When is the election period for the Flexible Benefits Plan?

You will make your initial election on or before the date you first become eligible to participate in the Flexible Benefits Plan by completing an enrollment form, as described above. Then, for each following Plan Year, the election period will be established by the Plan Administrator and applied uniformly to all Participants (each, an "annual election period"). It will normally be a period of time prior to the beginning of each Plan Year. The Plan Administrator will inform you each year about the annual election period.

What happens if I fail to complete an enrollment form during an election period?

In general, you must make an affirmative election to participate in the Benefit Options for a Plan Year, or to opt out of participation in the Flexible Benefits Plan. If you fail to return a completed enrollment form during your initial election period, you will be deemed to have elected only the default Benefit Options (if any) under the Plan, and will be deemed to have agreed to a salary redirection equal to the share of your cost of such default Benefit Options.

If you fail to return a completed enrollment form during any subsequent annual election period, you will be deemed to have elected to participate in the Flexible Benefits Plan with the same election as you had in effect for the preceding Plan Year for which salary redirection under this Flexible Benefits Plan is available to pay premiums pre-tax; however, you will not be considered a Participant for purposes of any FSA or Health Savings Account contributions available under the Flexible Benefits Plan.

You may also enroll during the Plan Year if you previously elected not to participate and you experience an event described in the Section entitled "**May I change my elections during the Plan Year (Life Events)?**" that allows you to become a Participant during the Plan Year, by completing an enrollment form as described above.

When does my participation in the Flexible Benefits Plan end?

Once you become a Participant, you continue to participate in the Flexible Benefits Plan until the earliest of the date that (i) the Flexible Benefits Plan terminates; (ii) your benefit election for all Benefit Options is terminated; (iii) you elect, during an election period (described above), not to participate in this Flexible Benefits Plan and/or all of the Benefit Options under the Flexible Benefits Plan; (iv) you cease to be an Eligible Employee (for example, because you terminate employment), provided that you may have rights to benefits with respect to the medical Benefit Option coverage, Health Care FSA or Limited Purpose Health Care FSA as described in the section "**What happens under the Flexible Benefits Plan if I terminate employment?**" below; or (v) you fail to make the required contribution for all Benefit Options by the due date.

How much of my pay may my Employer redirect, and will my redirected pay be subject to taxes?

Each Plan Year, on your behalf, we will automatically redirect enough of your compensation to pay for the Benefit Options you have selected. These amounts will be deducted from your pay over the course of the Plan Year. If you elect to participate in an FSA, we will establish a nominal (i.e., recordkeeping-only) account to keep a record of the contributions allocated to the account and the reimbursements to which you are entitled during the Plan Year. No actual account will be established.

The portion of your pay that is paid to the Flexible Benefits Plan is not subject to federal income or Social Security taxes. In other words, this allows you to use tax free (or "pre-tax") dollars to pay for certain kinds of benefits and expenses that you normally pay for with out of pocket, taxable dollars. Note that if you receive a reimbursement for an expense under the Flexible Benefits Plan, you cannot claim a federal income tax credit or deduction for the same expense(s) on your return.

How much will my Employer contribute each Plan Year?

For any Eligible Employee enrolled in a high deductible health plan ("HDHP") option under the Plan, your Employer may contribute a discretionary amount to your Health Savings Account (which may be in the form of a matching contribution), if applicable, which we will determine prior to the beginning of each Plan Year, and describe in the enrollment materials for that Plan Year.

Your Employer will also make nonelective employer contributions to pay its share (if any) of the Benefit Options you elect. If you elect not to participate in any of the Benefit Options, your Employer will not contribute to the Flexible Benefits Plan on your behalf. Refer to the enrollment materials for details.

May I change my elections during the Plan Year (Life Events)?

You are required by federal law to make your elections before the Plan Year begins, during the election period (discussed above). Generally, you cannot change the elections you have made after the beginning of the Plan Year, including, for example, the amount that you elect to contribute to an FSA.

However, your election to participate in the Flexible Benefits Plan will automatically terminate in the event you cease to satisfy the applicable eligibility requirements. Otherwise, you may change your elections during the Plan Year only if one of the following situations applies, and only to the extent permitted under the applicable Benefit Option:

1. Change in Status. If one or more of the following "Changes in Status" occur, you may, within 30 days of such Change in Status, revoke your old election and make a new election, provided that both the revocation and new election are *on account of* and *correspond with* the Change in Status (as described below). Those occurrences that qualify as Changes in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under IRS regulations:

    a. Marriage, divorce, death of a spouse, legal separation or annulment;

    b. Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

    c. Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

    d. One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, or any similar circumstance; and

    e. A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

With the exception of an election change to a Benefit Option that is a group health plan resulting from the birth, placement for adoption, or adoption, all election changes under the Flexible Benefits Plan must be prospective. Further, the election change must be on account of and correspond with (i.e., be consistent with) the Change in Status event as determined by the Plan Administrator. As a general rule, a desired election change will be considered consistent with a Change in Status event if the event affects eligibility for coverage under the applicable Benefit Option. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Flexible Benefits Plan. In addition, there is a special rule for Changes in Status in which you, your spouse, or your dependent gain eligibility for coverage under another employer's plan as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status. In that case, your election to cease or decrease coverage for that individual under the Flexible Benefits Plan would correspond with

that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan. You may be required to provide proof that coverage will become effective.

If you do not make a change to your election (and provide supporting documentation) within 30 days of the event that makes the change necessary, you cannot make a coverage change before the next annual enrollment period unless you or your eligible family member has another qualifying change in status.

In addition, if you are participating in the Dependent Care FSA, then there is a Change in Status when there is a change in dependent care providers, a change in dependent care costs, or such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with IRS regulations (and other guidance).

2. Special Enrollment Rights (generally applies to coverage under the medical plans only). If you, your spouse and/or a dependent are entitled to any of the following special enrollment rights, you may change your election to correspond with the special enrollment right provided you notify the Plan (and provide supporting documentation) within 30 days, or 60 days in the case of a Medicaid- or CHIP-related special enrollment event, of the event as described below and in the enrollment materials (and in the **Life Events** section of this SPD, above).

    a. Other Coverage. If you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect coverage for yourself and your eligible dependents who lost such coverage, provided that you request enrollment within the 30-day election change period.

    b. New Dependent. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within the 30-day election change period.

    c. Medicaid- and CHIP-Related Events. If you (or your dependent) are eligible for but not enrolled in medical coverage, you may be eligible to elect coverage for yourself and/or your dependent if (i) your (or your dependent's) coverage under a Medicaid plan or state children's health insurance program (commonly referred to as a "CHIP" plan) is terminated as a result of the loss of eligibility for such coverage or (ii) you (or your dependent) become eligible for a premium assistance subsidy from a Medicaid or CHIP plan with respect to medical coverage under the Plan. You must request enrollment within 60 days of the occurrence of either of these Medicaid- or CHIP-related events.

3. Certain Judgments, Decrees and Orders. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your child to be covered under a health care plan, you may change your election to provide the applicable coverage for the child identified in the order. If the order requires that another individual (such as your former spouse) cover the child, and such coverage is actually provided, you may change your election to revoke coverage for the child. A written copy of the judgment, decree or order may be requested by the Plan Administrator as verification of any such election change described in this section.

4. Entitlement to (or Loss of Eligibility for) Medicare or Medicaid. If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may revoke or change a benefit election with respect to such person under the health care plans or the Health Care FSA or Limited Purpose Health Care FSA (as applicable) for the balance of a period of coverage if the revocation is on account of and corresponds with you, your spouse, or your dependent becoming entitled to Medicare or Medicaid. Similarly, if you, your spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may, subject to the terms of the

underlying plan, elect to begin or increase that person's coverage under the health care plans and/or the Health Care FSA or Limited Purpose Health Care FSA (as applicable), as applicable.

5. Cost Changes (does not apply to Health Care FSA or Limited Purpose Health Care FSA elections). If the cost of a Benefit Option under the Plan increases or decreases by an insignificant amount during a Plan Year, the Employer will automatically increase or decrease, as the case may be, your salary redirection for that Benefit Option. If the cost significantly increases, you may choose to make an increase in your contributions, revoke your election and choose other coverage, or drop coverage. If the cost significantly decreases, you may revoke your election and make a new election to correspond with the decrease in cost. The Plan Administrator will have final authority to determine whether a cost change is significant.

6. Coverage Changes (does not apply to Health Care FSA or Limited Purpose Health Care FSA elections). If the coverage under a Benefit Option is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive (on a prospective basis) coverage under another Benefit Option with similar coverage, or you may drop coverage if no similar coverage is available. In addition, if the Employer adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant when such a coverage change is made, you may elect to join the Plan. Also, you may make an election change on account of and corresponding with a change under another employer plan (including a plan of the Employer's or another employer), so long as: (i) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (ii) the Plan Year for this Flexible Benefits Plan is different from the plan year of the other employer plan.

7. Approved Leave of Absence. If you take an approved leave of absence, your elections are subject to the following terms, depending, in part, on the type of leave you take, and the Employer's applicable leave policies:

    a. If you go on a qualifying paid leave under the Family and Medical Leave Act of 1993 ("FMLA"), to the extent required by the FMLA, the Employer will continue to maintain your coverage under the group health care plans (e.g., medical, dental, vision, and/or the Health Care or Limited Purpose Health Care FSAs (as applicable)) on the same terms and conditions as though you were still an active employee.

    b. To the extent the Company requires that your group health plan coverage be continued while on a paid FMLA leave, you will pay your share of the contributions on the same basis as existed prior to your leave: that is, with pre-tax contributions withheld from pay received while on leave.

    c. If you go on a qualifying unpaid leave under FMLA (or paid leave where coverage is not required to be continued), you may revoke coverage under any of the health care plans and/or the Health Care or Limited Purpose Health Care FSA (as applicable) while on FMLA leave and discontinue payment of the required premiums or pre-tax contributions during the period of unpaid FMLA leave and the Employer may recover your share of the unpaid premiums when you return to work.

    d. If you continue your coverage under the health care plans and/or the Health Care or Limited Purpose Health Care FSA (as applicable) during your unpaid leave, you may pre-pay for the coverage, pay for your coverage during your leave or you and the Employer may arrange a schedule for you to "catch up" your payments when you return. The payment options provided by the Employer will be established in accordance with Section 125 of

the Code, FMLA, and the Employer's policies and procedures regarding leaves of absences.

e. If your coverage under the health care plans and/or the Health Care or Limited Purpose Health Care FSA (as applicable) terminates while you are on FMLA leave due to your revocation of the benefit while on leave or due to your non-payment of required contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return, on the same basis as you were participating in such coverage prior to the leave, or as otherwise required by the FMLA. Your coverage under the health care plans and/or the Health Care or Limited Purpose Health Care FSA (as applicable) may be automatically reinstated provided that coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

f. The Employer may, on a uniform and consistent basis, continue your coverage under the health care plans and/or the Health Care or Limited Purpose Health Care FSA (as applicable) for the duration of the leave following your failure to pay the required contribution. In that case, upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.

g. The expenses you incur during the time you revoke your coverage under the Plan are not reimbursable.

h. The above provisions do not apply to the Dependent Care FSA. Your entitlement to continue coverage under the Dependent Care FSA during a period of FMLA leave will be determined by the Employer's established policy for providing such benefits when an employee is on other forms of leave (paid or unpaid, as appropriate).

