PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

for the

SCHUPAN & SONS, INC.
WELFARE BENEFIT PLAN

June 2023

INTRODUCTION

Schupan & Sons, Inc. ("Employer" and "Plan Sponsor") established the **Schupan & Sons, Inc. Welfare Benefit Plan** ("Plan"). The Plan includes various health and welfare benefits for eligible employees of Employer.

This document sets forth the terms of the Plan as of January 1, 2023. Employer intends that this document serves as the Plan Document and as the Summary Plan Description, along with the documents supplied by the claim administrators, insurers, benefit providers and Employer, for the health and welfare benefits under the Plan.

Certain health and welfare benefits under the Plan are provided on a self-funded basis. This means that these benefits will be paid by Plan Sponsor from its general assets rather than through a separate trust fund or an insurance company. Employer has selected one or more claim administrators for the self-funded benefits under the Plan. These claim administrators will provide a summary plan description and/or "Benefits-at-a-Glance Schedules of Benefits" and other information to employees enrolled in the Plan. The claim administrators are not the insurers of the Plan and any and all references in the documents to the claim administrators should be interpreted accordingly.

Other health and welfare benefits under the Plan are provided on a fully-insured basis. Generally, the terms and conditions under which an employee may be eligible to receive these benefits are set forth in the terms of each applicable insurance policy. Because the fully-insured benefits under the Plan are provided solely through insurance companies, Employer is not the insurer of these benefits. The insurance carrier is ultimately responsible for determining eligibility for, and the amount of, any benefits payable under its respective insurance policy.

Finally, Employer provides additional benefits which are not subject to ERISA and are technically not part of this Plan. However, these benefits are referred to in this document for informational purposes. Eligible employees will receive separate documentation describing these benefits.

The specific health and welfare benefits provided under the Plan and any additional benefits provided by Employer are listed in the "WELFARE BENEFIT PLAN" section. This section also indicates whether the health and welfare benefits are self-funded or fully-insured. In addition, the "OTHER BASIC INFORMATION ABOUT THE PLAN" section identifies the claim administrators and insurers for the benefits under the Plan.

The existence of the Plan does not grant employees any legal right to continue employment with Employer or affect the right of Employer to discharge employees. Questions about the Plan/Summary Plan Description should be directed to the Human Resources Department.

SCHUPAN & SONS, INC.

Dated: Sep 7, 2023, 2023

Phillip C Haan
Phillip C Haan (Sep 7, 2023 11:44 EDT)

Signature

Phillip C Haan

Printed Name and Title

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WELFARE BENEFIT PLAN

The Plan includes the following benefits:

HEALTH BENEFITS:	**Self-Funded**	**Fully-Insured**
Medical/Prescription Drug (includes On-Site Clinic)	☑	☐
Dental	☑	☐
Vision	☐	☑
WELFARE BENEFITS:		
Group Term Life/Accidental Death and Dismemberment ("AD&D")	☐	☑
Short-Term Disability	☐	☑
Long-Term Disability	☐	☑
Voluntary Term Life	☐	☑
Voluntary Whole Life	☐	☑
Voluntary Accident	☐	☑
Hospital Indemnity	☐	☑
Voluntary Critical Illness	☐	☑
Employee Assistance Program ("EAP")	☐	☑
Wellness Program	☑	☐
Medical Flexible Spending Accounts (under Employer's Section 125 plan)	☑	☐
TeleHealth Benefits (includes BCBSM and HealthJoy (Teledoc))	☐	☑

ADDITIONAL BENEFITS: (These benefits are not subject to ERISA and are technically not part of the Plan for Form 5500 purposes but are mentioned in this Plan/SPD for informational purposes.)

Dependent Care Flexible Spending Accounts
(under Employer's Section 125 Plan)

Health Savings Accounts ("HSAs")
(for employees enrolled in Employer's high deductible health plan)

Subsequent references throughout the document to "health benefits," "welfare benefits" and "additional benefits" mean the benefits described above.

Employees have received or will receive documentation describing each benefit in which they are enrolled. This Summary Plan Description is intended to supplement those materials. This document does not replace the provisions of the plan documents, summary plan descriptions, insurance applications, master plans, group insurance contracts and/or other documents for a benefit, including any applicable certificates and/or riders.

The other documentation for a benefit will contain the following information:

- With respect to the fully-insured benefits, the eligibility and participation conditions for any dependent coverage, if applicable.
- A summary of benefits.
- With respect to health benefits:
    - A description of any deductibles, coinsurance or copayment amounts.
    - A description of any limits on benefits.
    - Whether and under what circumstances preventive services are covered.
    - Whether and under what circumstances prescription drugs are covered.
    - Whether and under what circumstances coverage is provided for medical tests, devices and procedures.
    - Provisions governing the use of network providers (if any). If there is a network, the booklet(s) or certificate will contain a general description of the provider network and participants will be entitled to obtain a list of providers in the network.
    - Whether and under what circumstances coverage is provided for any out-of-network services.

- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.

- Any conditions or limits applicable to obtaining emergency medical care.

- Any provisions requiring preauthorization or utilization as a condition to obtaining a benefit.

- A description of the circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that the employee might otherwise reasonably expect the Plan to provide.

EMPLOYEE ELIGIBILITY AND PARTICIPATION

General Rules

Each full-time employee of Employer who is regularly scheduled to work at least 30 hours per week is eligible to receive all of the benefits under the Plan. A newly-eligible employee is eligible to participate in these benefits on the first day of the month after the employee's hire date with Employer.

Despite these general rules, as required by the employer shared responsibility rules of Health Care Reform, additional employees (including seasonal employees, variable hours employees and part-time employees) will also be eligible to participate in the benefits under the Plan in the following two circumstances:

- For newly-hired employees who are not full-time employees as described above, if the employee completes an initial measurement period beginning no later than the first day of the month after his or her date of hire during which the employee is credited with an average of at least 30 hours per week, the employee will be eligible to enroll in the benefits under the Plan for the stability period beginning immediately after the initial measurement period and any related administrative period ends.

- For ongoing employees who are not full-time employees as described above, for each plan year, there will be a standard measurement period before the beginning of the plan year. If the employee is credited with an average of at least 30 hours per week during the standard measurement period, the employee will be eligible to enroll in the benefits under the Plan for that plan year.

For each measurement period, Employer will notify non-full-time employees if they satisfy the at least 30 hours per week average and are eligible for coverage for the subsequent, related stability period or plan year.

Ineligible Employees

Notwithstanding the above, individuals who Employer classifies as independent contractors and leased employees are not eligible for the Plan.

Transfers

If a non-full-time employee transfers to a full-time position, the employee will be eligible for benefits under the Plan on the first day of the month following the date of transfer.

Breaks-in-Service

If an eligible employee has a break-in-service (for example, due to termination of employment) during which the employee is not credited with any hours of service for at least 13 weeks, the employee will be treated as a new hire upon resumption of service. If the break is less than 13 weeks and the employee was enrolled in benefits under the Plan and returns during the same stability period/plan year, the coverage will be offered as soon as administratively practicable upon resumption of service. Further, such an employee will be treated as a continuing employee upon resumption of service for purposes of any applicable measurement periods for benefits.

DEPENDENT ELIGIBILITY AND PARTICIPATION

The documentation for each fully-insured benefit contains the rules concerning when and how an eligible employee's eligible dependents may participate in that benefit.

This section sets forth the rules for a participating employee's spouse and dependent children who are eligible for the self-funded **medical/prescription drug and dental benefits** under the Plan.

Spouse

"Spouse" means a person who is legally married to an employee. The term "spouse" does not include a spouse who is legally separated (e.g., an order of separate maintenance has been entered with the court) or divorced from the employee. Moving out and filing for divorce is not legal separation for this purpose.

Employer has adopted a spousal mandate rule which impacts the medical/prescription drug benefits eligibility for spouses of employees. A spouse of an eligible employee is eligible to participate in the medical/prescription drug benefits under the Plan on a primary basis as an eligible dependent if the spouse is not employed or does not have medical/prescription drug coverage available through his or her employer. However, the spouse of an eligible employee is exempt from the spousal mandate rule if the employee falls under one of the following classifications:

- The spouse was enrolled in the medical/prescription drug benefits under the Plan prior to January 1, 2008, and the spouse has maintained continuous coverage since then.

- Individuals who became employees as a result of the Employer's acquisition of Tri-State Aluminum, if the spouse was enrolled in the plan providing medical/prescription drug benefits sponsored by Tri-State Aluminum.

- Individuals who became employees as a result of the Employer's acquisition of Shapiro, if the spouse was enrolled in the plan providing medical/prescription drug benefits sponsored by Shapiro.

- Individuals who became employees as a result of the Employer's acquisition of Mid America Recycling (Iowa), if the spouse was enrolled in the plan providing medical/prescription drug benefits sponsored by Mid America Recycling (Iowa).

- Individuals who became employees as a result of the Employer's acquisition of UBCR, LLC (Used Beverage Container Recycling), if the spouse was enrolled in the plan providing medical/prescription drug benefits sponsored by UBCR, LLC (Used Beverage Container Recycling).

- Individuals who became employees as a result of the Employer's acquisition of Synergistic, if the spouse was enrolled in the plan providing medical/prescription drug benefits sponsored by Synergistic.

