CSM Corporation

CSM Corporation
500 Washington Ave S Suite 3000
Minneapolis, MN 55415

CSM Corporation Wrap Plan

Summary Plan Description

Amended and Restated January 01, 2022

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I. SUMMARY PLAN DESCRIPTION SUPPLEMENT

This document and the certificates issued with respect to the Welfare Programs described herein (the "Certificates") together comprise the Summary Plan Description (SPD) for the CSM Corporation Wrap Plan (the "Plan"). If the terms of this document conflict with the terms of the Certificates, then the terms of the Certificates will control, unless otherwise required by law.

The SPD summarizes your rights and obligations as a participant (or beneficiary) in the Plan. It is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded to you by the Plan or any applicable state law not pre-empted by ERISA, those legal rights supersede the rights set forth in the SPD.

GENERAL INFORMATION

NAME OF PLAN:

CSM Corporation Wrap Plan

PLAN SPONSOR:

CSM Corporation
500 Washington Ave S Suite 3000
Minneapolis, MN 55415

The Plan Sponsor is sometimes referred to as the " ***Company***."

EMPLOYER IDENTIFICATION NUMBER:

41-1320338

PLAN NUMBER:

501

PLAN ADMINISTRATOR:

CSM Corporation
500 Washington Ave S Suite 3000
Minneapolis, MN 55415

TYPE OF PLAN:

CSM Corporation Wrap Plan including Medical, Dental, Vision, Basic Life, Long Term Disability, Voluntary Life, Accident Insurance, Critical Illness Insurance, Flex Spending Account and Hospital Indemnity benefits.

PLAN YEAR:

Other than any applicable short plan year, the Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 01 and ends on December 31.

CLAIMS ADMINISTRATION:

Claims for benefits are administered by the respective companies set forth at Appendix A that include but are not limited to: Medical, Dental, Vision, Basic Life, Long Term Disability, Voluntary Life, Accident Insurance, Critical Illness Insurance, Flex Spending Account and Hospital Indemnity.

AGENT FOR SERVICE OF LEGAL PROCESS:

CSM Corporation
500 Washington Ave S Suite 3000
Minneapolis, MN 55415

You may also serve legal process on the Plan Administrator or any successor in title or office of the current registered agent of the company.

TYPE OF ADMINISTRATION:

Some benefits under the Plan are fully insured and are paid pursuant to the terms of insurance policies

issued by insurance companies.

Other benefits are self-funded and are paid from the general assets of the Sponsor. The Sponsor has entered into contracts with third party vendors to assist the Sponsor in administering self-funded benefits.

ELIGIBILITY:

The eligibility and participation requirements for each Welfare Program are stated in the applicable Policy or Welfare Program document. Where the eligibility and/or participation requirements are not stated in the Policy or Welfare Program document, the eligibility and/or participation requirements stated in this SPD and the Plan Document shall control, as otherwise set forth below:

You will generally be eligible to participate in the Plan if you are a full-time employee regularly scheduled to work at least 30 hours per week ("full-time Employee").

Other individuals, such as an Eligible Employee's spouse, children, or other designated member, may be eligible to participate in and receive benefits under one or more of the Welfare Programs due to their relationship to an Eligible Employee. Information about such eligibility and coverage is found in the applicable Policy or Welfare Program Documents.

If you are an Employee who (i) is classified as a "Variable Employee" (i.e., a variable hour, seasonal or part-time Employee of the Employer or another class of Employee other than a "full-time Employee"), and (ii) averages at least 30 hours per week or 130 hours per month during a "Measurement Period" determined consistent with the Patient Protection and Affordable Care Act ("PPACA"), you will generally be eligible to participate in the medical and other Welfare Program provided under this Plan for not less than 6 months and no more than 12 months "Stability Period", and you will be eligible to enter the Plan following a 90 day "Administrative Period" determined by the Plan Administrator.

However, plan entry will be no later than the first day of the month coinciding with or next following an administrative period, not to exceed the first day of the month following the 13th full month of employment.

The initial "measurement period" will be the first full Twelve (12) months of your employment with the Employer measured from the day of the month coinciding with or next following your date of hire.

The standard "measurement period" shall mean the Twelve (12) month period beginning on October 05 and ending October 04 of each year, which period may overlap with your initial measurement period.