8. Reduction in Hours of Service or Enrollment in a Qualified Health Plan (generally only applicable to medical Benefit Options under the Plan). If either of the following apply to you, you may request to revoke coverage in your medical Benefit Option, if you make the request within 30 days of the event:

   a. Reduction in Hours of Service. If you have been in an employment status with the Employer under which you were reasonably expected to average at least 30 hours of services per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result you ceasing to be eligible under the medical Benefit Option, you may revoke your medical election under the Flexible Benefits Plan on a prospective basis, if that election corresponds to your intended enrollment in another plan that provides minimum essential coverage, and the new coverage is effective no later than the first day of the second month following the month that includes the date your medical coverage under the Plan is revoked.

   b. Enrollment in a Qualified Health Plan. If you are eligible for a special enrollment period to enroll, or you seek to enroll during annual open enrollment, in a qualified health plan through an exchange (i.e., the Health Insurance Marketplace) under the Affordable Care Act (www.HealthCare.gov), you may revoke your medical election under the Flexible Benefits Plan on a prospective basis, if that election corresponds to your intended enrollment in a qualified health plan through an exchange, and the new coverage is effective no later than the day immediately following the last day of your medical coverage under the Plan.

The mid-year election change rules described above do not apply to Health Savings Account contributions under this Flexible Benefits Plan. Instead, you may make a prospective change to your Health Savings

Account contribution election at any time during the Plan Year (subject to the Code contribution limits applicable to the Plan Year).

May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Flexible Benefits Plan for the upcoming Plan Year.

Except as otherwise specifically provided in the enrollment materials for the new Plan Year, if you do not make new elections during the election period before a new Plan Year begins, we will assume that you want your elections for the Benefit Options in which you are enrolled to remain the same, but you will not be considered a Participant for the FSA(s) and Health Savings Account contribution options, as applicable, under the Flexible Benefits Plan for the upcoming Plan Year. That is, you must make an affirmative election each annual election period with respect to the FSA(s) and/or Health Savings Account Benefit Option contribution(s) in order to continue to participate in those Benefit Options under the Flexible Benefits Plan for the upcoming Plan Year.

What are the Benefit Options offered under the Flexible Benefits Plan?

Under the Flexible Benefits Plan, you can choose to receive your entire compensation or use a portion to pay for the following Benefit Options during the year (each is discussed in more detail below):

- Health Care Flexible Spending Account
- Limited Purpose Health Care Flexible Spending Account (for anyone enrolled in a medical option that is a high deductible health plan ("HDHP"))
- Dependent Care Flexible Spending Account
- Health Care Savings Account (for anyone enrolled in an HDHP)
- Pre-tax premium redirections for medical (including prescription drug) coverage, dental coverage, and vision coverage

What is the Health Care Flexible Spending Account ("Health Care FSA")?

The Health Care FSA is not available to you if you are enrolled in a medical plan option under the Plan that is an HDHP. This is because participation in the Health Care FSA will disqualify you from being able to contribute to a Health Savings Account.

The Health Care FSA enables you to pay for expenses for "medical care" allowed under Sections 105 and 213(d) of the Code, incurred by you and your dependents, that are not covered by our (or another) group health plan and save taxes at the same time. This includes "over the counter" drugs or medicine and menstrual care products. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long term care expenses. A list of covered expenses is available from the FSA claims administrator (at www.viabenefitsaccounts.com) or the Plan Administrator.

The most that you can contribute to the Health Care FSA each Plan Year is limited by federal law, and will be communicated to you in the enrollment materials for the Plan Year. The limit for the 2022 Plan Year is **$2,850** (any future adjustments to this maximum will be communicated in the enrollment materials). The minimum amount that you may contribute to the Health Care FSA each Plan Year, if any, will be communicated to you in the enrollment materials for that Plan Year. In order to be reimbursed for a medical care expense, you must submit to the Plan Administrator (or its designee) an itemized bill from the service provider.

We may also provide you with a debit card to use to pay for medical expenses. The Plan Administrator or claims administrator for the Health Care FSA will provide you with details. Amounts reimbursed from the Flexible Benefits Plan may not be claimed as a deduction on your personal income tax return.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is your natural child, stepchild, adopted child, or a child placed with you for adoption.

The full annual amount of reimbursement you have elected under the Health Care FSA for the Plan Year (reduced by prior reimbursements made during the Plan Year) will be available for reimbursement of eligible medical care expenses at any time during the Plan Year and any applicable grace period, without regard to how much you have contributed to the Health Care FSA at that time, so long as you continue to make the contributions.

What impact might the Health Care FSA and its grace period have on other benefits?

If you participate in the Health Care FSA, you (and your spouse, as applicable) will be ineligible to contribute to a health savings account ("HSA") during the same months—this is because the IRS will not permit an individual to contribute to an HSA during any months in which the individual also participates in other, disqualifying coverage, such as this general purpose Health Care FSA (as required under Section 223 of the Code).

Also, if you have any balance (determined on a cash basis) remaining in your Health Care FSA on December 31 of the current Plan Year, the availability of the grace period (from January 1 through March 15 of the Plan Year immediately following) will impact your eligibility to contribute to an HSA during the months from January through March. Therefore, if you wish to enroll in an HDHP and/or you or your spouse (as applicable) are otherwise eligible to and wish to contribute to an HSA during the next January through March, you should be sure to completely exhaust your Health Care FSA balance by December 31 (such that your account balance on that date, determined on a cash basis, is $0).

What is the Limited Purpose Health Care Flexible Spending Account ("Limited Purpose Health Care FSA")?

The Limited Purpose Health Care FSA is available to you if you are enrolled in a medical plan option under the Plan that is an HDHP—participating in the Limited Purpose Health Care FSA will not disqualify you from contributing to an HSA.

The Limited Purpose Health Care FSA enables you to pay for expenses for "medical care" allowed under Sections 105 and 213(d) of the Code, incurred by you and your dependents *for dental or vision care only*, that are not covered by our (or another) group health plan and save taxes at the same time. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Plan Administrator.

The most that you can contribute to the Limited Purpose Health Care FSA each Plan Year is limited by federal law and will be communicated to you in the enrollment materials for the Plan Year. The limit for the 2022 Plan Year is **$2,850** (any future adjustments to this maximum will be communicated in the enrollment materials). The minimum amount that you may contribute to the Limited Purpose Health Care FSA each Plan Year, if any, will be communicated to you in the enrollment materials for that Plan Year. In order to be reimbursed for a dental or vision care expense, you must submit to the Plan Administrator an itemized bill from the service provider. We may also provide you with a debit card to use to pay for medical expenses. The Plan Administrator or claims administrator for the Limited Purpose Health Care FSA will provide you with details. Amounts reimbursed from the Flexible Benefits Plan may not be claimed as a deduction on your personal income tax return.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is your natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

The full annual amount of reimbursement you have elected under the Limited Purpose Health Care FSA for the Plan Year (reduced by prior reimbursements made during the Plan Year) will be available for reimbursement of eligible dental and/or vision expenses at any time during the Plan Year or any applicable grace period, without regard to how much you have contributed to the Limited Purpose Health Care FSA at that time, so long as you continue to make the contributions.

When must I incur and submit eligible expenses for reimbursement under the Health Care or Limited Purpose Health Care FSA?

In order to be eligible for reimbursement under the Health Care or Limited Purpose Health Care FSA, as applicable, you must incur the eligible medical, dental, and/or vision expense during the Plan Year and while you are a Participant in the Flexible Benefits Plan. If you are participating on December 31 of the Plan Year, you also have a grace period following the end of the Plan Year—from January 1 through March 15 of the following Plan Year—in which to incur the expense. Expenses under the Health Care and Limited Purpose Health Care FSA, as applicable, are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical, dental or vision care.

You may not be reimbursed for any expenses incurred before your Health Care or Limited Purpose Health Care FSA election, as applicable, becomes effective, or after your separation from service during the Plan Year (except for expenses incurred during an applicable COBRA continuation period).

In addition, you must submit all claims for eligible medical, dental, and/or vision expenses incurred during the Plan Year and any grace period no later than the March 31st immediately following the end of the Plan Year. If your election under the Health Care or Limited Purpose Health Care FSA is terminated during the Plan Year for any reason, you will have until the 90th day immediately following the date on which your election terminates to submit your claim(s) for qualifying medical, dental and/or vision expenses (as applicable) incurred by you *on or before the last day of the month* in which the termination of such election occurs, but you will not be able to obtain reimbursement for such expenses incurred or submitted thereafter, unless you timely elect COBRA continuation coverage, if available.

What is the Dependent Care Flexible Spending Account ("Dependent Care FSA")?

The Dependent Care FSA enables you to pay for out of pocket, work-related dependent day care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work (or if your spouse is actively looking for work) or, in some situations, if your spouse goes to school full time. Single Eligible Employees can also use the account.

An eligible dependent for the purpose of this account is generally someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent care arrangements that qualify include:

(a) A dependent (day) care center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An educational institution for preschool children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside your home. The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under Flexible Benefits Plan. We may also provide you with a debit card to use to pay for dependent care expenses. The

Plan Administrator or claims administrator for the Dependent Care FSA will provide you with further details.

The minimum amount that you may contribute to the Dependent Care FSA each Plan Year, if any, will be communicated in the enrollment materials for that Plan Year. The law places limits on the maximum amount of money that can be paid to you in a calendar year from your Dependent Care FSA. Generally, your reimbursements may not exceed the lesser of: (a) **$5,000** (if you are married filing a joint return or you are head of a household) or **$2,500** (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

You will only be reimbursed from the Dependent Care FSA to the extent there are sufficient funds in the FSA to cover your request.