Dependent Children

An eligible dependent child includes the following:

- The employee's natural child, legally adopted child or child placed with the employee for adoption.

- The employee's step child.

- A child over whom the employee has a legal guardianship provided the child lives with and is financially dependent on the employee.

- A child for whom the employee is required to provide medical care under a court order, other than a qualified medical child support order ("QMCSO"), provided the child lives with and is financially dependent on the employee. (See the QMCSO subsection under the "Special Rules Regarding the Health Benefits" section for information concerning the required coverage for children covered by a QMCSO.)

An eligible child may participate in the medical/prescription drug and dental benefits under the Plan until the end of the calendar year during which the child turns age 26.

The above age 26 rule also applies to the vision benefit.

An eligible child may participate in the voluntary dependent life benefit under the Plan until the child's 26th birthday.

For further information, please refer to the booklet or certificate which describes this benefit and is provided by the insurer.

A special definition of dependent child applies for purposes of the **HSA**. While the above definition of dependent child applies for purposes of Employer's high deductible health plan, the Internal Revenue Code does not allow this definition to be used for tax-free distribution purposes from an HSA. Rather, tax-free distributions from an employee's HSA are only permitted for uninsured health expenses of the employee, the employee's spouse and the employee's dependent children who qualify as the employee's qualifying child or qualifying relative (generally, the employee's tax dependent). As a result, if the employee enrolls an older child in the high deductible health plan who is not also the employee's tax dependent, the child's out-of-pocket expenses cannot be reimbursed on a tax-free basis from the HSA.

ENROLLMENT RULES

When employees initially become eligible to participate in the Plan, they may make the following benefit elections:

Health Benefits

Employees may elect to participate in the health benefits provided by Employer by applying for coverage and agreeing to pay the required premium contributions, if applicable. If the employee enrolls in Employer's high deductible health plan, the employee may also be eligible to make contributions to an HSA. (See the "HEALTH SAVINGS ACCOUNT ("HSA")" section for details.)

Employees may elect to participate in the wellness program (refer to wellness document provided by Employer).

Welfare Benefits

Employees will be automatically enrolled in the group term life/AD&D, short-term disability, long-term disability and the EAP benefits.

Employees may also elect to purchase voluntary term life at initial enrollment. Whole life, accident, hospital indemnity and critical illness benefits may be purchased at the annual open enrollment.

Flexible Spending Accounts

Employees may elect to contribute to the medical and/or dependent care flexible spending accounts under Employer's Section 125 plan upon initial enrollment and re-elect at open enrollment for each applicable plan year thereafter.

TeleHealth

Employees enrolled in BCBSM or HealthJoy (Teledoc) may participate in the TeleHealth benefits.

After the employee makes his or her elections upon initial enrollment, the pre-tax elections may not be changed until the first day of the next plan year unless the employee experiences:

- A change in status or other qualifying event (see the summary plan description for Employer's Section 125 plan for details), or
- A situation in which the employee has special enrollment rights, as explained below.

ANNUAL AND SPECIAL ENROLLMENT PERIODS

Annual Enrollment

Before the beginning of each plan year, employees will be notified by Employer of the dates for the open enrollment period, and non-full-time employees will be notified if they are eligible for benefits for the plan year. During the open enrollment period, employees will have the opportunity to make benefit election changes. Benefit elections will remain in effect until the end of the plan year unless the employee requests an election change due to a change in status or other qualifying event (see the summary plan description for Employer's Section 125 plan for details) or the employee has a special enrollment rights circumstance as explained below.

Special Enrollment

If an individual experiences a loss of health coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee and/or a dependent may have special enrollment rights to participate in medical/prescription drug coverage under the group health plan immediately without being required to wait until the next annual open enrollment period.

- A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), or a benefit package option is terminated unless the individual is provided a current right to enroll in alternative coverage. But a loss of other coverage for this purpose does not include a termination for:
  - Nonpayment of required contributions.

- Filing of a fraudulent application or claim.
- Voluntary termination of the other coverage.

- The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption.
- If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual has special enrollment rights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow immediate enrollment if the individual submits a request within 60 days after the loss or gain of eligibility.

SOURCES OF CONTRIBUTIONS AND COST OF COVERAGE

Employer may contribute to the cost of each benefit. In addition, employees may be required to contribute to the cost of one or more of the benefits, as periodically determined by Employer. Employer will notify employees of the required contribution, if applicable. Benefits are funded in the following manner:

Self-Funded

Benefits may be funded on a self-funded basis. Employer will pay the self-funded benefits from its general assets. Any required participant contributions (if applicable) may be paid on a pre-tax basis under Employer's Section 125 plan. Participant contributions toward the cost of a particular benefit will be used in their entirety before using Employer contributions to pay for the cost of such benefit. Employer may establish a separate bank account for the payment of self-funded benefits. If a separate bank account is established, it will be for bookkeeping purposes only.

Employer may also purchase stop loss insurance to protect Employer from large individual and/or aggregate losses under the self-funded plan. Any such stop loss policy is not a Plan asset and any proceeds will be payable to Employer and will not be used to provide self-funded benefits under the Plan.

Fully-Insured

Employer may purchase insurance to provide benefits on a fully-insured basis. Any required participant contributions (if applicable) may be paid on a pre-tax basis under Employer's Section 125 plan or on a post-tax basis.

TERMINATION OF COVERAGE

To remain eligible for benefits under the Plan, the employee must be actively working for Employer on a regular full-time basis. However, all benefits under the Plan can be continued if the employee goes on a family or medical leave, as defined by the Family and Medical Leave Act of 1993 ("FMLA"). (See the "Family and Medical Leave Act" subsection.) The employee must pay the same premium amount for the benefits during the leave or upon their return to active employment as actively working employees.

If an employee has a reduction in hours so the employee is no longer full-time, the employee will become ineligible for all benefits under the Plan except medical/prescription drug benefits. With respect to medical/prescription drug benefits, if the employee was offered minimum value coverage by no later than the first day of the third month after the employee's date of hire until the reduction in hours and the employee is credited with less than an average of 30 hours per week for three consecutive full calendar months following the change to part-time status, Employer will determine the employee's eligibility for benefits on a month-to-month basis in accordance with the employee's credited hours for each subsequent month. In other words, if such an employee's credited hours for each month following the change in status are less than an average of 30 hours per week, medical/prescription drug benefits will be terminated after three consecutive full calendar months following the change in status and eligibility for subsequent months during the stability period or plan year will be determined on a month-to-month basis. However, if the employee is credited with more than an average of 30 hours per week for any of the three consecutive full calendar months following the change in status, the employee will remain eligible for medical/prescription drug benefits through the end of the applicable stability period or plan year.

Further, if an employee goes on an Employer-approved FMLA, non-FMLA, or other leave of absence, and is receiving wage replacement benefits from Workers' Compensation; or benefits under the short-term disability benefit, long-term disability benefit, or the Paid Parental Leave Policy sponsored by Employer, all benefits under the Plan can be continued for up to five months, subject to Employer's verification that the employee intends to return to work and subject to the carrier's certificate of coverage. The employee must pay the same premium amount for the benefits during the leave or upon their return to active employment as actively working employees. The extension of coverage during these employer-approved leaves will not run concurrently with COBRA (i.e., following the end of the five month continuation of coverage during the employer-approved leave, the employee will be offered COBRA continuation coverage, if applicable).

Except as otherwise described above, all benefits of an employee and the employee's dependents terminate on the day the employee's active full-time regular employment ends.

Benefits under the Plan will also terminate on:

- The date an individual ceases to be eligible for coverage.
- The first day any required participant contributions are not timely paid.
- The effective date of the individual's voluntary withdrawal from the Plan due to a change in status or during an open enrollment period.

- The date the Plan is discontinued as a whole or a particular benefit is discontinued.

- The date on which the participant's coverage is terminated for cause by the plan administrator. (Termination for cause means the participant is found to have misrepresented information in the application for participation or on a claim for benefits.)

In certain circumstances after coverage ends as described above, the employee and/or his or her eligible dependents may be eligible for COBRA continuation coverage and/or a conversion policy, as explained in the following sections. In the event of a non-FMLA medical leave or an Employer-approved leave, for a period of two months, Employer may subsidize the employee's COBRA continuation coverage at the same rate (or in the same amount) as active employee.

CONTINUATION OF HEALTH COVERAGE UNDER COBRA AND USERRA

The federal law known as COBRA allows eligible individuals to temporarily extend health coverage under the Plan in certain circumstances where health coverage would otherwise end. The federal law known as USERRA gives employees who cease to be eligible for health coverage due to service in the U.S. military additional rights regarding continuation of health coverage. This section provides information regarding extensions of coverage under these laws.

COBRA Continuation Coverage

COBRA continuation coverage allows the employee and/or his or her dependents (including a child for whom the employee is required to provide health insurance coverage pursuant to a QMCSO) an opportunity to temporarily extend health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end. The employee may also have continuation coverage rights with respect to his or her medical flexible spending account under Employer's Section 125 plan. (See the summary plan description of that plan for details.)