If you are a participant, terminate employment, and are rehired, you will generally be eligible to reenter the Plan when you once again meet the Plan's eligibility requirements, subject to special rules if you incur a "break-in-service" of less that 13-weeks.

Once eligible, if you do not properly and timely enroll as required by the Plan Administrator (or upon subsequent eligibility upon rehire), you will be deemed to have declined coverage for the period following any eligibility to participate in the Plan, and shall be required to wait until the next open enrollment period to elect to participate in the Plan and corresponding Welfare Program benefits.

If you have any questions about the rehiring process as it relates to your benefits, please ask the Plan Administrator for more detail.

You will enter the plan on 1st of the month following or coinciding with 30 days of employment.

A reemployed former Participant shall again be eligible to become a Participant in the Plan when the Participant again satisfies the requirements set forth in the Section titled: "Eligibility and Participation".

AMENDMENT AND TERMINATION:

The CSM Corporation Wrap Plan (the "Plan Document") contains all the terms of the Plan and may be amended from time to time at its sole discretion by your Employer. Any changes made shall be binding on each Covered Participant and any other Covered Persons referred to in the Plan Document.

The Booklet will disclose any Plan provisions governing your benefits, rights and obligations upon plan termination or the amendment or elimination of benefits under the Plan.

NO CONTRACT OF EMPLOYMENT:

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the companies listed below to the effect that you will be employed for any specific period of time.

BENEFITS AND ADMINISTRATION:

The Plan provides benefits for eligible employees and covered dependents as administered under policies of insurance as listed in Appendix A that include but are not limited to: Medical, Dental, Vision,

Basic Life, Long Term Disability, Voluntary Life, Accident Insurance, Critical Illness Insurance, Flex Spending Account and Hospital Indemnity. These Welfare Programs are insured or administered by the companies also listed in Appendix A and are generally described in the Plan Document. The administrative functions include paying claims and determining medical necessity.

Replacements for lost or misplaced copies of the Plan Document may be obtained by writing to the Plan Administrator. Notification will be given of changes in benefits that may occur from time to time.

Please refer to the Plan Document for a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits.

II. SUMMARY OF PLAN BENEFITS

The Plan provides you and your eligible dependents with the coverages summarized in Appendix A. A summary of the benefits provided under the Plan is set forth in the certificates issued by the insurance companies.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

WOMEN'S HEALTH CANCER RIGHTS ACT:

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

1. All stages of reconstruction of the breast upon which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications during all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits under this Plan.

LOSS OF BENEFITS:

The provisions regarding termination of coverage and limitations and exclusions of benefits that may result in reduction or loss of benefits are explained in the Welfare Benefit Booklet.

CONTRIBUTIONS:

Contributions to the Plan are provided by the Employer and Employees. Employee contributions are made via automatic payroll deductions. The Plan Administrator will provide a schedule of the applicable premiums during open enrollment periods and upon request.

HOW TO RECEIVE YOUR BENEFITS:

This information is explained in the article entitled "CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS" or "CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA" as the case may be.

BENEFIT-SPECIFIC INFORMATION:

Please refer to the appropriate insurance policies and/or summaries of coverage for the following information:

- A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which you or a beneficiary will be responsible;
- Any annual or lifetime caps or other limits on benefits under the Plan;
- The extent to which preventative services are covered under the Plan;
- Whether, and under what circumstances, existing and new drugs are covered under the Plan;
- Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers;
- The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;

- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care; and
- Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

III. CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. ***To the extent that a claims procedure is not prescribed for a self-funded Welfare Program, and the self-funded Welfare Program is not subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section shall apply with respect to such self-funded Welfare Program.*** If the self-funded Welfare Program is subject to PPACA, the claims procedure applicable to such self-funded Welfare Program is described in the section entitled "Claims Procedure for Plans Subject to PPACA."

A "claim" is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

NON-GROUP HEALTH & DISABILITY CLAIMS PROCEDURES:

1. **Time for Decision on a Claim.** A claim shall be filed in writing with the Plan Administrator and decided within 45 days by the Plan Administrator. If special circumstances require an extension of time to review the claim, a maximum of two 30- day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

2. **Notification of Adverse Determination.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

    ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse benefit determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and a description of any limitation period within which the suit must be filed including the exact date the limitation period ends; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts

whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and (8) 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.