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a participant in this Flexible Benefits Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care FSA under the Flexible Benefits Plan. You should work with your tax adviser to determine which is better for you.

When must I incur and submit eligible expenses for reimbursement under the Dependent Care FSA?

In order to be eligible for reimbursement under the Dependent Care FSA, you must incur the expense during the Plan Year and while you are participating in the Flexible Benefits Plan. If you are participating on December 31 of the Plan Year, and are employed by the Employer on that date, you also have a grace period following the end of the Plan Year—from January 1 through March 15 of the following Plan Year—in which to incur the expense. Expenses under the Dependent Care FSA are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or when you pay for the expense(s). You may not be reimbursed for any expenses incurred before your Dependent Care FSA election becomes effective

In addition, you must submit all claims for reimbursement of eligible dependent care expenses incurred during the Plan Year and any grace period no later than the March 31st immediately following the close of the Plan Year. However, if your election under the Dependent Care FSA is terminated during the Plan Year for any reason, you will have until the 90th day immediately following the date on which your election terminates to submit your claim(s) for eligible dependent care expenses incurred by you *on or before the last day of the month* in which the termination of such election occurs, up to the amounts credited to your account (less any reimbursements previously made) as of the last day such election was in effect, but you will not be eligible for any applicable grace period.

What is the claims process under the Flexible Benefits Plan?

During the course of the Plan Year and through March 31 immediately following the end of the Plan Year, you may submit requests for the reimbursement of expenses you have incurred during the Plan Year and any applicable grace period. The Plan Administrator (or the claims administrator) will provide you with acceptable forms for submitting these requests for reimbursement. Claims for reimbursement of eligible expenses under the FSAs should be submitted online at www.viabenefitsaccounts.com. A step-by-step summary of submitting claims online is available at www.getardentbenefits.com/flexible-spending-accounts.

You should submit all reimbursement claims incurred during the Plan Year and any applicable grace period by the deadlines described in the sections above entitled "**When must I incur and submit eligible expenses for reimbursement under the Health Care or Limited Purpose Health Care FSA?**" and/or "**When must I incur and submit eligible expenses for reimbursement under the Dependent Care FSA?**" as applicable. Any claims submitted after the applicable deadline described in those sections will not be considered.

If the request qualifies as a benefit or expense that the applicable FSA under the Flexible Benefits Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements that are made from the Flexible Benefits Plan are generally not subject to federal income tax or withholding, nor are they subject to Social Security taxes.

Claims under the medical, dental, and/or vision Benefit Options will be handled in accordance with the procedures under those programs (see **Appendix A** to this SPD for information).

Claims for reimbursement of eligible expenses under the Health Care FSA or Limited Purpose Health Care FSA will use the claims procedures described for post-service group health coverage in **Appendix A** to this SPD (the Health Care and Limited Purpose Health Care FSAs provide for one level of appeal). All other general requests should be directed to the Plan Administrator.

If a dependent care claim under the Dependent Care FSA is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reason(s) for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim, including an explanation of why such information is necessary, and an explanation of the claims review procedure, including the deadline for submitting a written request for reconsideration of the denial to the Plan Administrator.

What happens if I don't spend all FSA contributions during the Plan Year or its grace period?

You will forfeit any amounts you have allocated to the Health Care, Limited Purpose Health Care and/or Dependent Care FSA(s) if they have not been applied to reimburse your eligible medical, dental, vision and/or dependent care expenses incurred during the Plan Year or any applicable grace period by timely submitted claims. Amounts forfeited as described in this section will be used to offset administrative expenses and future costs and/or applied in a manner consistent with the Flexible Benefits Plan and applicable IRS regulations.

Because it is possible that you might forfeit some or all of the amounts in your FSA(s) if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

What happens if I receive erroneous or excess reimbursements from the FSAs?

If, as of the end of any Plan Year, it is determined that you have received payments under the FSAs that exceed the amount of eligible expenses that have been properly substantiated during the Plan Year as set forth in this Section of the SPD, or reimbursements have been made in error (e.g., reimbursements were made for expenses for the care of an individual who was not a qualifying individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways: (i) the Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of such notification (or, within sixty (60) days of receipt of such notice for reimbursements under the Dependent Care FSA); (ii) the Plan Administrator may offset the excess reimbursement against any other eligible expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) the Plan Administrator may withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (i) – (iii) above, the Plan Administrator will notify the Employer

that the funds could not be recouped and the Employer will treat the excess reimbursement to you as it would any other bad business debt. This could result in adverse income tax consequences to you.

May I direct Flexible Benefits Plan contributions to my Health Savings Account?

Yes. If you enroll in a high deductible health plan (HDHP) available under the Plan, you may elect to contribute to your Health Savings Account through the Flexible Benefits Plan. The Health Savings Account is an account established and maintained outside the Flexible Benefits Plan. Please see the enrollment materials or contact the Plan Administrator for details.

Your contributions to your Health Savings Account, combined with any contributions made by the Employer on your behalf (refer to the enrollment materials for details), are subject to legal limits, depending on your tier of HDHP coverage (i.e., single or family coverage). *The limits applicable to the current Plan Year are described in the enrollment materials for that Plan Year.* For 2022, the annual Health Savings Account contribution limits for self-only HDHP coverage is **$3,650**, and the limit for family HDHP coverage is **$7,300**. These amounts may be reduced if you are married and your spouse also contributes to a Health Savings Account. If you reach age 55 by the end of the current Plan Year, an additional $1,000 "catch-up" contribution is also permitted. Consult with your tax advisor about how these limitations apply to you.

Amounts contributed to your Health Savings Account but not fully spent during the Plan Year will not be forfeited. Please see enrollment materials for more information.

What happens under the Flexible Benefits Plan if I terminate employment?

If you terminate employment (or otherwise lose eligibility under the Flexible Benefits Plan) during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by the applicable Benefit Option(s), but only for the period for which premiums have been paid prior to your termination of employment.

(b) No further salary redirection or Employer contributions will be made on your behalf after you terminate.

(c) You may be reimbursed only for Health Care FSA or Limited Purpose Health Care FSA claims incurred through the last day of the month in which your employment terminated that are submitted within 90 days of your termination, and only up to amounts credited in your FSA (reduced by any reimbursements previously made) as of the last day you were employed by the Employer (unless you are eligible for and you timely elect COBRA for the Health Care or Limited Purpose Health Care FSA, as described in (e) below).

(d) You may be reimbursed only for Dependent Care FSA claims incurred through the last day of the month in which your employment terminated, up to the amounts credited to your Dependent Care FSA (reduced by any reimbursements previously made) as of the last day you were employed by the Employer, provided that such claims are submitted within 90 days of your termination.

(e) For group health plan Benefit Option coverage, Health Care FSA and/or Limited Purpose Health Care FSA coverage on termination of employment, refer to the **COBRA Continuation Coverage** section of this SPD. Your further participation will be governed by the COBRA rights you may have (if any), as described in that section.

(f) Your Health Savings Account will remain yours event after your termination of employment.

Will my Social Security benefits be affected if I participate in the Flexible Benefits Plan?

Your Social Security benefits may be slightly reduced because when you receive tax free benefits under the Flexible Benefits Plan, it reduces the amount of contributions that you make to the federal Social Security system as well as our contribution to Social Security on your behalf.

Do limitations apply to highly compensated employees?

Under the Code, highly compensated employees and key employees generally are participants who are officers, shareholders or highly paid. If you are within these categories, the amount of contributions and benefits for you may be limited so that the Flexible Benefits Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. For example, federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under the Flexible Benefits Plan.

Flexible Benefits Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

Will periodic FSA statements be provided?

The claims administrator will provide you with a statement of your FSA(s) periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year. The amount of dependent care assistance you receive under the Dependent Care FSA will also be reported on your W-2 for the year (in Box 10).

How the Plan is Administered

Plan Administration

The Plan Administrator (named in the **Important Information about the Plan** section above) is a named fiduciary within the meaning of ERISA and has the sole and unlimited discretionary authority to administer and control the Plan in accordance with its terms, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan.

The principal duty of the Plan Administrator is to see that the Plan is carried out in accordance with its terms and for the exclusive benefit of participants and beneficiaries. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities—*whenever the term "Plan Administrator" is used in this SPD, it means the Plan Administrator or its delegate*.

The insurance companies and other benefit vendors listed in the **Benefit Programs and Vendors** section of this SPD may be responsible for any or all of the following: (1) determining eligibility for benefits under their respective benefit programs; (2) determining the amount of any benefits payable under their respective benefit programs; and (3) prescribing claims procedures to be followed and the claim forms to be used by participants or beneficiaries under benefit programs they insure and/or administer. Refer to the applicable benefit booklet for specific information.

Effect of Determinations under the Plan

Any determination by the Plan Administrator (or its delegate) is final and conclusive, unless arbitrary or capricious. As a condition of coverage under the Plan, you agree that whenever the Plan Administrator (or its delegate) makes a reasonable determination in the administration of the Plan, such determination shall be final and conclusive.

Claims for Benefits

To claim benefits under the Plan, you (or your authorized representative, or a beneficiary) must use the Plan's claims procedures, which are generally described in **Appendix A** to this SPD, and more specifically described in the applicable benefit booklet(s). Your claims for benefits will be decided in accordance with reasonable claims procedures, as required by ERISA and the Affordable Care Act (as applicable) and other applicable law.

You must fully follow and exhaust the Plan's claims procedures before you can file a lawsuit in state or federal court. Except as otherwise provided in the applicable benefit booklet(s), a suit for benefits under the Plan must be brought within one year following (i) the date on which the claim arose (e.g., the date on which the expense(s) for which benefits are claimed were incurred) or, if later, (ii) the date on which the Plan's internal claims procedures with respect to that claim were exhausted.

Circumstances That May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See **Termination of Participation** in the **Eligibility and Participation** section above. Your benefits will also cease on termination of the Plan.

Other circumstances can result in disqualification or ineligibility, or the termination, reduction or denial of benefits. You should review the applicable benefit booklet(s) for information.