The plan administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator. The employee and spouse (if any) will be informed if a COBRA administrator is appointed and which responsibilities the COBRA administrator has assumed, including whether notices required to be provided to the plan administrator should be sent to the COBRA administrator. (See the "OTHER BASIC INFORMATION ABOUT THE PLAN" section for the name of the COBRA administrator.)

Eligibility

The employee and/or his or her dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to or adopted by or placed for adoption with the employee during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a qualified

beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if Employer pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours[1] or termination of employment[2]	Employee and Dependents	18
Employee's death	Dependents	36
Employee's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's divorce/legal separation[3]	Dependents	36

Extension of Continuation Coverage

If the employee and/or his or her dependents become entitled to continuation coverage as a result of the employee's termination of employment or reduction in hours, the 18-month continuation period may be extended for the employee and/or his or her dependents in the three circumstances described below ("extension events").

Second Qualifying Event

If a second qualifying event that is a divorce, legal separation, the employee's death, or a dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or 29 months, if there is a disability extension), the employee's dependents may

[1] A reduction in hours due to a family or medical leave, as defined by the FMLA, will not cause an employee's participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if the employee does not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

[2] Continuation coverage is not available if employment is terminated for gross misconduct.

[3] Elimination of the employee's spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example), is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the date of the divorce or legal separation.

be eligible to elect continuation coverage for a period of 36 months, beginning on the date of the employee's termination of employment or reduction in hours. ***Notice of this second qualifying event must be provided to the plan administrator within 60 days of the date of the second qualifying event.***

Employee's Entitlement to Medicare

If the employee becomes entitled to Medicare benefits during the initial 18-month period, his or her dependents may be eligible to elect continuation coverage for a period of 36 months, if, ignoring the original qualifying event, the employee's entitlement to Medicare would have been a qualifying event under the Plan. The 36-month continuation period begins on the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the date on which the employee became entitled to Medicare.***

A special rule applies if the employee became entitled to Medicare before his or her termination of employment or reduction in hours. In that situation, the maximum continuation period for the employee's dependents may be extended, and may end on the later of: 36 months after the date of the employee's Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the employee's termination of employment or reduction in hours.***

Social Security Disability Determination

If it is determined that the employee or one of his or her dependents is entitled to Social Security disability benefits either before the employee's termination of employment or reduction in hours or within 60 days after the employee's termination of employment or reduction in hours, the disabled individual and the qualified beneficiaries who are his or her family members will be entitled to an additional 11 months of continuation coverage (29 months total). ***Notice of the Social Security disability determination must be provided to the plan administrator within 60 days of the date of the disability determination (or within 60 days of the employee's termination of employment or reduction in hours, if later) and before the end of the 18-month continuation period.***

If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary ***must notify the plan administrator of that determination within 30 days of the date of the final determination.*** In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more

than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

Plan Administrator's Notice Obligations

The plan administrator will provide the employee and his or her spouse (if any) with certain information regarding their rights under COBRA in the following situations:

Notice of Eligibility to Elect COBRA

The plan administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event.

However, a special rule applies where the qualified beneficiary is required to provide the plan administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the plan administrator will notify the qualified beneficiary of his or her eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was timely submitted in accordance with the requirements described in the "Notice Procedures" subsection.

Notice of Unavailability of Continuation Coverage

The plan administrator will provide a notice of the unavailability of continuation coverage in the following situations:

- Where the plan administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event that is a divorce, legal separation or a dependent child's loss of eligibility for health coverage under the Plan.

- Where the plan administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

The determination that continuation coverage or an extension of continuation coverage is not available could be made because the plan administrator determines that no qualifying event or extension event occurred, or because the notice of the qualifying event or extension event was defective. A notice will be defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the "Notice Procedures" subsection.

The plan administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the plan administrator receives the notice of the potential qualifying event or extension event, or if later, the deadline for submission of additional information requested by the plan administrator to supplement a defective notice. The notice of the unavailability of continuation coverage will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

Qualified Beneficiary's Notice Obligations

In some situations, the employee and/or his or her dependents have the obligation to provide notice of a qualifying event or extension event to the plan administrator in order to trigger eligibility for continuation coverage or an extension of continuation coverage. The employee and/or his or her dependents have this obligation in the following situations:

Notice of Certain Initial Qualifying Events

The employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependents must inform the plan administrator of a qualifying event that is a divorce or legal separation, or of a child losing dependent status under the Plan within 60 days after the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

Notice of an Extension Event

In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, the employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependent must notify the plan administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

These notices must be provided in accordance with the requirements of the "Notice Procedures" subsection. If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

Notice Procedures

This subsection describes the procedures a qualified beneficiary must follow to notify the plan administrator of qualifying events and extension events.

The plan administrator has a form which may be used to provide the required notice. The form may be obtained by contacting the plan administrator at the address or telephone number listed at the end of this Summary Plan Description. While use of the notice form will help ensure that the qualified beneficiary provides all of the required information, use of the notice form is not required. Written notification that contains all of the following information will also be accepted:

- The name of the employee or former employee.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).
- The current address of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the qualifying event or extension event.
- The nature of the qualifying event or extension event (for example, a divorce).
- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the judgment of separate maintenance or other relevant court documents establishing the legal separation.
- If the notice relates to the employee's entitlement to Medicare, a copy of the document(s) establishing the entitlement.
- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.
- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline, is not made in writing and/or does not contain all of the required information is deemed to be defective and may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

If the plan administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the plan administrator will request the missing information. If the defective notice was provided by the representative of a qualified beneficiary or a potential qualified beneficiary, the plan administrator will send the request to the representative and each individual who is a qualified beneficiary or a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the plan administrator requests the additional information, the notice may be rejected. If the notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The plan administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the plan administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the plan administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or

- The date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage.

Notification is made by timely returning the election form to the plan administrator at the address specified in the election notice. If the qualified beneficiary does not choose continuation coverage during the 60-day period, his or her participation in the Plan will end as provided in the "Termination" subsection.

Coverage

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the qualified beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage. Alternatively, the qualified beneficiary may initially elect to purchase one or more of the medical/prescription drug, dental and vision coverages which are provided by Employer pursuant to any separate group health plans and/or which may be separately elected pursuant to Employer's Section 125 plan, if applicable. However, each coverage is initially available only if the

qualified beneficiary was receiving coverage immediately before the qualifying event.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to the qualified beneficiary and his or her dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

Cost of Continuation Coverage

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

Termination

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

Coverage Terminated

Employer no longer offers a group health plan to any of its employees.

Unpaid Premium

The premium for continuation coverage is not timely paid, to the extent payment is required.

Other Coverage

A qualified beneficiary becomes covered under another group health plan. Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan.

Medicare

A qualified beneficiary becomes entitled to Medicare (Part A or Part B). Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B). See below for more details regarding the impact of Medicare on COBRA continuation coverage.

Cause

A qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits). Continuation coverage will end as of the date on which the qualified beneficiary's coverage is terminated for cause.

The plan administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the qualified beneficiary has elected continuation coverage. The notification will be provided as soon as practicable following the plan administrator's determination that continuation coverage will terminate.

COBRA Continuation Coverage and Medicare

In general, if an employee does not enroll in Medicare Part A or B when first eligible because he/she is still employed, after the Medicare initial enrollment period, the employee has an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

If the employee does not enroll in Medicare and elects COBRA continuation coverage instead, the employee may have to pay a Part B late enrollment penalty and have a gap in coverage if the employee wants Part B later. If the employee elects COBRA continuation coverage and later enrolls in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the employee enrolls in the other part of Medicare after the date of the election of COBRA coverage.

If the employee is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation

coverage will pay second. Certain plans may pay as if secondary to Medicare, even if the employee is not enrolled in Medicare.

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

Other Coverage Options

There may be other coverage options for you and your family through the Health Insurance Marketplace (also known as the Exchange). In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Questions

Employees and/or their dependents should contact the plan administrator at the address or telephone number listed at the end of this Summary Plan Description if they have questions regarding COBRA that are not answered in this Summary Plan Description. They may also visit the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

Keep Plan Administrator Informed of Address Changes

To protect their rights under COBRA, it is important that the employee and the employee's dependents keep the plan administrator informed of any changes in address. They should also keep a copy, for their records, of any notices that are sent to the plan administrator.

Continuation of Health Coverage Upon Military Leave

If an employee ceases to be eligible for health coverage under the Plan due to service in the U.S. military, the employee and his or her eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). The employee and his or her dependents may also be entitled to elect to continue health coverage under COBRA if the employee ceases to be eligible for health coverage due to his or her military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

An employee may elect to continue health coverage under the Plan for himself or herself and his or her eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day the employee is absent from work to perform military service; or

- The period beginning on the first day the employee is absent from work to perform military service and ending with the date the employee fails to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If an employee gives Employer advance notice of a period of military service that will be 30 days or less, the plan administrator will treat the employee's notice as an election to continue health coverage during his or her military service unless the employee specifically informs Employer, in writing, that he or she wants to cancel health coverage during his or her military leave. The employee will have to pay the required premiums for his or her health coverage, but the employee will not have to complete any additional forms or paperwork to continue health coverage during his or her military service.