In the case of a claim for disability benefits filed under this Plan after April 1, 2018, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

3. **Right to Review.** A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant’s right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Plan Administrator to consider.

4. **Review Procedures.** During the review process, the Plan Administrator will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall 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; (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on any new or additional evidence, such evidence will be provided to the claimant sufficiently in advance of the date on which the notice of adverse benefit determination on review is to be provided, so as to give the claimant reasonable opportunity to respond to the new evidence prior to that date; (vi) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vii) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (viii) that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

5. **Time for Decision on Review.** Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension may be for up to 45 additional days.

6. **Notification of Determination on Review.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) 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; (4) a statement describing

any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) 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; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan.

7. **Legal Remedies.**

i. A suit under Section 502(a) of ERISA may be filed only after these review procedures have been exhausted and only if filed within the earlier of 90 days or a limitation period listed in the plan, after the final decision is provided.

ii. If the Plan fails to strictly adhere to these claims review procedure requirements with respect to a claim for disability benefits filed under this Plan after April 1, 2018, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except as provided in the paragraph below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

iii. Except as provided in the paragraph above, the administrative remedies available under the Plan with respect to a claim for disability benefits filed under this Plan after April 1, 2018, will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the

violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

GROUP HEALTH CLAIMS PROCEDURES:

1. **Pre-Service Claim Determinations.** When a covered person requests a medical necessity determination prior to receiving care, the Claims Administrator (as defined in the Plan) will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Administrator's control, the Claims Administrator will notify the individual of this fact within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

   If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain which cannot be managed without the requested services, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator will notify the covered person of the expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Supervisor will notify the individual within 24 hours after receiving the request, specifying what information is needed. The covered person must provide the specified information to the Claims Supervisor within a reasonable amount of time, not to exceed 48 hours. The Claims Supervisor will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

   If the covered person fails to follow the Claims Supervisor's procedures for requesting a pre-service medical necessity determination, the Claims Administrator will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

2. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Administrator shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

   When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Administrator will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

3. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Supervisor will notify the individual of that fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

4. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be

provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

5. **Appeal of Denied Claim.**

    1. **First Level of Appeal.** If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

        The Claims Administrator's review will be processed in accordance with the following time frames:

        1. 72 hours in the case of an urgent care claim;
        2. 30 days in the case of a pre-service claim;
        3. before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment;
        4. 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or
        5. 60 days in the case of a post-service claim.

    2. **Second Level Of Appeal.** If, after exhausting the first level appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the claimant has first exhausted the claims procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

        The Employer may require submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

        The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth above.

        After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law. A deemed exhaustion, however, does not occur if violations of the claims review process are de minimis, violations that do not cause, and are not likely to cause prejudice or harm to the claimant so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between the claimant and the Plan Administrator, claims administrator or Named Fiduciary.

6. **Notice of Benefit Determination on Appeal.** Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information (as defined below); (4) a statement describing any voluntary appeal procedures offered by the Plan and any claimant's right to bring

an action under ERISA Section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency.

Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

7. **Review Procedures on Appeal.** In the conduct of any review, the following will apply:

    1. No deference will be afforded to the initial adverse determination;

    2. The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

    3. In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

    4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

    5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual; and

    6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

IV. CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. ***To the extent that a claims procedure is not prescribed for a Welfare Program, and the Welfare Program is subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section shall apply with respect to such Welfare Program.*** If the Welfare Program is not subject to PPACA, the claims procedure applicable to such Welfare Program is described in the section entitled "Claims Procedure for PPACA Exempt Plans."

A "claim" is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

NON-GROUP HEALTH & DISABILITY CLAIMS PROCEDURES:

1. **Time for Decision on a Claim.** A claim shall be filed in writing with the Plan Administrator and decided within 45 days by the Plan Administrator. If special circumstances require an extension of time to review the claim, a maximum of two 30- day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

2. **Notification of Adverse Determination.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

    ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse benefit determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and a description of any limitation period within which the suit must be filed including the exact date the limitation period ends; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse

benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and (8) 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.

In the case of a claim for disability benefits filed under this Plan after April 1, 2018, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

3. **Right to Review.** A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant’s right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Plan Administrator to consider.