Subrogation, Reimbursement, and Other Important Rights of the Plan

The Plan has certain important rights with regard to the benefits it provides. If a benefit program's booklet(s) contain subrogation/third-party reimbursement provisions, such provisions shall apply with respect to such benefit program. You should carefully review the applicable benefit booklet(s) for details. In all other cases, the following provisions apply to each benefit program that provides health care or disability benefits:

(a) When an Eligible Employee, Dependent or beneficiary or the estate thereof (a "covered person") receives or is entitled to receive any benefits under the Plan for which such covered person has, may have, or asserts any claim, demand, action or right to recovery against any entity (including but not limited to third parties or insurance companies), then any payments under this Plan are made on the condition that the Plan shall have the right to be subrogated, in first priority, to such claim, demand, action or right. The amount of such subrogation will equal the total amount paid under the Plan related to such claim, demand, action or right that is or may be asserted.

(b) If a covered person receives benefits under the Plan for expenses or amounts which are (or may be characterized as) paid by another person or business entity (including an insurance company), by way of judgment, settlement, or otherwise, such individual agrees to reimburse the Plan in full, in first priority, for any benefits paid by it, and the Plan shall be considered to have an equitable lien against such monies and shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by such individual. Pending reimbursement, such covered person (or such individual's representative who receives any such recovery) shall be deemed to hold such amounts in constructive trust for the benefit of the Plan. The obligation to reimburse the Plan in full, in first priority, exists regardless of whether the settlement or judgment specifically designates the recovery, or a portion thereof, as including medical or disability expenses. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full.

(c) The Plan will not pay or reduce its equitable lien for the individual's attorney's fees and costs incurred while enforcing its subrogation or reimbursement rights under this section, unless approved by the Plan Administrator in writing. The Plan specifically disavows any "make whole" doctrine, common fund doctrine, or similar provision with respect to its subrogation and reimbursement rights.

(d) If a repayment agreement is required to be signed, this section shall remain in effect, regardless of whether such agreement is actually signed.

(e) The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering such third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault, or school insurance coverages (including but not limited to auto, homeowners or otherwise) which are paid or payable, or any settlement fund. The Plan shall be considered to have an equitable lien with respect to the amount of such funds to the extent of the Plan's reimbursement and subrogation rights and such covered person (or such individual's representative who receives any such recovery) shall be deemed to hold such amounts in constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full. A covered person shall repay the Plan immediately upon recovery. If a covered person receives a recovery and does not immediately provide the Plan with the full amount allowed under this section, the Plan will have the right to withhold or reduce future benefits on the claims submitted by the covered person or the eligible dependents associated with the covered person, regardless of whether the future claims received by the Plan are related to the claim giving rise to the recovery, until the Plan has recovered the full amount allowed under this section. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverages to which the covered person may be entitled.

(f) The Plan Administrator or claims administrator may contact a third party regarding any or all subrogation matters affecting the Plan, and may delegate to such third party the power to act on the Plan Administrator's or claims administrator's behalf concerning third party liability or subrogation.

(g) All amounts referenced in this section are recoverable by the Plan, regardless of whether such amounts have been dissipated or commingled with other assets. The Plan has no obligation to trace or identify the amounts owed to the Plan under this section.

(h) The claimant agrees that acceptance of the Plan's payment of benefits for any claim for which the Plan's rights under this section are triggered shall constitute notice of all provisions of this section.

Forfeiture Due to Inability to Locate (or Contact) Payee

If the Plan Administrator (or its delegate) is unable to make a payment to you or any other person to whom a payment is due under the Plan because it cannot ascertain your or such other person's identity or whereabouts (or has been unable to contact you or such other person) after reasonable efforts have been made to identify, locate, or contact you or such other person, then such payment and any and all subsequent payments otherwise due to you or such other person shall be forfeited following a reasonable time, as determined in the Plan Administrator's sole discretion, after the date such payment(s) first become payable, except as otherwise provided in the benefit booklet or required by law. Refer to the benefit booklet(s) for additional information.

Non-Assignability of Benefits and Other Rights and Obligations

Except as expressly provided in the Plan, the benefits under this Plan:

- Are not in any way subject to your debts or other obligations or the debts or other obligations of any person covered under this Plan;
- May not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered; and
- Shall not be subject to being taken by your creditors or the creditors of any person covered under this Plan by any process whatsoever.

Any attempt to cause the benefits under this Plan to be so subjected will not be recognized, except to the extent required by law (e.g., as required by the tax withholding provisions of applicable law).

Similarly, except as expressly provided in the Plan (including, with respect to a particular benefit, in the applicable benefit booklet or other coverage document), any other rights and/or obligations under the Plan to or with respect to you or any person covered under this Plan may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered, and any attempt to cause such right or obligation to be so subjected will not be recognized except to the extent required by law (e.g., by the designation of any authorized representative pursuant to the Plan's claims procedures, described in **Appendix A** to this SPD).

Tax Considerations under the Plan

The Employer makes no commitment or guarantee that any amounts paid to you or for your benefit under the Plan will be excludable from your gross income for federal, state, and/or local income tax purposes, or that any other tax treatment will apply or be available to you.

You are responsible for determining whether each payment or benefit under the Plan is excludable from your gross income for federal, state, and/or local income tax purposes, and to notify the Plan Administrator if you have any reason to believe that such payment is not so excludable.

Statement of ERISA Rights

This Statement of ERISA Rights is required by federal law and regulation. This Statement of ERISA Rights does not apply to the Flexible Benefits Plan, other than to the Health Care and Limited Purpose Health Care FSAs offered under the Flexible Benefits Plan.

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants in the Plan shall be entitled to:

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents have to pay for such coverage. Review the **COBRA Continuation Coverage** section of this SPD 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 people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day (adjusted for inflation) 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 or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator, whose contact information appears in the section of this SPD entitled **Important Information about the Plan**. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA Continuation and Marketplace Coverage

It is important that you follow the notification procedures described under **Your Notice Obligations** below. Failure to follow these notification procedures will result in the loss of your rights under COBRA.

This section explains your rights and responsibilities under COBRA. You and your dependents should read this material carefully and keep it with your records. COBRA is a federal law that requires most

group health plans to give participants and their eligible family members the opportunity to continue their health care coverage at their own expense for a period of time when there is a "qualifying event" that results in a loss of coverage under an employer's plan.

Special Rule Applicable to the Health Care and Limited Purpose Health Care FSAs—Limited COBRA Coverage Available: You may only continue to participate in the Health Care or Limited Purpose Health Care FSA, as applicable, under COBRA for the remainder of the current Plan Year and any applicable grace period, and only if you elected to contribute more money for the Plan Year than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the applicable Health Care or Limited Purpose Health Care FSA under COBRA. If you elect to continue (and you timely pay for) Health Care or Limited Purpose Health Care FSA coverage, as applicable, then you would be able to continue to receive your reimbursements for eligible expenses for the remainder of the Plan Year and any applicable grace period up to the full amount of your election ($500, in the example). However, you must continue to pay for the coverage (and an additional 2% administration fee) on an after tax basis.

For additional information about your rights and responsibilities under the Plan and under federal law, you should contact the Plan Administrator, whose contact information appears in the **Important Information about the Plan** section of this SPD. You may also contact the COBRA administrator whose contact information is provided later in this section and in the COBRA notice(s) you receive.

COBRA Qualifying Events

COBRA continuation coverage is a continuation of coverage under the group health plan when such coverage would otherwise end because 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." Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such COBRA continuation coverage.

If you are an ***Eligible Employee*** participating in the Plan, you will become a "qualified beneficiary" if you lose your coverage under the group health plan because of one of the following "qualifying events":

- Your employment with your Employer ends for any reason other than your gross misconduct; or
- Your hours of employment are reduced.

If you are on an approved leave of absence subject to the FMLA, only the failure to return to work at the end of the approved leave constitutes a "qualifying event." If you are on an approved military leave of absence under USERRA for less than 31 days and you fail to return to work at the end of the leave, your "qualifying event" occurs on the first day after you fail to return to work at the end of your leave. There may be additional circumstances where you will experience a reduction in hours of employment, but will not lose your coverage under the group health plan until a later date, as permitted under the group health plan and the Employer's leave policies. In these circumstances, you will become a "qualified beneficiary" and will be offered COBRA continuation coverage once group health plan coverage is actually lost.

If you are the ***spouse*** or ***dependent child*** of an Eligible Employee participating in the Plan, you will become a "qualified beneficiary" if you lose your coverage under the group health plan because of any of the following "qualifying events":

- The death of the Eligible Employee;
- The Eligible Employee's employment with his or her Employer ends for any reason other than his or her gross misconduct;
- The Eligible Employee's hours of employment are reduced;

- The Eligible Employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The Eligible Employee and his or her spouse divorce or legally separate; or
- In the case of a ***dependent child***, the child ceases to be a "dependent child" under the terms of the Plan.

A *spouse* and/or *dependent children* who do not have dependent health care coverage under the Plan on the day before a qualifying event are not qualified beneficiaries and are therefore not generally eligible for COBRA continuation coverage. However, a child born to, adopted by, or placed for adoption with an Eligible Employee during a period of COBRA continuation coverage is a qualified beneficiary. The covered Employee or family member must notify the Plan within 30 days of the birth, adoption, or placement for adoption to enroll the child for COBRA continuation coverage. Additionally, a child of the covered Employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Plan Administrator during the covered Employee's period of employment with the Employer is entitled to the same rights under COBRA as a dependent child of the covered Employee. Finally, if a spouse loses coverage in anticipation of divorce, the spouse may be a qualified beneficiary upon actual divorce despite having been removed from coverage prior to the qualifying event.

Special Rules Regarding Domestic Partners: Please note that domestic partners are not considered "qualified beneficiaries" under COBRA, and therefore do not have independent rights to elect COBRA continuation coverage under federal law.