If an employee gives Employer advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide the employee with a notice of his or her right to elect to continue health coverage pursuant to USERRA and a form for the employee to elect USERRA continuation coverage for himself or herself and his or her eligible dependents. Unlike COBRA, the employee's dependents do not have a separate right to elect USERRA coverage. If the employee wants USERRA continuation coverage for any member of his or her family, the employee must elect it for himself or herself and all eligible dependents who are covered under the Plan when the employee's military service begins.

If an employee chooses USERRA continuation coverage, he or she must return the USERRA election form to the plan administrator within 60 days of the date it was provided to the employee. If the employee does not timely return the election form, USERRA continuation coverage will not be available to the employee and his or her eligible dependents.

A special rule applies if the employee does not give Employer advance notice of his or her military service. In that case, the employee and his or her eligible dependents will not be provided with USERRA continuation coverage during any portion of the employee's military service, but the employee can elect to reinstate health coverage (and the coverage of his or her eligible dependents) retroactive to the first day the employee was absent from work for military service under the following circumstances:

- The employee is excused from providing advance notice of his or her military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for the employee to provide advance notice or the advance notice was precluded by military necessity);

- The employee affirmatively elects to reinstate the coverage; and

- The employee pays all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, the employee's required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If the employee's period of military service is more than 30 days, beginning on the 31st day of his or her military service the employee's required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if the employee does not timely pay any required premiums for health coverage. If the employee's USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated.

The initial premium must be paid within 45 days after the date the employee elects USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the employee initially elects USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of the employee's USERRA continuation coverage.

If the employee complies with USERRA upon returning to active employment after military service, the employee may re-enroll himself or herself and his or her eligible dependents in health coverage immediately upon returning to active employment, even if the employee and his or her eligible dependents did not elect USERRA continuation coverage during the employee's military service. Reinstatement will occur without any waiting periods.

CONVERSION PRIVILEGES

When the employee or one of his or her dependents is no longer eligible under the Plan (either as an active participant, the eligible dependent of an active participant, or as a qualified beneficiary receiving continuation coverage), the employee and/or the employee's dependents may be eligible to obtain an individual conversion policy for one or more fully-insured benefits. The availability of this conversion and the rules concerning eligibility are set forth in the policy with each insurance carrier. See Employer for details. A conversion option is not available for the self-funded benefits.

SPECIAL RULES REGARDING THE HEALTH BENEFITS

There are several special rules that apply to the health benefits under the Plan but do not apply to the welfare or additional benefits. This section summarizes these special rules.

Qualified Medical Child Support Orders ("QMCSO")

Despite any contrary provision in any group health benefit under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a QMCSO. Participants can obtain, without charge, a copy of the Plan's QMCSO procedures from the plan administrator.

Health Care Reform

The medical/prescription drug benefits under the Plan comply, and will continue to comply, with the patient protections of the Patient Protection and Affordable Care Act ("PPACA"), the Health Care and Education Reconciliation Act ("HCERA"), and the Consolidated Appropriations Act, 2021 ("CAA"). Collectively, the PPACA, HCERA, and CAA are known as Health Care Reform. The required changes include the following:

- Dependent children must be eligible to participate in the medical/prescription drug benefits under the Plan until at least the child's 26th birthday. However, Employer has voluntarily extended coverage until the end of the calendar year in which the child turns age 26.

  The dental and vision benefits under the Plan are "excepted benefits" that are not subject to Health Care Reform. However, Employer voluntarily amended the definition of dependent child for purposes of these benefits to align with the definition under the medical/prescription drug benefits. In other words, the dental and vision benefits under the Plan are also extended to dependent children until the end of the calendar year in which the child turns age 26.

- Lifetime limits on the dollar value of essential health benefits under the Plan no longer apply.

- Annual limits on the dollar value of essential health benefits under the Plan no longer apply.

- Coverage may not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation or failure to timely pay required premiums for coverage. Thirty days advance notice may be required before coverage may be retroactively terminated.

- Pre-existing condition limitations or exclusions no longer apply.

- Where a participant is required to have a primary care physician ("PCP"), the participant may designate any participating PCP, including a pediatrician, as the PCP.

- The Plan may not require preauthorization or referral when a participant seeks coverage for obstetric or gynecological care from a participating OB-GYN.

- The Plan is not a grandfathered plan under the PPACA and HCERA. Accordingly, the following additional patient protections under the PPACA and HCERA apply:

    - The Plan must provide certain preventive care items and services without required participant cost-sharing.

    - Maximum out-of-pocket limits are restricted.

    - Certain routine patient costs associated with clinical trials are covered.

    - Participants must be afforded additional rights with respect to internal appeals under the Plan and must be provided with the opportunity to undergo an external review procedure.

- The following patient protections apply with respect to emergency services:

    - The Plan must cover emergency services without requiring you to get approval for emergency services in advance (prior authorization).

    - The Plan must cover emergency services by out-of-network providers.

    - The Plan must base what you owe the provider or facility (your cost-sharing) on the amount that you would pay an in-network provider or facility, and show that amount in the explanation of benefits.

    - The Plan must count any amount you pay for emergency services toward your in-network deductible and out-of-pocket limit.

- The out-of-network provider or facility is not permitted to "balance bill" you for emergency services (see the "No Surprises Act" subsection for more information).

"Emergency services" generally means: (1) an appropriate medical screening that is within the capabilities of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate an "emergency medical condition;" and (2) further medical examination and treatment that is within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, to stabilize you (regardless of the department of the hospital in which such further examination or treatment is furnished).

An "emergency medical condition" generally means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to: (1) place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) result in serious impairment to bodily functions; or (3) result in serious dysfunction of any bodily organ or part.

- If you receive non-emergency services at an in-network hospital or ambulatory surgery center and you are treated by an out-of-network provider, the following patient protections apply (unless you waive these protections):

  - Your cost-sharing requirement for items or services provided by the out-of-network provider may not be greater than the cost-sharing requirement that would apply if the items or services were provided by an in-network provider. Additionally, the Plan generally must base the cost-sharing amount on the lesser of: (1) the amount billed by the out-of-network provider; and (2) the median of the Plan's (or the claim administrator's) contracted rates with in-network providers for the items or services in the same geographic region.

  - The Plan must count any amount you pay for the items or services provided by the out-of-network provider toward your in-network deductible and out-of-pocket limit.

  - The out-of-network provider is not permitted to "balance bill" you for these items or services (see the "No Surprises Act" subsection for more information).

NOTE: Providers of ancillary services are not permitted to ask you to waive these patient protections. Ancillary services currently include the following: (1) emergency medicine, anesthesiology, pathology, radiology, or neonatology (whether provided by a physician or non-physician practitioner); (2) assistant surgeons, hospitalists, and intensivists; (3) diagnostic services (including radiology and laboratory services); and (4) items and services provided by an out-of-network provider when there is no in-network provider available to furnish the items or services.

- If you receive air ambulance services (either by airplane or helicopter) from an out-of-network air ambulance provider, the following patient protections apply:

    - Your cost-sharing requirement for items or services provided by the out-of-network air ambulance provider may not be greater than the cost-sharing requirement that would apply if the items or services were provided by an in-network air ambulance provider. Additionally, the Plan generally must base the cost-sharing amount on the lesser of: (1) the amount billed by the out-of-network air ambulance provider; and (2) the median of the Plan's (or the claim administrator's) contracted rates with in-network air ambulance providers for the items or services in the same geographic region.

    - The Plan must count any amount you pay for the items or services provided by the out-of-network air ambulance provider toward your in-network deductible and out-of-pocket limit.

    - The out-of-network air ambulance provider is not permitted to "balance bill" you for its services.

- If you are a "continuing care patient," you will receive a notice from the Plan that you may elect "transitional care" if an in-network provider or facility that is providing you care leaves the Plan's network for reasons other than the provider's or facility's failure to meet applicable quality standards, or for fraud. If you timely notify the Plan (through the claim administrator) of your need for "transitional care," charges from the provider or facility that moved out-of-network will continue to be paid on an in-network basis, and will be subject to the same terms and conditions that apply in-network for a period of 90 days or, if shorter, the date that you are no longer a "continuing care patient." This 90-day period begins on the date that you receive the notice from the Plan regarding the transitional care.

  You are a "continuing care patient" if you: (1) are undergoing a course of treatment for a "serious and complex" condition; (2) are undergoing a course of institutional care or inpatient care; (3) are scheduled to undergo non-elective surgery, including receipt of postoperative care with respect to the non-elective surgery; (4) are pregnant and undergoing a course of

treatment for the pregnancy; or (5) were determined to be "terminally ill" and are receiving treatment for the terminal illness.

- If you receive items or services from an out-of-network provider or at an out-of-network facility on the belief that the provider or facility was in-network after consulting the Plan's (or claim administrator's) provider directory (which includes a telephone or electronic, web-based, or internet-based response protocol), the following patient protections apply:

    - The Plan is required to limit your cost-sharing to an amount that is no greater than the cost-sharing that would apply under the Plan if the items or services were provided by an in-network provider or at an in-network facility.

    - The Plan must count any amount you pay for the items or services provided by the out-of-network provider or at an out-of-network facility toward your in-network deductible and out-of-pocket limit.

For more information concerning Health Care Reform or any of these required changes, please contact the plan administrator.