4. **Review Procedures.** During the review process, the Plan Administrator will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall 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; (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on any new or additional evidence, such evidence will be provided to the claimant sufficiently in advance of the date on which the notice of adverse benefit determination on review is to be provided, so as to give the claimant reasonable opportunity to respond to the new evidence prior to that date; (vi) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vii) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (viii) that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

5. **Time for Decision on Review.** Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension may be for up to 45 additional days.

6. **Notification of Determination on Review.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) 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; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the

information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) 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; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan.

7. **Legal Remedies.**

i. A suit under Section 502(a) of ERISA may be filed only after these review procedures have been exhausted and only if filed within the earlier of 90 days or a limitation period listed in the plan, after the final decision is provided.

ii. If the Plan fails to strictly adhere to these claims review procedure requirements with respect to a claim for disability benefits filed under this Plan after April 1, 2018, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except as provided in the paragraph below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

iii. Except as provided in the paragraph above, the administrative remedies available under the Plan with respect to a claim for disability benefits filed under this Plan after April 1, 2018, will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including

a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

GROUP HEALTH CLAIMS PROCEDURES:

1. **Pre-Service Claim Determinations.** When a covered person requests a medical necessity determination prior to receiving care, the Claims Administrator will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Administrator’s control, the Claims Administrator will notify the individual of that fact within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

   If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person’s health condition, would cause severe pain which cannot be managed without the requested services, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator will notify the covered person of the expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Administrator will notify the individual within 24 hours after receiving the request specifying what information is needed. The covered person must provide the specified information to the Claims Administrator within a reasonable amount of time not to exceed 48 hours. The Claims Administrator will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

   If the covered person fails to follow the Claims Supervisor’s procedures for requesting a pre-service medical necessity determination, the Claims Administrator will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

2. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Administrator shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

   When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Administrator will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

3. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator’s control, the Claims Supervisor will notify the individual of that fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice or 45 days after the covered person's receipt of the notice.

4. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be provided in writing or electronically in a culturally and linguistically appropriate manner calculated

to be understood by the claimant, as required by law, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) a description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim; and (8) the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

5. **Appeal of Denied Claim.**

    1. **First Level of Appeal.** If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

        The Claims Administrator's review will be processed in accordance with the following time frames: (a) 72 hours in the case of an urgent care claim; (b) 30 days in the case of a pre-service claim; (c) before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment; (d) 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or (e) 60 days in the case of a post-service claim.

    2. **Second Level Of Appeal.** If, after exhausting the first level appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the claimant has first exhausted the appeal procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

        The Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

        The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth above.

        After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article VII, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law.

6. **Notice of Benefit Determination on Appeal.** Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (5) a statement describing any voluntary appeal procedures offered by the Plan; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (7) a statement that claimant may have other voluntary alternative dispute resolution options such as

mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office or state insurance regulatory agency.

Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

"Relevant Information" is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

7. **Review Procedures on Appeal.** In the conduct of any review, the following will apply:

    1. No deference will be afforded to the initial adverse determination;

    2. The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

    3. In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

    4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

    5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual;

    6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method; and

    7. The claimant will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

8. **External Claims Procedure.** After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the Plan a request for an external review, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the Plan is not eligible for the external review process. A claimant may request from the Plan Administrator additional information describing the Plan's external review procedure.

V. WHEN COVERAGE MAY BE CONTINUED

You and your covered dependents may continue your medical coverage under this Plan under certain circumstances, according to the terms of your employer's Leave of Absence Policy, the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment And Reemployment Rights Act (USERRA), and the Consolidated Omnibus Budget Reconciliation Act (COBRA). Medical coverage for yourself and your covered dependents may be continued if you cease active work because of an approved medical, family, personal, or military leave of absence or if your employment with the Company ends.

COBRA CONTINUATION OPTIONS:

To the extent a description of COBRA rights is not provided for a Welfare Program, the following applies:

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Are there other coverage options?