Maximum COBRA Continuation Coverage Period for Each Qualifying Event

For any qualified beneficiary, the COBRA continuation coverage period is up to 18 months if the qualifying event is an Eligible Employee's termination of employment or reduction in hours. For a spouse or dependent child, the COBRA continuation coverage period is up to 36 months for any qualifying event other than an Eligible Employee's termination of employment or reduction in hours. These coverage periods may be extended or shortened under the following circumstances:

> **If an Eligible Employee or covered dependent is disabled** at the time of the qualifying event or within the first 60 days of COBRA continuation coverage, an 18 month COBRA continuation coverage period may be extended for all qualified beneficiaries for up to an additional 11 months (**29 months in total** from the date of the termination of employment or reduction in hours). Pursuant to Title II or Title XVI of the Social Security Act, the Social Security Administration ("SSA") will determine whether the disability exists and when it began. The Eligible Employee or eligible dependent must give the Plan notice and a copy of the SSA determination within 60 days after the latest of: (i) the date the qualified beneficiary is notified of the disability determination by the SSA, (ii) the date of the qualifying event, or (iii) the date coverage is lost due to the qualifying event; and within the initial 18 months of COBRA continuation coverage to be eligible for this disability extension.
>
> **If a dependent covered under COBRA as a qualified beneficiary experiences a second qualifying event** (for example, the Eligible Employee dies, gets divorced or legally separated, or the dependent child stops being eligible under the Plan as a dependent child) within the 18-month or 29-month coverage period, as applicable, the maximum coverage period may be extended to up to a total of **36 months**. An event is a "second qualifying event" only if the event would have caused the dependent to lose coverage under the Plan had the first qualifying event not occurred. An Eligible Employee or eligible dependent must provide notice to the Plan of the second qualifying event within 60 days of the event. *A termination of employment that follows a reduction in hours that was a qualifying event is never a second qualifying event resulting in an extension of the maximum coverage period.*

If the Eligible Employee is entitled to Medicare prior to a termination of employment or reduction in hours that is a qualifying event, the Eligible Employee's spouse and dependent children may extend coverage for up to 36 months from the date of Medicare entitlement. To be eligible for this extension, the qualified beneficiary must provide notice to the Plan of Medicare entitlement and must provide a copy of his or her Medicare card.

Your Notice Obligations

In order to protect your COBRA rights, you or a dependent must inform the Plan in the following situations:

- **Disability of a Qualified Beneficiary**. To extend the COBRA continuation coverage period to 29 months because of a qualified beneficiary's disability, you or a dependent must be or become disabled within the first 60 days after the COBRA qualifying event, and you must notify the COBRA administrator **before the end of the first 18 months of COBRA continuation coverage and within 60 days after the latest of: (i) the date the qualified beneficiary is notified of the disability determination by the SSA, (ii) the date of the qualifying event, or (iii) the date coverage is lost due to the qualifying event**. A copy of the SSA disability determination must be enclosed with your notification to the COBRA administrator.
- **Qualifying Events and Second Qualifying Events**. You or a dependent must inform the Plan Administrator or the COBRA administrator about a divorce, legal separation, entitlement to Medicare, a child's loss of dependent status under the Plan, or a former Eligible Employee's death. If one of these events happens *as a first qualifying event*, you must provide notice to the Plan Administrator (instructions are provided in the box below) **within 60 days of the event**. Notice of a *second qualifying event* must be received by the COBRA administrator within **60 days of the event *and* before the end of the initial 18 month COBRA continuation coverage period**.
- **COBRA Terminating Events**. You or a dependent must inform the COBRA administrator **within 30 days** about entitlement to Medicare (Part A and/or Part B) or enrollment in another group health plan if that event would terminate COBRA continuation coverage rights. You must also notify the COBRA administrator **within 30 days after the SSA's final determination that you are, or your dependent is, no longer disabled**. If you fail to provide this notice, the Plan is entitled to reimbursement for expenses paid during periods where you were not entitled to coverage and may impose a lien or reduce future benefit payments to offset for these amounts.

When Your Notice is Required: Your notice must be in writing and timely submitted to the Plan Administrator (whose contact information appears in the section of the SPD entitled **Important Information about the Plan**) in the event of a first qualifying event; or to the COBRA administrator (contact information appears later in this section) for all other events.

Your notice must include the name, address, and telephone number of the individual(s) experiencing the event, the name and Social Security Number (SSN) of the Eligible Employee, the group health plan coverage(s) impacted, the date of the qualifying event, and the type of qualifying event. If applicable, a copy of the Social Security determination, Medicare card, divorce decree, or other documentation must be included with your notice, and other documentation may be required by the Plan Administrator (or its delegate) and/or COBRA administrator.

Also, you must immediately inform the Plan and the COBRA administrator when you or any of your family members have a change of address so that notices can be sent to the correct address. Failure to provide a current address could cause you to lose your COBRA rights. See **Keep Your Plan Informed of Address Changes**, below.

COBRA Election Rights

When the Plan is timely notified that a qualifying event has occurred, the Plan Administrator (or the COBRA administrator, as applicable) will in turn notify qualified beneficiaries of their right to elect COBRA continuation coverage. Covered Employees may elect coverage on behalf of their spouses, and parents may elect coverage on behalf of their children. Each qualified beneficiary has an independent right to make his or her own election, and that right is not dependent on other family members' elections. Thus, if the Eligible Employee does not elect COBRA continuation coverage, his or her eligible family members who are qualified beneficiaries may still elect (and pay for) COBRA continuation coverage.

You and/or your eligible family members may elect COBRA continuation coverage by filing a COBRA election form with the Plan within 60 days of the later of (1) the date coverage is lost under the Plan because of the qualifying event, or (2) the date you and/or your dependents are notified of the right to elect continuation coverage under COBRA. Election forms will be provided to you and also may be obtained by contacting the COBRA administrator (whose contact information appears below) or the Plan Administrator (whose contact information appears under **Important Information about the Plan**). Election forms should be timely submitted to the COBRA administrator at the address on the COBRA election form. If a qualified beneficiary does not elect COBRA continuation coverage within this election period, then all rights to continue coverage under COBRA will be lost.

Your coverage will be retroactively reinstated to the date that your Plan coverage ended once your election and first COBRA premium payment are received. If a health provider calls for verification of eligibility or benefits during the election period or during a period when you have not made payment by the due date, but you are in your payment grace period (described below), the health provider will be told that you do not have coverage, but that coverage will be retroactively reinstated if a proper COBRA election and payment is made.

You May Have Other Coverage Options Besides COBRA. Note that, instead of COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov. You can also learn more about Medicare at https://www.medicare.gov/medicare-and-you.

Premium Payment Requirements

You will not have to show that you are insurable to elect COBRA. Your cost for COBRA continuation coverage is based upon the current premiums (this includes both the Eligible Employee's contribution and the Employer's contribution) for similarly situated active Eligible Employees with similar coverage under the Plan. The cost of COBRA continuation coverage may be 102% of the premium. The cost may be 150% of the premium during months 19 through 29 for a disabled qualified beneficiary and his or her family members whose COBRA is extended due to disability.

The first COBRA payment must be made not later than 45 days after the date COBRA is timely elected (this is the date the COBRA election form is postmarked, if mailed). If the first payment is not timely made in full, all COBRA rights will be lost. The amount of the first payment is equal to the amount owed for COBRA continuation coverage starting on the day COBRA continuation coverage commences through the month preceding the month in which you make the actual payment. This may be as little as one (1) month or over three (3) months of COBRA continuation coverage, depending on when you elect COBRA and when you make the first payment. Although you are encouraged to call the COBRA administrator if you are unclear about the amount due, you are responsible for making sure that the amount of your first payment is correct.

After you make the first payment, COBRA payments are due on the first day of the month for that month of coverage and are considered late if they are not received within 30 days after the due date. COBRA continuation coverage will be provided for each month as long as payment for that month is made prior to the end of the 30-day grace period for that payment. If any of your COBRA payments are not made prior to the end of the grace period, COBRA continuation coverage will be terminated back to the last day for which the Plan received a full premium payment, and you will lose all of your COBRA continuation coverage rights.

Failure to pay the premium within 45 days of initially electing COBRA continuation coverage, or within 30 days after the due date for subsequent months of coverage, will result in the loss of your COBRA continuation coverage and any rights you may have under COBRA.

Your first payment and all subsequent monthly payments for COBRA continuation coverage should be sent to the COBRA administrator at the address provided in the COBRA election notice.

End of COBRA Continuation Coverage

COBRA continuation coverage ends when your 18-, 29- or 36-month COBRA continuation coverage period ends, but it may end earlier upon the occurrence of any of the following events:

- Your failure to make a timely payment for COBRA continuation coverage;
- After your COBRA election, your becoming covered under another group health plan that has no preexisting condition exclusions or limitations that apply to you after electing COBRA continuation coverage (note that there are limitations on medical plans imposing preexisting condition exclusions, and such exclusions became prohibited for certain plans beginning in 2014 under the Affordable Care Act). If the other plan has applicable exclusions or limitations, your COBRA continuation coverage will terminate when the exclusion or limitation no longer applies;
- After your COBRA election, your becoming entitled to Medicare (Part A and/or Part B) coverage after electing COBRA continuation coverage (this applies only to the person who became entitled to Medicare, not his or her family members);
- If you become entitled to an 11-month extension of coverage period due to the disability of a qualified beneficiary, and a final determination is then made by the SSA that the qualified beneficiary is no longer disabled;
- Any event that would terminate coverage of a participant in the Plan who is not on COBRA (e.g., fraud); or
- The Plan's termination.

Annual Open Enrollment Period

Qualified beneficiaries are offered the same rights (for example, to change coverage or add/delete eligible dependents) as similarly situated active Eligible Employees during the Plan's annual open enrollment period. Although a part of the family unit, dependents added during the annual open enrollment period may not be considered qualified beneficiaries under COBRA and will generally not have the same rights as the qualified beneficiaries in the family.

Consider COBRA Continuation Coverage Carefully

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 coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of your COBRA continuation

coverage period if you get COBRA continuation coverage for the maximum time available to you. Refer also to the **You May Have Other Coverage Options Besides COBRA** section above.

Trade Adjustment Assistance/Health Coverage Tax Credit

The Trade Act of 2002 created a tax credit (the Health Coverage Tax Credit or "HCTC") for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). The HCTC expired on January 1, 2014, but was retroactively reinstated and modified by the Trade Adjustment Assistance Reauthorization Act of 2015 for coverage periods through 2019, and was also extended through 2020, and then again through 2021. Under these most recent tax provisions, eligible individuals could either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including COBRA continuation coverage. For more information, visit www.doleta.gov/tradeact/ or www.irs.gov/HCTC.

For More Information

If you have any questions concerning the information in this section, your rights to COBRA continuation coverage, or if you need another copy of the COBRA notice or the SPD for the Plan, you should contact the Plan Administrator (whose contact information appears in the **Important Information about the Plan** section of this SPD) or the COBRA administrator.