No Surprises Act

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than the Plan's copayments, coinsurance, and/or deductible.

What is "Balance Billing" (Sometimes Called "Surprise Billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in the Plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with the Plan (through the Plan's claim administrator) to provide services. Out-of-network providers may be allowed to bill you for the difference between what the Plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward the Plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an

out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are Protected from Balance Billing for the Following Services:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is the Plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in the Plan's network.

When Balance Billing Isn't Allowed

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). The Plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, the Plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "**prior authorization**").

- Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the Department of Health and Human Services at https://www.cms.gov/nosurprises/consumers or 1-800-985-3059. The Department of Health and Human Services will route your complaint to the Department of Labor's Employee Benefits Security Administration.

Visit dol.gov/agencies/ebsa for more information about your rights under federal law.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Health Insurance Portability and Accountability Act

Under the Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, certain privacy and security rules apply to the Plan. Specifically, group health plans and health insurance issuers must make sure that medical information identifying a participant is kept private, must maintain and follow privacy policies and procedures and must notify participants of the privacy policies and procedures. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form. Further, group health plans and health insurance issuers must comply with the changes made to the HIPAA privacy and security rules under the federal law known as HITECH, including, but not limited to, the new breach notification requirements. (See the "HIPAA PRIVACY AND SECURITY RULES" section for further details.)

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 ("FMLA") applies to the Plan during any calendar year when Employer employs 50 or more employees (including part-time employees) each working day during 20 or more calendar weeks in the current or preceding calendar year. Further, the FMLA provisions apply only to eligible employees (i.e., participating employees who have been employed by Employer for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave).

A participant on an FMLA leave may continue health coverage, and all other coverages under the Plan as permitted by Employer, during the leave on the same basis and at the same participant contribution rate as if the employee had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by Employer). However, if the employee takes a leave under the FMLA to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA is 26 weeks per 12-month period. If health coverage ends at the end of an FMLA leave, COBRA continuation coverage is available.

TELEHEALTH

Employees and their family members will also have access to services through TeleHealth. Services include health advocacy, billing error resolution, chronic care solutions, support in making health care and health insurance decisions and pricing transparency tools. More information is available from Human Resources or as follows:

BCBSM at www.bcbsm.com

HealthJoy at www.healthjoy.com

EMPLOYEE ASSISTANCE PROGRAM ("EAP")

The EAP is designed to assist employees in addressing and resolving personal problems. The purpose of the EAP is to provide problem identification, assessment and counseling services. The EAP is considered part of this Plan. The EAP provides employees with referral services and a limited number of outpatient counseling sessions. Employees will receive an additional description of the benefits provided by the EAP provider HealthJoy (CuraLinc) effective on or after September 1, 2023.

WELLNESS PROGRAM

Employer maintains a wellness program that may include health risk assessments and screenings, tobacco cessation programs, weight management programs, targeted condition management programs and preventive screenings. Employees and their spouses may be asked to participate in the wellness program in order to qualify for a reduced premium contribution requirement for group health coverage. Employer will provide participants with additional written materials detailing the wellness program.

HEALTH SAVINGS ACCOUNT ("HSA")

An employee who enrolls in Employer's high deductible health plan ("HDHP") may be eligible to make contributions to an HSA. This section describes the rules concerning HSAs.

What is an HSA?

An HSA is a tax-favored IRA-type account established for an eligible individual. Contributions to an HSA are fully vested when made, and investment earnings are not taxable when earned. Distributions from the HSA are tax-free if they are used to pay qualified health care expenses. Unused benefits can be carried forward and used in future years.

Who is Eligible to Participate in an HSA?

Employees are eligible to establish and make contributions to an HSA upon satisfying two requirements:

- The employee participates in Employer's HDHP (as that term is defined in the Internal Revenue Code) with an annual minimum deductible determined by law; and
- The employee does **not** participate in any health plan that is **not** an HDHP. The employee will **fail** to satisfy this requirement if:
    - The employee participates in a "traditional" health plan (for example, through Employer or a spouse's employer); or

- The employee participates in a medical flexible spending account (for example, through a spouse's employer) that permits reimbursement of all types of medical claims.

  Therefore, if you participate in Employer's qualified HDHP, you and your dependents are not eligible to participate in the medical spending account portion of Employer's Section 125 plan for the entire plan year in which you are enrolled in the HDHP. This is because the medical spending account portion of that plan is an ineligible, non-HDHP for HSA purposes.

Who Administers the Employee's HSA?

An HSA must be held by a trustee or custodian (such as a bank). Employer has selected UMB as the trustee/custodian for the HSA. However, this arrangement will not prohibit the employee from subsequently transferring his or her current HSA balance to another qualified trustee or custodian. If the employee elects to contribute to an HSA, Employer will forward the contributions to the trustee or custodian. The money in the HSA will be invested by the trustee or custodian. The trustee or custodian will provide the employee with more information regarding how the HSA balance will be invested and any election opportunities the employee has with respect to the investments.

What are the Rules for Making HSA Contributions?

IRS rules govern who is eligible to make HSA contributions and the amount that can be contributed each calendar year.

Employees may begin to contribute to an HSA on the first day of the month on or after the date the employee becomes enrolled in Employer's HDHP and is eligible to make HSA contributions.

Employees can make tax-deductible contributions directly to an HSA, or employees can elect to make pre-tax contributions to an HSA through Employer's Section 125 plan, if applicable.

What are the Election Procedures for Making Pre-Tax HSA Contributions?

Employees must make an affirmative election in order to make pre-tax contributions to the HSA through Employer's Section 125 plan. If the employee elects to make pre-tax contributions to an HSA through Employer's Section 125 plan, Employer will directly deposit the contributions with the trustee or custodian of the HSA.

If the employee does not make an affirmative election with Employer before the required date (i.e., initial date of participation in Employer's HDHP), no pre-tax pay reductions will be initially made to the HSA. However, pre-tax pay reductions to the HSA may be made starting as of a subsequent date in accordance with the procedures established by Employer.

Employees can elect to increase, decrease, stop or begin pre-tax HSA contributions at least monthly, as of any prospective date, in accordance with procedures established by Employer.

The ability to make pre-tax contributions to the HSA ends on the date that the employee ceases to meet the eligibility requirements under Employer's Section 125 plan.

Will Employer Make Contributions to Employees' HSAs?

Employer may contribute to employees' HSAs. The amount, if any, provided by Employer will be based on a formula determined by Employer which is permissible under the Internal Revenue Code and communicated to employees during the open enrollment period.

Is There a Limit on HSA Contributions?

The IRS limits the HSA contributions the employee may make each calendar year. The maximum amount depends on whether the employee is enrolled in single/employee-only or family coverage. The maximum may be adjusted each year for changes in the cost-of-living. Employer will inform you what the specific maximum annual contribution amounts are for each calendar year.

If the employee will be at least age 55 by December 31, the maximum annual HSA contribution limit for that calendar year will be increased under a special catch-up rule. The additional catch-up contribution amount is $1,000, regardless of whether the employee is enrolled in single/employee-only or family coverage. This amount may be adjusted in future years for changes in the cost-of-living. Employer will inform you if this catch-up contribution amount changes.

When Do Employees Lose Eligibility to Make HSA Contributions?

If the employee terminates employment, loses or drops coverage under Employer's HDHP, or otherwise becomes ineligible to make HSA contributions (for example, by becoming covered by a medical flexible spending account that reimburses all types of medical claims), the employee will no longer be eligible to contribute to the HSA as of the last day of the month during which the employee terminates employment or otherwise becomes ineligible.

However, if the employee continues to participate in Employer's HDHP (for example, by electing COBRA), the employee may still be eligible to make tax-deductible contributions directly to the HSA.

How Can the Employee Access His or Her HSA Funds?

Once an HSA is established, it may be accessed by following the procedures established by the trustee or custodian. The employee will be issued a debit card for this purpose. Alternatively, the employee will also typically be allowed to submit a written reimbursement request form to the trustee or custodian.

Amounts in the employee's HSA can be distributed to cover the deductible requirements under the HDHP. The employee can also use HSA money to pay for eligible health care expenses not covered by the HDHP. Amounts distributed for health care expenses are tax-free. The employee can also request a distribution for other purposes. For expenses other than eligible health care expenses, the amount distributed is taxable income and is also subject to a 20% penalty tax. But in certain circumstances the 20% penalty tax may be waived (such as for individuals who are disabled or at least age 65).

What if the Employee Changes Jobs?

HSAs are permanent and portable. Employees can take their HSA with them to their next job. The dollars in the HSA account can continue to grow through investment or the employee can use the monies for eligible health care expenses. However, in order to actively continue to contribute to an HSA, the employee must be covered under a qualified HDHP either through his or her new employer or through an individual policy.

What Happens to the HSA after the Employee Turns Age 65?

Employees that are enrolled in Medicare (e.g., are age 65 or older) are not eligible to make or receive contributions to the HSA. After the employee reaches age 65, the HSA can be used to pay eligible health care expenses and certain insurance premiums like Medicare Parts B and D. Monies cannot be used to purchase a Medigap policy. Distributions for eligible health care expenses are tax-free. Distributions for other expenses are taxable.