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (the "Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Please note that certain excepted benefits such as health flexible spending accounts, integrated health reimbursement arrangements, or standalone vision or dental plans will not be offered under the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a Covered Employee, the spouse of a Covered Employee, or a dependent child of a Covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "Covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility for these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a Covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding sentence, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a Covered

Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a Covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a Covered Employee's employment.
3. The divorce or legal separation of a Covered Employee from the Employee's spouse. If the Employee reduces or eliminates the Employee's spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. A Covered Employee's enrollment in any part of the Medicare program.
5. A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the Covered Employee, or the covered spouse or a dependent child of the Covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a Covered Employee, or the spouse, or a dependent child of the Covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

Premiums. This plan can charge up to 102% of the total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

Enrolling in another Group Health Plan. You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA vs. Marketplace. Other factors to consider when weighing your coverage options include: premium costs, whether a change in coverage will affect your access to certain providers, service areas or drug formularies and whether the coverage change will affect your cost sharing (i.e., new deductibles, etc.). See the discussion above under “Are there other coverage options?” for more information on your options for Marketplace coverage.

What is the election period and how long must it last?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his or her right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation

coverage are forfeited.

Note: If a Covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for the Employee and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a Covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. death of the Employee,
3. commencement of a proceeding in bankruptcy with respect to the Employer, or
4. the Employee's entitlement to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (e.g., divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60 day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing*****.** Oral notice, including notice by telephone, is not acceptable. You must mail, email, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Benefit Express
1700 E Golf Road Suite 1000
Schaumburg, IL 60173

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their dependent children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

5. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

    1. 29 months after the date of the Qualifying Event or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

    2. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a Covered Employee's entitlement to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of:

    1. 36 months after the date the Covered Employee becomes entitled to Medicare; or

    2. 18 months (or 29 months, if there is a disability extension) after the date of the Covered Employee's termination of employment or reduction of hours of employment.

3. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18 month or 29 month maximum coverage period is followed, within that 18 or 29 month period, by a second Qualifying Event that gives rise to a 36 months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the Covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a Covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of

the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan at a later date is also considered Timely Payment if either (i) under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed to make the payment until that later date, or (ii) under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed to pay for coverage of similarly situated non COBRA beneficiaries for the period in question until that later date.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. You should be aware that if you do not pay a premium by the first day of a period of coverage, but pay the premium within the grace period for that period of coverage, the plan has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Failure to make payment in full before the end of a grace period could cause you to lose all COBRA rights.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

For more information

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

FAMILY AND MEDICAL LEAVE ACT:

Except to the extent otherwise provided in the appropriate insurance policies and/or summaries of coverage, the provisions provided in this document with respect to the Family and Medical Leave Act of 1993 (FMLA) will apply. If you meet certain service requirements, you may be entitled to take a maximum of 12 weeks of unpaid leave each year for certain specified family and medical reasons under the FMLA. Upon your return to work after FMLA leave, you will be entitled to the position that you held when your FMLA leave began or an equivalent position with equivalent pay, benefits and other terms and conditions of employment.

Under certain circumstances, when restoration of employment would cause substantial and grievous economic injury to the Company’s operations, certain highly paid “key” employees may not be reinstated after FMLA leave.

You must notify your Plan Administrator at least 30 days before the beginning of your leave if the leave is foreseeable. If the leave is not foreseeable, you must provide such notification as soon as possible. Please contact the Plan Administrator to determine whether you qualify for FMLA leave.

If you take leave under FMLA, you will be entitled during your leave to continue your benefits at the same coverage level in effect at the time of your leave. If you marry or have or adopt a child (or you

otherwise acquire a new dependent) during your leave, your new spouse or dependent will also be eligible for coverage during your leave (if you continued your coverage under the Plan and such spouse or dependent meets the plan's eligibility requirements). You will be responsible for paying your portion of these benefits at active employee rates while you are on leave. You will be required to pay your contributions for your benefits on a monthly basis (with after-tax dollars) in the manner required by the Company. Please contact your Plan Administrator for more information.

You will be eligible for new benefits that are offered by the Company during your leave. Your coverage will also be affected by any changes that the Company makes to the benefit plans and programs during your leave. If the costs for providing new or changed benefits increase during your leave, your contributions may increase accordingly.

When you return from your FMLA leave, you will continue your benefits in accordance with your coverage elections that were in effect immediately before your leave. You will be able to make coverage elections that differ from those that were in effect before your leave only if there is an annual open enrollment period at that time or you have a life change event.

FMLA and leave to care for a service member

If you need to care for a family member who was injured or became ill while on active military duty, you may be entitled to up to 26 weeks of FMLA leave. Additionally, unpaid active duty leave may also be available. Any leave related to military duty or military illness or injury will be administered in accordance with applicable federal requirements.