The COBRA administrator's contact information is:

BenefitConnect | COBRA
DEPT: COBRA
P.O. Box 981915
El Paso, TX 79998
1-877-29-COBRA (1-877-292-6272) (858-314-5108 International Only)
Website: https://cobra.ehr.com

For more information about your rights under ERISA, including COBRA, the Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa, or call their toll-free number at (888) 444-3272. For information about other health insurance options available through a Health Insurance Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator and the COBRA administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator and/or the COBRA administrator.

HIPAA Privacy and Security

The Plan is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and complies with all applicable requirements related to the privacy and security of your health information (called protected health information). These rules only apply to the health care components of the Plan (e.g., the medical, dental, Health Care FSA, and Limited Purpose Health Care FSA coverages). HIPAA also gives you some individual rights as a participant in the Plan.

A HIPAA Notice of Privacy Practices is available on the benefit pages of the Company's intranet site, www.getardentbenefits.com. If you need a paper copy, contact the Plan Administrator. This is an important document that explains what types of health information the Plan receives and how it is used.

Generally, the Plan will use the information only to assure that claims are paid correctly and as necessary for Plan administration. If the Plan needs to use your health information for a purpose other than treatment, payment, or health care operations, it will request your written authorization in advance, except as otherwise required or permitted by law. Please refer to the Notice of Privacy Practices for details.

Definitions

Many of the capitalized words used in this SPD have special meanings, and may be defined in the text of the SPD and/or the Plan Document. However, for your convenience, some of the capitalized terms used in this SPD are defined below:

Affordable Care Act

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and as subsequently amended, and the applicable regulations and other guidance issued from time to time thereunder.

Ardent Health Services

"Ardent Health Services" means AHS Management Company, Inc., or any successor thereto that elects to continue the Plan.

Benefit Option

"Benefit Option" means the options Eligible Employees participating in the Flexible Benefits Plan may elect to receive in lieu of cash compensation. Currently, the Benefit Options are:

- Payment of the Participant's share of the premium for medical (including prescription drug), dental, and vision coverage under the Plan for the Participant and his/her eligible dependent(s) (as permitted by the Code;
- Reimbursement of eligible medical care expenses incurred by the Participant and his/her eligible dependents (as permitted by the Code) under the Health Care Flexible Spending Account;
- Reimbursement of eligible dental and vision care expenses incurred by the Participant and his/her eligible dependents (as permitted by the Code) under the Limited Purpose Health Care Flexible Spending Account, for Eligible Employees enrolled in an applicable HDHP medical plan option under the Plan;
- Reimbursement of work-related dependent care expenses incurred by the Participant under the Dependent Care Flexible Spending Account; and
- Contributions to the Health Savings Account of an Eligible Employee enrolled in an applicable HDHP medical plan option under the Plan.

CHIPRA

"CHIPRA" means the Children's Health Insurance Program Reauthorization Act of 2009, as amended.

COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code

"Code" means the Internal Revenue Code of 1986, as amended.

Eligible Employee

"Eligible Employee" means an Employee who satisfies the eligibility requirements of the Plan, as described in the **Eligibility and Participation** section of this SPD.

Employee

"Employee" generally means a person who is employed by the Employer as a common law employee and is on the Employer's W-2 payroll (or who would be, but for an approved leave of absence). "Employee" does not include a leased employee or individual classified by the Employer as an independent contractor or as self-employed, or any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which the individual is paid by such agency.

Employer

"Employer" means Ardent Health Services and any other affiliated employer (which may include a former affiliated employer) Ardent Health Services allows to participate in the Plan, as set forth from time to time in the Plan Document.

ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Flexible Benefits Plan

"Flexible Benefits Plan" means the Flexible Benefits Plan, a part of the Plan, established and maintained by Ardent Health Services pursuant to Section 125 of the Code and providing Eligible Employees the opportunity to pay for certain benefit programs and/or make certain contributions on a pre-tax (salary reduction) basis. The Flexible Benefits Plan, which includes the Flexible Spending Accounts ("FSAs"), is described in the **Flexible Benefits Plan** section of this SPD.

FMLA

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

IRS

"IRS" means the Internal Revenue Service.

Plan

"Plan" means the Ardent Health Services Welfare Benefit Plan.

Plan Administrator

"Plan Administrator" means the Ardent Health Services Benefits Committee, or such person(s) or committee as may be appointed by the Board of Directors of Ardent Health Services to administer the Plan. The Plan Administrator's contact information appears under **Important Information about the Plan** at the beginning of this SPD.

Plan Document

"Plan Document" means the Ardent Health Services Welfare Benefit Plan, as amended and restated effective as of January 1, 2021, and as thereafter amended from time to time, and the insurance contracts and policies and other coverage documents incorporated from time to time by reference into that document.

Rescission or Rescinded

"Rescission" or "Rescinded" means a "rescission" within the meaning of the Affordable Care Act. In general, a Rescission (or coverage that has been Rescinded) is cancellation or discontinuance of medical coverage that has a retroactive effect, but does not include, for example, a retroactive cancellation or

discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions (e.g., for COBRA coverage) or that is initiated by the participant without influence by the Employer, Plan, etc.

The term "Rescission" also includes a cancellation or discontinuance of disability coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of disability coverage.

Summary Plan Description or SPD

"Summary Plan Description" or "SPD" means the summary plan description (as required by ERISA) that summarizes the Plan, and includes this document, any summaries of material modifications (SMMs) to this document, and the benefit booklets prepared for participants under the Plan.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Appendix A
ERISA BENEFIT CLAIM DETERMINATIONS (AND ELIGIBILITY DETERMINATIONS) UNDER THE PLAN

This Appendix A generally describes benefit claim procedures under the Plan, as required by ERISA. ***Specific claim filing information is described in the applicable benefit booklets—therefore, you should first consult the applicable benefit booklet to address your specific claim situation.***

What is a Claim for Benefits?

A claim for benefits is a request for a Plan benefit or benefits you make in accordance with the Plan's reasonable procedures for filing benefit claims (as described in this appendix).

If you ask a question concerning eligibility for coverage under the Plan without making a claim for benefits, the eligibility determination is not a claim for benefits governed by the ERISA claims procedure rules (however, see the section entitled "Eligibility Determinations under the Plan" at the end of this Appendix for information about eligibility determinations under the Plan).

How to File a Claim for Benefits

Where you submit your claim for benefits and the deadline for filing your claim depend on the benefit program under which you are submitting your claim for benefits. In some benefit programs, if you go to a network or contracted provider, the provider will generally file a claim for you. Otherwise, you will need to file a claim yourself. Generally, you should file a claim as soon as possible (even if you have not met your deductible, if applicable under such benefit program). If you do not file a proper claim within the particular benefit program's claim filing deadline, your claim for benefits will generally be denied. *Specific claim filing information is described in the applicable benefit booklets (and, for the Flexible Spending Accounts, in the* ***Flexible Benefits Plan*** *section of this SPD).* If no claim filing deadline is described in the applicable benefit booklet(s), then the deadline for filing a claim for benefits is 180 days after the date on which the services were originally performed or the claim otherwise arose (provided, however, that if a claimant is unable to meet that deadline for reasons beyond the claimant's reasonable control, then claims will still be accepted if filed within 30 days of the date that the circumstances causing the delay are removed, but not later than the end of the calendar year following the year in which the claim was originally incurred).

The claims administrators and/or the Plan Administrator have the right to request repayment if they overpay a claim for any reason (or pay a claim in error).

Designating an Authorized Representative

You may provide the claims administrator and/or the Plan Administrator, as applicable, with a written designation and authorization (on a form prescribed or approved by the claims administrator or Plan Administrator) for an "authorized representative" to represent you and act on your behalf and consent to the release of information related to you to the authorized representative with respect to a claim for benefits or an appeal. Refer to the applicable benefit booklet or contact the applicable benefit vendor to determine how to designate an authorized representative under that benefit program.

ERISA Benefit Claim Review Process and Applicable Time Periods

The benefit programs of the Plan have a claim review process that is followed whenever you submit a claim for benefits. When you file a claim for benefits, the claims administrator for the particular benefit

program reviews your claim and makes a decision either to approve or deny the claim, in whole or in part. If your claim is approved, benefits will be paid either to you or on your behalf. If your claim is denied, or if the claims administrator needs more information before it can approve your claim, you will be notified in writing within certain time periods. If your claim is denied, you can appeal. For more information, see the section below entitled **If Your Claim for Benefits Is Denied**. *A participant or beneficiary must exhaust the Plan's reasonable claims procedures prior to bringing any court action to obtain Plan benefits.*

You must fully follow and exhaust the Plan's claims procedures before you can file a lawsuit in state or federal court. Except as otherwise provided in the applicable benefit booklet(s), a suit for benefits under the Plan must be brought within one year following (i) the date on which the claim arose (e.g., the date on which the expense for which benefits are claimed was incurred) or, if later, (ii) the date on which the Plan's internal claims procedures with respect to that claim were exhausted.

The claims administrator processes payments for claims, answers questions, and reviews appeals according to the particular benefit program's provisions. Except where the Plan Administrator (or its delegate) has retained this authority, the ERISA claims administrator is the named fiduciary that serves as the final review committee and, in its sole discretion, has the authority to interpret Plan provisions as well as facts and other information related to claims and appeals.

The following chart will help you determine which time periods (outlined in the **Claims and Appeals Timetable** below) apply under ERISA for claims administrators' decisions about your claims and appeals, depending on:

- The particular benefit program to which you are submitting the claim; and
- In the case of some benefit programs, the **type of claim** you are submitting:

If you submit a claim for benefits under the following benefit program(s) (lists are not exhaustive):	**And your claim is of the following type:**	**Then refer to this section of the Claims and Appeals Timetable (below) for the applicable time periods for receiving claim and appeal decisions:**
● medical (including prescription drug) coverage (called **"medical coverage"** in this Appendix A) ● dental coverage ● vision coverage ● Health Care or Limited Purpose Health Care Flexible Spending Account called **"group health coverage"** in this Appendix A	**Urgent Care**, which means a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care decisions could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. (In the case of **medical coverage** to which the Affordable Care Act applies, the determination whether the claim is for **urgent care** is determined by the attending provider and the Plan shall defer to that determination.)	See the section of the **Claims and Appeals Timetable** (below) entitled **Urgent Care Claims.**
	Pre-Service, which means any claim for a benefit with respect to which the terms of the Plan condition the receipt of the benefit, in whole or in part, on the approval of the benefit in advance of obtaining medical care.	See the section of the **Claims and Appeals Timetable** (below) entitled **Pre-Service Claims**.