CLAIM AND APPEAL PROCEDURES

Each insurance carrier is responsible for prescribing the claims procedures to be followed with regard to the benefits provided pursuant to that carrier's policy. The summary plan description, insurance certificates or booklets from the third party administrators and the insurers for a benefit that are coupled with this Summary Plan Description contain a summary of the claims procedures. However, the claims procedures must provide the employee with claims and appeal rights at least as favorable as the following: (Note: The claims procedures for the flexible spending accounts are set forth in the summary plan description for those benefits.)

Initial Decision

A claimant will be notified of a benefit determination as follows:

Urgent Care Health Claims

An urgent care health claim is a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A claimant will be notified of a benefit

determination regarding an urgent care health claim as soon as possible, consistent with the medical exigencies involved, but no later than 72 hours after the Plan's receipt of the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the claimant will be notified within 24 hours after the Plan's receipt of the claim of the information necessary to complete the claim. The claimant will be granted 48 hours to provide the information. The claimant will then be notified of the benefit determination within 48 hours after the earlier of the Plan's receipt of the information or the end of the period granted the claimant to provide the information.

Pre-Service Health Claims

A pre-service health claim is a claim for a benefit which is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. A claimant will be notified of a benefit determination regarding a pre-service health claim within 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be granted 45 days from receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Post-Service Health Claims

A post-service health claim is a claim for a health benefit that is not a pre-service claim or an urgent care claim. If a post-service health claim is denied, in whole or in part, the claimant will be notified of the adverse determination within 30 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will be granted 45 days from the receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Concurrent Care Health Claims

If the Plan has approved an ongoing course of health treatment to be provided over a period of time or over a number of treatments, any reduction or termination by the Plan of that course of treatment (other than by Plan amendment or termination), will constitute an adverse benefit determination. Notice will be provided in accordance with the "Notice of Adverse Benefit Determination" subsection below and will be given at least 30 days before the course of treatment is reduced or terminated in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. Any request to extend a course of treatment for urgent care will be decided as soon as possible and the claimant will be notified of the determination within 24 hours, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed course of treatment for urgent care.

Disability Claims

In deciding a disability claim, the Plan may rely on independent medical or other advice, and require other evidence necessary to decide the claimant's claim for benefits. The Plan will not base decisions regarding the hiring, compensation, termination, promotion, or other similar matters with respect to any individual (e.g., a claims adjudicator, or medical or vocational expert) upon the likelihood that the individual will deny a claimant's claim for benefits.

If a disability claim is denied, in whole or in part, the claimant will be provided with a written notice of adverse benefit determination within a reasonable time, but no later than 45 days after the claim is received. Upon prior notice, this 45-day period may be extended for two additional 30-day periods (a maximum of 105 days) for matters beyond the control of the Plan, or in situations where the claimant's claim for benefits is incomplete.

Other Welfare Claims

If a claim for another welfare benefit (such as group term life/AD&D insurance) is denied, in whole or in part, the Plan must notify the claimant of the adverse benefit determination within 90 days after receipt of the claim, unless the Plan determines that special circumstances require an extension of the time for processing the claim. If the Plan determines that an extension of time for processing the claim is required, written notice of the extension will be furnished to the claimant before the end of the initial 90-day period. In no event will the extension exceed a period of 90 days from the end of the initial period. The extension will indicate the circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Notice of Adverse Benefit Determination

The claimant will be provided with a written or electronic notification of any adverse benefit determination. The notice will set forth the specific reason or reasons for the

adverse benefit determination, refer to the Plan provisions on which the determination is based, and describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a statement will be included in the notice that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request. With regard to disability claims, the notice will include the internal rule, guideline, protocol, standard or other similar criterion, or a statement that such internal rule, guideline, protocol, standard or other similar criterion do not exist.

If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will contain either an explanation of the scientific or clinical judgment for the adverse benefit determination, applying the terms of the Plan to the claimant's medical circumstance, or a statement that such an explanation will be provided free of charge to the claimant upon request.

The notice will also describe the Plan's review procedures and related time limits, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA (a federal law) following an adverse benefit determination on review. For disability claims, any notice of adverse benefit determination on review with respect to a disability claim will also contain the calendar date on which a contractual limitation period to bring a civil action under Section 502(a) of ERISA expires.

For any disability claim, the notice will also contain a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits. Further, if applicable, the notice will contain an explanation for the Plan's basis for disagreeing with (or not following):

- The views, presented by the claimant, of any health care professional treating the claimant, or vocational professional who evaluated the claimant.

- The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether this advice was relied on in making the adverse benefit determination.

- A disability determination presented by the claimant that was made by the Social Security Administration.

Appeal of Denial

Health Claims

The claimant may request a review of an adverse benefit determination regarding a health claim by submitting a written application to the Plan within 180 days following receipt of the denial of the claim. However, in the case of an adverse benefit determination regarding a welfare benefit claim such as group term life or AD&D insurance, the time deadline is 60 days rather than 180 days. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. In addition, with respect to a non-grandfathered health plan subject to Health Care Reform, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under a non-grandfathered health plan subject to Health Care Reform. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination.

In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claimant's claim for benefits. For this purpose, a document, record or other information will be considered relevant if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit. In connection with the appeal of an adverse benefit determination under a non-grandfathered health plan subject to Health Care Reform, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale for the adverse benefit determination. Further, with respect to an appeal of an adverse benefit determination under a non-grandfathered health plan subject to Health Care Reform, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

The appeal procedure will provide for a review that does not rely on the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor is a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involving the judgment. The health care professional engaged for purposes of reviewing the appeal will be an individual who is neither an individual who is consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual. The Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination without regard to whether the advice was relied upon. With respect to a claim under a non-grandfathered health plan subject to Health Care Reform, the Plan will not base

decisions regarding the hiring, compensation, termination or promotion of a claims adjudicator, medical expert or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

In an appeal of an adverse benefit determination regarding an urgent care health claim, a request for an expedited appeal may be made orally or in writing and all necessary information including the Plan's determination on review may be transmitted between the Plan and the claimant by telephone, facsimile or any other available similarly expeditious method.

Disability Claims

If the Plan makes an adverse benefit determination with respect to a claimant's claim for benefits based on a disability, the claimant may appeal the adverse benefit determination to the Plan for a review of the denied claim for benefits. The appeal must be made in writing within 180 days of the initial notice of adverse benefit determination.

The written appeal should state the reasons that the claimant believes the claimant's claim for benefits should not have been denied. It should include any additional facts and/or documents to support the claimant's claim for benefits. The claimant may also ask additional questions and make written comments, and may request access to or copies of (free of charge) all documents, records and other information relevant to the claimant's claim for benefits, without regard to whether such information was submitted or considered during the initial benefit determination.

The individual representative(s) of the Plan who decide(s) the appeal will not be the same individual(s) who decided the initial claim denial, and will not be a subordinate of that(those) individual(s).

The Plan may rely on independent medical or other advice from an expert with appropriate training and experience, and require other evidence necessary to decide an appeal. However, any medical expert consulted in connection with an appeal will be different from any expert consulted in connection with the claimant's initial claim for benefits, and will not be that expert's subordinate. (The identity of any medical expert consulted in connection with an appeal will be provided.) Further, the Plan will not base decisions regarding the hiring, compensation, termination, promotion, or other similar matters with respect to any individual (e.g., claims adjudicator, or medical or vocational expert) upon the likelihood that the individual will support the denial of the claimant's claim for benefits.

Before the Plan may issue an adverse benefit determination on review (i.e., affirm the initial adverse benefit determination), if applicable, the Plan must:

- Provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan during the appeal. The Plan must provide the claimant with this additional information as soon as possible and sufficiently in advance of the

date that the Plan issues the notice of adverse benefit determination on review, so that the claimant has a reasonable opportunity to respond before such date.

- Provide the claimant, free of charge, with any new or additional rationale on which the adverse benefit determination on review is based. The Plan must provide the claimant with this new or additional rationale as soon as possible and sufficiently in advance of the date the Plan issues the notice of adverse benefit determination on review, so that the claimant has a reasonable opportunity to respond before such date.

Final Decision

The Plan will make a decision regarding a request for review as follows:

Urgent Care Health Claims

The claimant will be notified of the Plan's determination on review regarding an urgent care health claim within 72 hours after the Plan's receipt of the claimant's request for a review of an adverse benefit determination.

Pre-Service Health Claims

There will be two levels of appeal for pre-service claims. Both levels of appeal will be conducted by the claim administrator (and the claim administrator will be a Plan fiduciary for this purpose). The claim administrator will notify the claimant of its determination regarding a first level appeal within 15 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level of appeal to the claim administrator within 60 days after receiving written notice of the denial of the first level appeal. If the claimant submits a second appeal, the claim administrator will notify the claimant of its determination regarding a second level appeal within 15 days after receipt of the claimant's request of a second level review of an adverse benefit determination.

Post-Service Health Claims

There will be two levels of appeal for post-service claims. Both levels of appeal will be conducted by the claim administrator (and the claim administrator will be a Plan fiduciary for this purpose). The claim administrator will notify the claimant of its determination regarding a first level appeal within 30 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level of appeal to the claim administrator within 60 days after receiving written notice of the denial of the first level appeal. If the claimant submits a second appeal, the claim administrator will notify the claimant of its determination regarding a second level

appeal within 30 days after receipt of the claimant's request of a second level review of an adverse benefit determination.