If you submit a claim for benefits under the following benefit program(s) (lists are not exhaustive):	And your claim is of the following type:	Then refer to this section of the Claims and Appeals Timetable (below) for the applicable time periods for receiving claim and appeal decisions:
	Post-Service, which means any claim for a benefit that is not a pre-service claim; that is, it does not require approval in advance of obtaining medical care, and a claim for such benefits is filed after the medical care has been received. *All claims submitted for reimbursement under the Health Care FSA or Limited Purpose Health Care FSA are post-service claims.*	See the section of the **Claims and Appeals Timetable** (below) entitled **Post-Service Claims**.
	Concurrent Care, which means that the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and there is a reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments.	See the section of the **Claims and Appeals Timetable** (below) entitled **Concurrent Care Claims**.
● long term disability (LTD) ● short term disability (STD) called "**disability coverage**" in this Appendix A	Any claim for benefits under a disability coverage.	See the section of the **Claims and Appeals Timetable** (below) entitled **Claims for Disability Benefits.**
● life insurance ● accidental death and dismemberment (AD&D) insurance called "**other coverage**" in this Appendix A	Any claim for benefits under the other coverage(s).	See the section of the **Claims and Appeals Timetable** (below) entitled **Claims for Other Benefits.**

If Your Claim for Benefits Is Denied or Your Coverage Is Rescinded

If your claim for a benefit is denied, in whole or in part (or if your **medical coverage** or your **disability coverage** is Rescinded, if required by law), you will receive a written notice of the adverse benefit determination from the claims administrator (or the Plan Administrator) within the applicable time period outlined in the **Claims and Appeals Timetable** below. (Note, however, that if your claim is an **urgent care** claim, this notice may be given to you orally within the applicable time period, and a written or electronic notice will follow within three days of such oral notice.) The notice will include:

- The specific reason(s) for the adverse benefit determination;
- References to specific Plan provisions on which the adverse benefit determination is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why the material or information is necessary; and
- An explanation of the steps you must take (and the time limits applicable to those steps) if you disagree with the adverse benefit determination and wish to have the adverse benefit determination reviewed, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

Additional Information Provided for Group Health Coverage Claims

In addition to the information listed above, in the case of an adverse benefit determination under a **group health coverage**, your written notice will also include:

- A copy of any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that the rule, guideline, protocol, or other criterion was used and that you can request a copy of such rule, guideline, protocol, or other criterion free of charge; and
- If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the medical determination, applying the terms of the Plan to your medical circumstances, or a statement that you can request the explanation free of charge.

In the case of an adverse benefit determination under a **medical coverage** to which the Affordable Care Act applies, your written notice will also include the following:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), etc., and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The denial code and its corresponding meaning that corresponds to the specific reason(s) for the adverse benefit determination and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any available internal appeals and external review processes, including information describing how to initiate an appeal; and
- A description of the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the claims and appeals and review process.

Additional Information Provided for Disability Coverage Claims

In addition to the information applicable to all benefit claims and listed at the beginning of this section, above, in the case of an adverse benefit determination under a **disability coverage**, your written notice will also include the following:

- A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following, if applicable: (i) the views of health care professionals treating you and vocational professionals who evaluated you that you presented to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination; and (iii) a disability determination made by the Social Security Administration about you that you presented to the Plan;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse benefit determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

How to Request Review of an Adverse Benefit Determination

If you do not agree with the adverse benefit determination (including a Rescission of your **medical coverage** or **disability coverage**), you (or your authorized representative) may request that the adverse benefit determination be reviewed by the ERISA claims administrator, in accordance with the reasonable claims procedures described here and in the applicable benefit booklet. Addresses of these claims administrators are available in the applicable benefit booklets.

Unless the applicable benefit booklet provides otherwise, you must file your written request for review of any **group health coverage** or **disability coverage** adverse benefit determinations within **180 days** after you receive the written notification of the adverse benefit determination. Written requests for review of any **other coverage** adverse benefit determination must be filed within **60 days** after you receive the written notification of the adverse benefit determination (unless the applicable benefit booklet provides otherwise). Your request for review must be in writing and must include the following:

- A description of your claim sufficient to identify the claim (for example, for a claim for benefits under a group health coverage, the patient's name and identification number from the ID card, the date(s) of medical service(s), and the provider's name);
- A summary of all the reasons why you believe the benefits should be paid (or coverage should not be Rescinded), including any documents, records or other information relating to or that support your claim; and
- Any issues or comments that you think are pertinent to your claim.

However, if your claim involves **urgent care**, your request for review may be submitted orally or in writing, and all necessary information related to the review may be transmitted between you and the Plan by telephone, facsimile, or other available, similarly expeditious method.

You may include with your request for review written comment, documents, records, and/or other information relating to your claim. During the time limit for requesting an appeal, upon request and free of charge, you will be given reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

Your claim and the adverse benefit determination will be reviewed fairly and fully, and a decision will be made on your benefit claim within the time period outlined in the **Claims and Appeals Timetable** below (for the applicable coverage and claim type) following receipt of your review request. As described in the **Claims and Appeals Timetable**, if additional time is needed to render a decision, you will be notified of the reasons why the extension is needed and the date by which you may expect a decision.

In the case of a claim for benefits under a **group health coverage** or **disability coverage**, the party considering the appeal will not give deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor his or her subordinate. Additionally, if a **group health coverage** or **disability coverage** adverse benefit determination is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate), the fiduciary deciding the appeal will consult with an appropriate health care professional (who was not consulted during the initial adverse benefit determination and is not subordinate to a professional consulted during the initial adverse benefit determination). In addition, the claims administrator will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the adverse benefit determination.

In the case of a claim for benefits under a **medical coverage** that is subject to the requirements of the Affordable Care Act, as part of its full and fair review, you must be provided (free of charge) with the new

or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim as soon as possible and sufficiently in advance of the date on which the final adverse benefit determination is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date. In addition, before the Plan can issue a final adverse benefit determination based on a new or additional rationale, you must be provided (free of charge) with the rationale as soon as possible and sufficiently in advance of the date on which the final adverse benefit determination is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the time period will be tolled to give you a reasonable opportunity to respond.

In the case of a claim for benefits under a **disability coverage**, before the Plan can issue an adverse benefit determination on review, you shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date. In addition, before the Plan can issue an adverse benefit determination on review based on a new or additional rationale, the Plan shall provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date.

Notice of Decision on Appeal

If the claims administrator determines that your explanation and additional information support the payment of your claim, the claims administrator will process your claim, in accordance with the reasonable claims procedures described here and in the applicable benefit booklet. Benefits are generally paid to you or your beneficiary unless, in the case of a **group health coverage**, the health care provider notifies the claims administrator that you have assigned benefits directly to that provider.

If the original adverse benefit determination is upheld in whole or in part, you will receive a written notice within the time period outlined in the **Claims and Appeals Timetable** below (for the applicable coverage and claim type) stating:

- The specific reason(s) for the adverse benefit determination;
- References to specific Plan provisions on which the adverse benefit determination is based;
- A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits; and
- A statement describing any voluntary appeal procedures offered by the Plan and your right to bring an action under Section 502(a) of ERISA following an adverse benefit determination after completion of all levels of appeal required by the particular benefit program.

Additional Information Provided for Group Health Coverage Claims

In addition to the information listed above, in the case of an adverse benefit determination on review under a **group health coverage**, your written notice will <u>also</u> include:

- A copy of any internal rule, guideline, protocol or other similar criterion relied upon to determine the claim, or a statement that the rule, guideline, protocol, or other criterion was used and that you can request a copy of such rule, guideline, protocol, or other criterion free of charge; and
- If the denial of your claim is based on a medical necessity, experimental treatment or similar

exclusion or limit, an explanation of the scientific or clinical judgment for the medical determination, or a statement that you can request the explanation free of charge.

In the case of an adverse benefit determination under a **medical coverage** to which the Affordable Care Act applies, your written notice will also include the following:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), etc., and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The denial code and its corresponding meaning that corresponds to the specific reason(s) for the adverse benefit determination and a description of the Plan's standard, if any, that was used in denying the claim, including a discussion of the decision;
- A description of any available internal appeals and external review processes; and
- A description of the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the claims and appeals and review process.

Additional Information Provided for Disability Coverage Claims

In addition to the information applicable to all benefit claims and listed at the beginning of this section, above, in the case of an adverse benefit determination on review under a **disability coverage**, your written notice will also include the following:

- A description of any contractual limitations period that applies to your right to bring an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for your claim;
- A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following, if applicable: (i) the views of health care professionals treating you and vocational professionals who evaluated you, and that you presented to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination; and (iii) a disability determination made by the Social Security Administration about you that you presented to the Plan;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse benefit determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If, on the first appeal, the claims administrator upholds the denial of your claim for benefits, *and the claims administrator allows two internal levels of appeal*, you may file a second appeal within **90 days** after receiving the notice of denial of your first appeal (unless the applicable benefit booklet provides otherwise). The second appeal will follow the same procedures as outlined above for the initial appeal. Note that even if a claims administrator allows for two levels of appeal, *there is typically only one level of appeal for an **urgent care** claim*. Refer to the applicable benefit booklet, or contact the particular claims administrator or the Plan Administrator, to determine whether a particular benefit program allows for two levels of appeal.

Claims and Appeals Timetable

Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
Urgent Care Claims	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your claim by the claims administrator. If you fail to provide sufficient information with your claim to determine whether, or to what extent, benefits are covered or payable from the Plan, you will be notified no later than **24 hours** after the claims administrator receives your claim of the specific information you need to submit. You will have at least **48 hours** to provide this information. You will be notified of the claim decision as soon as possible, but not later than **48 hours** after the earlier of: (a) the claims administrator's receipt of the specified information or (b) the deadline to provide this information passes. **If you fail to follow proper claim procedures with respect to a pre-service urgent care claim:** If you fail to follow the proper claims procedures, you will be notified of the failure as soon as possible, but not later than **24 hours** after your claim was received by the claims administrator. The notice will describe the proper procedures for filing a claim. The 24-hour time period only applies if your claim is made to the proper person and names a specific claimant; his or her specific medical condition or symptom; and the specific treatment, service, or product for which approval is requested.	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your request for review by the claims administrator.
Pre-Service Claims	Within a reasonable period of time appropriate to the medical circumstances but not later than **15 days** after receipt of your claim by the claims administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the claims administrator. **Extension of time for processing claim:** If an extension is needed, you will be notified before the end of the first 15-day period why the extension is necessary and when the claims administrator expects to render a decision. If an extension is necessary because you failed to submit necessary information, the notice will specify what information is necessary, and you will have at least **45 days** to provide it. You will be notified of the claims administrator's decision within **15 days** after its receipt of the additional information. **If you fail to follow proper claim procedures:** If you do not follow the proper claims procedures, you will be notified of the failure to follow the proper claims procedures as soon as possible, but no later than **5 days** after your claim was received by the claims administrator. The notice will describe the proper procedures for filing a claim. The 5-day time period only applies if your claim is made to the proper person and names a specific claimant; his or her specific medical condition or symptom; and the specific treatment, service, or product for which approval is requested.	**If the benefit program allows one internal level of appeal:** A reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review by the claims administrator. **If the benefit program allows two internal levels of appeal:** A reasonable period of time appropriate to the medical circumstances, but not later than **15 days** after receipt of your request for first or second review by the claims administrator.

Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
Post-Service Claims	Within a reasonable period of time, but not later than **30 days** after receipt of your claim by the claims administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the claims administrator. **Extension of time for processing claim:** If an extension is needed, you will be notified before the end of the initial 30-day period why the extension is necessary and when the claims administrator expects to render a decision. If an extension is necessary because you failed to submit necessary information, the notice will specify what information is necessary, and you will have at least **45 days** to provide it. You will be notified of the claims administrator's decision within **15 days** after its receipt of the additional information or within **15 days** after the 45-day deadline to provide the additional information passes, whichever is sooner.	**If the benefit program allows <u>one</u> internal level of appeal:** A reasonable period of time, but not later than **60 days** after receipt of the request for review by the claims administrator. **If the benefit program allows <u>two</u> internal levels of appeal:** A reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of your request for first or second review by the claims administrator.
Concurrent Care Claims	If there is a reduction or termination of the course of treatment (other than by Plan amendment or termination), the claims administrator must notify you sufficiently in advance to allow you to appeal and obtain a determination on review before the treatment is reduced or terminated. If the treatment involves **urgent care** and you request an extension of the course of treatment, the claims administrator must notify you of its determination as soon as possible, taking into account the medical exigencies, but generally no later than **24 hours** after receipt of the claim. Your request must be made within **24 hours** prior to the expiration of the prescribed period of time or number of treatments. *To the extent required by law, the Plan will provide continued coverage for an ongoing course of treatment pending the outcome of internal appeals.*	If it is a **non-urgent** claim for ongoing care, the timing of the notice of decision on review will be handled under either the **Pre-Service Claim** or **Post-Service Claim** time periods outlined above, as appropriate for the type of claim. If it is an **urgent care** claim for ongoing care, as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your request for review by the claims administrator.
Claims for Disability Benefits	Within a reasonable period of time, but not later than **45 days** after receipt of your claim by the claims administrator, unless an extension of up to an additional **30 days** is necessary due to matters beyond the control of the claims administrator. **Extension of time for processing claim:** If an extension is needed, you will be notified before the end of the initial 45-day period why the extension is necessary and when the claims administrator expects to render a decision. If, due to matters beyond the claims administrator's control, a decision cannot be made within this 30-day extension period, the claims administrator may extend the determination period for an additional **30 days**, provided you are notified prior to the end of the initial 30-day extension. The notice will explain the circumstances requiring the extension and the date when the claims administrator expects to make a decision. If you file a disability claim that is not complete, the claims administrator will notify you within **45 days** after receiving your claim of the information that is necessary to complete the claim. You will have **45 days** to provide the additional information. The claims administrator will notify you of its decision within 30 days after receiving the additional information or within **30 days** after the 45-day deadline to provide the additional information passes, whichever is sooner.	A reasonable period of time, but not later than **45 days** after receipt of your request for review by the claims administrator. If necessary due to special circumstances, the period may be extended for an additional **45 days**. In this case, you will be notified in writing prior to the extension of the special circumstances and the date a decision will be rendered. A decision shall be made as soon as possible, but no later than **90 days** after receipt of the request for review.

Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
Claims for Other Benefits	Within a reasonable period of time, but not later than **90 days** after receipt of your claim by the claims administrator. **Extension of time for processing claim:** If special circumstances require an extension of time for processing the claim, you will receive a written notice before the end of the initial 90-day period, and this extension will not exceed an additional **90 days**. The notice will explain why an extension of time is necessary and when the claims administrator expects to render a decision.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the claims administrator. If necessary, the period may be extended for an additional **60 days**. In this case, you will be notified in writing prior to the extension of the special circumstances and the date a decision will be rendered. A decision shall be made as soon as possible, but no later than **120 days** after receipt of the request for review.

Deemed Exhaustion of Internal Claims and Appeals Procedures—*Medical and Disability Coverages*

In the case of a claim for benefits under **medical coverage** to which the Affordable Care Act applies, if the Plan fails to strictly adhere to the internal claims and appeals procedures described in this Appendix, you will be deemed to have exhausted the internal claims and appeals procedures. Accordingly, you may initiate an external review as described below, as applicable. You are also entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable internal claims and appeals procedure that would yield a decision on the merits of the claim. If you choose to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

In the case of a claim for benefits under **disability coverage**, if the Plan fails to strictly adhere to the claims and appeals procedures described in this Appendix, you will be deemed to have exhausted the claims and appeals procedures. Accordingly, you will be entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims and appeals procedure that would yield a decision on the merits of the claim. If you choose to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Exceptions for De Minimis *Violations*

The paragraphs above will not apply to *de minimis* violations of these procedures that do not cause, and are not likely to cause, prejudice or harm to you, so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing, good faith exchange of information between you and the Plan. In addition, the violation must not be a part of a pattern or practice of violations by the Plan.

With respect to a claim for **medical coverage** benefits, you may request a written explanation of the violation from the Plan, and the Plan shall provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violations should not cause the internal claims and appeals procedures under the Plan to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review as described above on the basis that the Plan met the standards for this "*de minimis*" exception, you have the right to resubmit and pursue the internal appeal of the claim and the Plan will, within a reasonable period of time (not to exceed 10 days), provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. The time periods for re-filing the claim shall begin to run upon your receipt of this notice from the Plan.

With respect to a claim for **disability coverage** benefits, you may request a written explanation of the violation from the Plan, and the Plan shall provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violations should not cause the administrative remedies under the Plan to be deemed exhausted. If a court rejects your request for immediate review as described above on the basis that the Plan met the standards for this "*de minimis*" exception, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable period of time after the receipt of that decision, the Plan shall provide you with notice of the resubmission.

External Review Process Available Under Certain Circumstances—*Medical Coverage Only*

In the case of a final internal adverse benefit determination on your appeal (described in the **Notice of Decision on Appeal** section of this Appendix A above) under a **medical coverage** that is subject to these requirements of the Affordable Care Act, you may, *only under certain circumstances as required by the Affordable Care Act (generally, these include decisions involving "medical judgment" or a Rescission of coverage)*, be entitled to request an independent, external review of the adverse benefit determination. You will be provided with information about the external review process with the notice you receive of the final internal benefit determination on your claim.

Also, under a new law called the Consolidated Appropriations Act, 2021 ("CAA"), which includes the No Surprises Act (Title I of division BB of the CAA) and Transparency provisions (Title II of division BB of the CAA), you may have certain additional rights, including to external review of a final adverse benefit determination relating (as required by the CAA) to coverage of emergency services received from an out-of-network provider or facility or to certain services provided by an out-of-network provider while you are at an in-network hospital.

For details, refer to the Explanation of Benefits (EOB) that you receive from the medical claims administrator and/or the benefit booklet for your medical coverage or contact the Plan Administrator (contact information is provided in the **Important Information about the Plan** section of this SPD) or the claims administrator (contact information is provided in the benefit booklet). You may also contact the Employee Benefits Security Administration at (866) 444-EBSA for information about your rights or for assistance.

Eligibility Determinations under the Plan

Eligibility Review Process and Applicable Time Periods

The Plan has a review process that is followed whenever you submit a request to participate in a coverage option or to change an election to participate during the Plan Year. For example, it may be a request to begin, add, or stop participation in the Plan. *Except where the Plan Administrator has delegated this to the claims administrator* (refer to the applicable benefit booklet or contact the Plan Administrator), the Plan Administrator makes all eligibility determinations under the Plan and is authorized to administer the Plan and has the discretionary authority to interpret the Plan and decide all eligibility questions. Any decision made by the Plan Administrator in connection with the Plan is conclusive and binding on all persons.

You must fully follow and exhaust the Plan's eligibility procedures before you can file a lawsuit in state or federal court. Except as otherwise provided in the applicable benefit booklet(s), a suit for benefits under the Plan must be brought within one year following (i) the date on which the claim for eligibility arose or, if later, (ii) the date on which the Plan's procedures with respect to that eligibility determination were exhausted.

Timing for Eligibility Determinations

The Plan Administrator will make an eligibility determination within a reasonable period of time, but not later than 90 days after receipt of your request to participate or change an election to participate in the Plan.

Extension of Time for Processing Eligibility Determinations

If special circumstances require an extension of time for processing the request, you will receive a written notice before the end of the initial 90-day period, and this extension will not exceed an additional 90 days. The notice will explain why an extension of time is necessary and when the Plan Administrator expects to render a decision.

How to Request Review of a Denied Eligibility Request

If you do not agree with the eligibility determination, you (or your authorized representative) may request that the determination be reviewed by the Plan Administrator. To request this review, please submit your request in writing to the Plan Administrator, whose contact information is provided in the **Important Information about the Plan** section of this SPD.

You must file your written request for review of any eligibility determination under the Plan within **60 days** after you receive the written notification of an adverse eligibility determination. Your request for review must be in writing and must include the following:

- A summary of all the reasons why you believe your eligibility request should be granted, including any documents, records or other information relating to or that support your position; and
- Any issues or comments that you think are pertinent to your position.

Timing and Notification of Appeal Decision

Your request will be reviewed and a decision will be made within a reasonable period of time, but not later than 60 days after receipt of the request for review by the Plan Administrator. If necessary, the period may be extended for an additional 60 days. In this case, you will be notified in writing prior to the extension, and a decision shall be made as soon as possible, but no later than 120 days after receipt of the request for review.