Disability Claims

The claimant will be notified of the Plan's determination on review regarding a disability claim within 45 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination, unless the Plan determines that special circumstances require an extension of time for processing the appeal. If the Plan determines that special circumstances (e.g., additional information is required to complete the review of the appeal) require, the Plan may, with prior written notice, extend the review period for up to an additional 45 days (a maximum 90 days). The written notice of the extension will include an explanation of the special circumstances requiring the extension, and the time and date that the Plan expects to decide the appeal.

Other Welfare Claims

The claimant will be notified of the Plan's determination on review regarding a welfare benefit claim such as group term life insurance within 60 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination unless the Plan determines its special circumstances require an extension of time for processing the appeal. If the Plan determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 60-day period. In no event will an extension exceed a period of 60 days from the end of the initial period. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected to be made.

External Review

If the claimant has exhausted the internal appeal procedure with regard to the non-grandfathered health benefits that are subject to Health Care Reform, the claimant may submit a request for an external review with respect to a denied claim. If you think that the Plan has violated the patient protections under the No Surprises Act (see the "No Surprises Act" subsection), that determination may also be eligible for external review. The external review procedure must comply with the requirements of Health Care Reform. If the non-grandfathered health benefits are fully-insured, the requisite external review procedure will be prescribed by applicable state insurance law (if the state insurance law procedure complies with the external review procedure requirements of Health Care Reform). Otherwise, the procedure described in the balance of this section will apply. The primary type of external review is a standard external review. A claimant must file a request for a standard external review within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination.

Within five business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether:

- The claimant had coverage under the Plan at the time the service or supply was provided;

- Whether the claimant has exhausted the Plan's internal appeal process unless not required to do so as described above; and

- Whether the claimant has provided all information and forms necessary to process the external review.

Within one business day after completing the preliminary review, the Plan will issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In such case, the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If the Plan determines that an adverse benefit determination or final internal adverse benefit determination is eligible for external review, the Plan will assign the external review to an independent review organization ("IRO") that is accredited by URAC or by a similar nationally recognized accrediting organization. The Plan will take action against bias and to ensure independence. Contracts will be in place with at least three IROs. External reviews will be rotated among the IROs. In addition, an IRO will not be eligible for any financial incentive based on the likelihood that the IRO will support the denial of benefits.

- The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. In order to be eligible for external review, the adverse benefit determination or final internal adverse benefit determination must involve a medical judgment or rescission of coverage. The IRO will make this determination when considering the request's eligibility for external review. If accepted, the notice will include a statement that the claimant may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information for the IRO to consider when conducting the external review.

- Within five business days after the date of the assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

- Upon any receipt of any information submitted by the claimant, the IRO must, within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit

determination or final internal adverse benefit determination. The external review may be terminated as a result of the reconsideration only if the Plan reverses its adverse benefit determination or final internal adverse benefit determination and provides coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan.

- The IRO will review all the information and documents timely received. In reaching a decision the assigned IRO will review the claim "de novo" (i.e., anew) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider additional documents and information in conducting the external review including the claimant's medical records, the attending health care professional's recommendation, reports from appropriate health care professionals and other documents submitted by the Plan, claimant or claimant's treating provider, the terms of the Plan, appropriate practice guidelines (including applicable evidence-based standards), any applicable clinical review criteria developed and used by the Plan, unless inconsistent with the terms of the Plan or applicable law, and the opinion of the IROs clinical reviewer(s).

- The IRO must provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of its final external review decision to the claimant and the Plan.

- The IRO's decision notice will contain a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date(s) of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial), the date the IRO received the assignment to conduct the external review and date of the IRO decision, references to the evidence or documentation considered in reaching its decision, a discussion of the principal reason(s) for its decision, a statement that the determination is binding except to the extent that other remedies may be available under state or federal law, a statement that judicial review may be available, and current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.

- After a final external review, the IRO must maintain records of all claims and notices associated with the external review for six years. The IRO must make such records available for examination by the claimant, Plan or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of final external review reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment in connection with the claim.

The second type of external review is an expedited external review. The Plan must allow a claimant to make a request for an expedited external review in two situations. First, an expedited external review is available where the claimant has received an adverse benefit determination and it involves a medical condition of the claimant for which the time frame for completing an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited external appeal. Second, an expedited external review is available where the claimant has received a final internal adverse benefit determination and the claimant has a medical condition where the time frame for completing a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged for a facility.

- Immediately upon the receipt of a request for an expedited external review, the Plan must determine whether the request meets the review ability requirements set forth above for a standard external review. The Plan must immediately send a written notice that meet the requirements set forth above for a standard external review to the claimant regarding its eligibility determination.

- Upon a determination that the request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for a standard external review. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the same procedures for a standard external review. In reaching a decision, the IRO must review the claim "de novo" (i.e., anew) and is not bound by any decisions or conclusions reached during the Plan's internal claim and appeals process.

- The IRO will provide notice of its decision in the same manner as a standard external review and will do so as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Legal Actions

No legal action may be brought to recover benefits under the Plan until the participant has exhausted the claim review procedure. Further, with respect to the self-funded benefits under the Plan, no legal action may be brought after the expiration of one year after the participant has been provided with a written notice denying the final level of Plan appeal concerning a claim and must be brought in the Federal District Court for the Western District of Michigan. If the Plan fails to strictly adhere to the internal claim and appeal procedures described above with respect to a claim under a non-grandfathered health plan subject to Health Care Reform, the claimant will be deemed to have exhausted the internal claim and appeal procedures and as a result, may initiate an external review and/or file a legal proceeding. However, this rule will not apply to minor, de minimis violations.

Special Rules Regarding the Wellness Program

Employees may elect to participate in the wellness program. Furthermore, employees and their spouses may be asked to participate in the wellness program in order to qualify for a reduced premium contribution requirement for group health coverage or for wellness incentives. For additional details, participants should refer to the wellness document provided by Employer. A claimant who believes that a benefit under the wellness program is being denied, in whole or in part, can submit an appeal to the plan administrator. The appeal must be submitted in writing within 180 days following any adverse benefit determination. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial review. In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of all documents, records or other information relevant to his or her claim for benefits.

The appeal procedure will provide for a review that does not defer to the initial benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial determination nor a subordinate of that individual.

The plan administrator will notify the claimant of the Plan's determination on review within 60 days after the Plan's receipt of the request for a review of a benefit determination. If adverse, the notice will set forth the specific reason or reasons for the determination, refer to the specific Plan provisions on which the determination is based and describe any additional material information for the claimant to perfect the claim. The notice will also include a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA. If the determination was based upon an internal rule, guideline, protocol or similar criteria, a copy will be provided to the claimant free of charge upon request. No legal action may be brought to recover benefits under the Plan until the claimant has exhausted this appeal procedure. Further, no legal action may be brought after the expiration of one year the claimant has been provided with a written notice denying the Plan's appeal concerning a wellness program claim.

ADMINISTRATION

Plan Sponsor is the plan administrator. The plan administrator is the designated named fiduciary and is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan.

With respect to the self-funded benefits, Plan Sponsor, as the plan administrator, has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the Plan. However, the plan administrator may delegate claims administration for some or all of the self-funded benefits to a third party administrator. Such a third party administrator may be a named fiduciary for benefit appeals pursuant to the applicable benefit.

The fully-insured benefits are provided pursuant to an insurance policy and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy. The insurers are the exclusive source of payment for the fully-insured benefits.

AMENDMENT OR TERMINATION

Although Plan Sponsor intends to maintain the Plan indefinitely, Plan Sponsor has the authority to amend or terminate the Plan or any benefit at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits. Participants will be informed of any material amendment affecting their benefits or changing the operation of the Plan.

HIPAA PRIVACY AND SECURITY RULES

This section applies to the health benefits under the Plan and is required by the privacy and security rules of HIPAA.

Permitted and Required Uses and Disclosure of Protected Health Information ("PHI")

Subject to obtaining written certification (see below), the Plan may disclose PHI to Plan Sponsor, provided Plan Sponsor does not use or disclose such PHI except for the following purposes:

- Performing Plan Administrative Functions which Plan Sponsor performs for the Plan.
- Obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan; or
- Modifying, amending or terminating the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event will Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Conditions of Disclosure

Plan Sponsor agrees that with respect to any PHI, it will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Plan Sponsor with respect to PHI.

- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor.

- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.

- Make available to a participant who requests access, the participant's PHI in accordance with 45 CFR §164.524.

- Make available to a participant the right to request an amendment to the participant's PHI and incorporate any amendments to the participant's PHI in accordance with 45 CFR §164.526.

- Make available to a participant who requests an accounting of disclosures of the participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

- Make its internal practices, books, and records, relating to the use and disclosures of PHI received from the Plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy rules.

- If feasible, return or destroy all PHI received from the Plan that Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure that the adequate separation between Plan and Plan Sponsor, required in 45 CFR §164.504(f)(2)(iii), is satisfied and that terms set forth below are followed.

- Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and Plan Sponsor will ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware.

Certification of Plan Sponsor

The Plan will disclose PHI to Plan Sponsor only upon the receipt of a certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Plan Sponsor agrees to the conditions of disclosure set forth above.

Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to Plan Sponsor, provided such Summary Health Information is only used by Plan Sponsor for the purpose of:

- Obtaining premium bids from health plan providers for providing health coverage under the Plan; or

- Modifying, amending or terminating the Plan.

Adequate Separation Between Plan and Plan Sponsor

- The employees, or classes of employees, listed in Plan Sponsor's HIPAA privacy policies and procedures will be given access to PHI.

- The access to and use of PHI by the individuals described above will be restricted to the Plan Administrative Functions that Plan Sponsor performs for the Plan.

- In the event any of the individuals described above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the plan administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written

warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

- To comply with the HIPAA security rules, Plan Sponsor will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

Disclosure of Certain Enrollment Information to Plan Sponsor

Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any health insurance issuer or health maintenance organization offered by the Plan.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

Plan Sponsor authorizes and directs the Plan, through the plan administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the HIPAA privacy rules.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the HIPAA privacy rules.

Definitions

For purposes of this section, the following terms have the following meanings:

- **"Business Associate"** means a person or entity who:
  - Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.); or
  - Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.
- **"Plan Administrative Functions"** mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administrative functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-plans–such as dental. PHI for these purposes may not be used by or between the Plan or business associates of the Plan in a manner

inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan administrative functions specifically do not include any employment-related functions.

- **"Protected Health Information"** or **"PHI"** means information that is created or received by the Plan, or a business associate of the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant (whether living or deceased). The following components of a participant's information are considered to enable identification:

    - Names;
    - Street address, city, county, precinct, zip code;
    - Dates directly related to a participant's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death;
    - Telephone numbers, fax numbers and electronic mail addresses;
    - Social Security numbers;
    - Medical record numbers;
    - Health plan beneficiary numbers;
    - Account numbers;
    - Certificate/license numbers;
    - Vehicle identifiers and serial numbers, including license plate numbers;
    - Device identifiers and serial numbers;
    - Web Universal Resource Locators (URLs);
    - Biometric identifiers, including finger and voice prints;
    - Full face photographic images and any comparable images; and
    - Any other unique identifying number, characteristic or code.

- **"Summary Health Information"** means information that may be individually identifiable health information:

    - That summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Employer has provided health benefits under a health plan; and

    - From which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

Fully-Insured Health Plans Administered Under "Hands Off" Approach

Pursuant to HIPAA, if a group health plan is fully-insured and only enrollment/ disenrollment information and Summary Health Information rather than Protected Health Information is disclosed to Plan Sponsor and Plan Sponsor only uses the Summary Health Information to obtain premium bids and/or to amend/terminate the Plan, then the responsibility to comply with the HIPAA privacy rules generally shifts from the Plan to the insurer. This is known as the "hands off" approach to administration. Any fully-insured health benefits under the Plan which are administered under the hands off approach will not otherwise be subject to the HIPAA privacy and security rules set forth in this Article (i.e., simply because they are included in the Plan for Form 5500 filing purposes).

Hybrid Entity

To the extent the Plan provides any non-health benefits such as (but not limited to), disability benefits or group term life insurance benefits, those benefits will be considered "non-covered functions." The Plan is a separate legal entity whose business activities include the functions covered by the HIPAA privacy and security rules and non-covered functions. As a result, the Plan is a hybrid entity, as that term is defined in HIPAA. The Plan's covered functions are its health benefits ("health care component"). All other benefits are non-covered functions. Therefore, the Plan hereby designates that it will only be a covered entity under the HIPAA privacy and security rules with respect to the health care component (the health benefits) of the Plan.

GOVERNING LAW

The Plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), as well as other various federal laws, including, but not limited to, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, HIPAA, FMLA, COBRA, USERRA and Health Care Reform, as well as certain state insurance laws. (However, this document refers to HSAs and dependent care flexible spending accounts that are not subject to ERISA.)

To the extent not preempted by the federal law known as ERISA, the Plan will be interpreted under the laws of the state of Michigan. Further, state laws apply to the Plan's fully-insured health benefits. For example, some states mandate that certain benefits be provided under a group health insurance policy or may impose dependent eligibility requirements which are broader than federal

law. Further, some states maintain laws which are similar to federal laws like COBRA and the HIPAA privacy rules but which require additional protections for participants.

FORM 5500

The health and welfare benefits described in this Plan (except for the non-ERISA benefits) will be considered a single plan for purposes of satisfying any obligation to file an annual Form 5500.

PLAN PARTICIPANTS' RIGHTS

Notwithstanding anything to the contrary in a booklet or certificate, participants in the Plan are entitled to certain rights and protections under ERISA with respect to the benefits under the Plan that are subject to ERISA.

Information About the Plan and its Benefits

ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the plan administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if 100 or more participants, 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, any updated Summary Plan Description and, if 100 or more participants, a copy of the latest annual report (Form 5500 Series). The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report if there are 100 or more participants in the Plan and the Plan is not funded solely through Employer's general assets. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for themselves, spouses or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Participants or their dependents may have to pay for such coverage. Participants should review the rules governing COBRA continuation coverage rights described elsewhere in this Summary Plan Description.

Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called

"fiduciaries" of the Plan, have a duty to do so prudently in the interest of the Plan participants and beneficiaries. No one, including Employer, or any other person, may fire a participant or otherwise discriminate against the participant in any way to prevent the participant from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcement of Rights

If a participant's claim for a welfare benefit is denied or ignored, in whole or in part, the participant has 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 limits.

Under ERISA, there are steps participants can take to enforce the above rights. For instance, if a participant requests materials from the plan administrator and does not receive them within 30 days, the participant may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay the participant up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If the participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in a state or federal court. In addition, if the participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the participant may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the participant is discriminated against for asserting his or her rights, the participant may seek assistance from the U.S. Department of Labor, or the participant may file suit in federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person the participant sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees, for example, if it finds the participant's claim is frivolous.

Assistance With Questions

If the participant has any questions about the Plan, he or she should contact the plan administrator. If the participant has any questions about this statement ("PLAN PARTICIPANTS' RIGHTS") or about his or her rights under ERISA, or needs assistance in obtaining documents from the plan administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. The participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or viewing its website at www.dol.gov/ebsa.

OTHER BASIC INFORMATION ABOUT THE PLAN

Name of Plan:	Schupan & Sons, Inc. Welfare Benefit Plan
Name, Address, Telephone Number and Taxpayer Identification Number of Plan Sponsor:	Schupan & Sons, Inc. 2619 Miller Road Kalamazoo, MI 49001 (269) 382-0000 38-2116904
Plan Number:	502
Type of Plan:	Welfare Benefit Plan providing medical/prescription drug, dental, vision, group term life/AD&D, short-term disability, long-term disability, voluntary term life, whole life, accident, hospital indemnity and critical illness benefits, EAP, wellness program, medical flexible spending accounts, and TeleHealth (BCBSM and HealthJoy (Teledoc)) benefits. Employer also provides dependent care flexible spending accounts and HSAs which are not subject to ERISA and technically are not part of this Plan.
Type of Administration:	The Plan is administered by the plan administrator. With respect to each self-funded benefit, the plan administrator may retain the services of a third party administrator to provide administrative services. With respect to each fully-insured benefit, the insurer provides administrative services.
Plan Administrator:	Plan Sponsor
Agent for Service of Legal Process:	Chief Financial Officer Schupan & Sons, Inc. 2619 Miller Road Kalamazoo, MI 49001 Service of legal process may also be made on the plan administrator.

COBRA Administrator:	Paycom 7501 W Memorial Rd Oklahoma City, OK 73142 (800) 580-4505
Claim Administrators/Insurers:	**For Self-Funded Medical/Prescription Drug Benefits:** Blue Cross Blue Shield of Michigan **For the Self-Funded Dental Benefits:** Delta Dental **For the Fully-Insured Vision Benefits:** EyeMed **For Fully-Insured Group Term Life/AD&D, Short-Term and Long-Term Disability and Voluntary Term Life Benefits:** Mutual of Omaha **For Fully-Insured Voluntary Whole Life, Accident, Hospital Indemnity and Critical Illness Benefits:** Trustmark **For Medical and Dependent Care Flexible Spending Account Claims Under the Section 125 Plan:** Flex Administrators **For Wellness Program Benefits:** Health Plan Advocate **For Employee Assistance Program Benefits:** HealthJoy (CuraLinc) effective September 1, 2023 **For TeleHealth Benefits:** BCBSM and HealthJoy (Teledoc)

	See booklets for addresses and telephone numbers of claim administrators and insurers.
Plan Year for Fiscal Record Purposes:	January 1 through December 31 However, the Plan may maintain a different 12-month period for other purposes. For example, insurance policies may renew based on a different 12-month cycle, participants may make annual benefit elections on a different 12-month cycle and the period of coverage for deductibles, annual out-of-pocket limits and other annual benefit provisions may operate on a different 12-month period.

Schupan Sons Inc. Welfare Benefit Plan SPD (2023)

Final Audit Report 2023-09-07

Created:	2023-09-07
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