Caregiver Leave

Caregiver leave, which is unpaid, will be granted to you in the event that you are needed to care for a family member who is an Armed Forces service member recovering from a serious illness or injury. If you are the spouse, son, daughter, parent, or nearest blood relative of a service member who is medically unfit to perform the duties of his or her office, grade, rank or rating, and the service member is undergoing medical treatment, recuperation, or therapy, is in an outpatient status, or is on the temporary disability retired list, you may take job-protected leave in order to care for the service member.

Caregiver leave will not be provided in addition to FMLA leave taken for other reasons, and the 26-week caregiver leave may only be taken in a single 12-month period.

Active Duty Leave

If you are eligible for FMLA leave, active duty unpaid leave (when required by the government) will be granted if a family member has been called up to or engaged in active military duty. Under the active duty leave provision, the Company will grant up to 12 weeks of FMLA leave. This leave will be granted for events outlined in regulations, and the leave will be available if your spouse, son, daughter, or parent is on or is called into active duty against another military force. If you request this leave you must provide the Company with notice as soon as it is "reasonable and practicable" and you may be required to provide certification supporting the active duty of the affected family member.

If you have any questions regarding whether FMLA leave applies to you, you should contact your human resources office.

CONTINUATION OF COVERAGE UNDER USERRA:

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of health care coverage for employees called for active duty military service.

Except to the extent greater benefits are provided under the terms of the appropriate insurance policies and/or summaries of coverage, the maximum length of extended coverage under USERRA is the lesser of:

1. 24 months beginning on the date that the military leave begins; or
2. A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee.

If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

COBRA continuation coverage and USERRA continuation coverage are concurrent.

VI. QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan. A QMCSO may apply to coverage under the Plan. Once the Plan Administrator determines that the order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Plan Administrator receives a QMCSO, you and the affected child will be notified by the Plan Administrator before benefits are assigned pursuant to the order.

VII. SUBROGATION & RIGHT OF REIMBURSEMENT

The provisions of this section pertaining to subrogation shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to subrogation, or (ii) a court, arbitrator, mediator or other judicial body determines that the subrogation provisions of a Welfare Program are not enforceable. The provisions of this section pertaining to a right of reimbursement shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to a right of reimbursement, or (ii) a court, arbitrator, mediator or other judicial body determines that the right of reimbursement provisions of a Welfare Program are not enforceable.

If a covered person becomes sick or injured and has the right to receive benefits under this Plan, but also has the right to receive compensation for the sickness or injury from a third party (such as an insurance company, for example), the Plan, or the Plan's designee, has a right of recovery.

The Plan's right of recovery includes the right to be reimbursed from any payment by the third party for the covered person's sickness or injury, for Plan benefits paid with respect to the sickness or injury. The Plan's right of recovery also includes the right of subrogation which means that the Plan can choose to assert the covered person's right of recovery against the third party. The Plan's right of recovery extends to any right of recovery the covered person's estate, spouse, dependents, guardian or other representative may have against the third party.

The Plan will have a first priority lien on any full or partial recovery by or on behalf of the covered person from the third party. The covered person (and the covered person's personal representative, beneficiary, or estate) shall agree to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the sickness or injury. The covered person (or the covered person's personal representative, beneficiary, or estate) shall serve as a constructive trustee over the funds due and owed to the Plan and hold such funds in trust.

The Plan's right of recovery will apply regardless of whether the covered person is made whole from the recovery against the third party, and will not be reduced or prorated by or on account of the covered person's attorneys' fees and costs. Any full or partial recovery by the covered person against a third party shall be deemed to be recovery for Plan benefits incurred with respect to the injury or sickness for which the third party is liable, regardless of whether or not the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically limited to certain kinds of damages or payments.

The Plan's right of recovery may be from the third party, any liability or other insurance covering the third party, malpractice insurance; the covered person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal injury protection (PIP), or any other first or third party insurance coverages which are paid or payable.

If the Plan takes legal action to enforce its recovery rights, the Plan shall be entitled to recover its attorneys' fees and costs from the covered person.

The covered person shall not do anything to hinder the Plan's right of recovery. The covered person shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the third party or any insurance coverages to which the covered person may be entitled. The Plan is not obligated to pay Plan benefits incurred with respect to a covered person's injury or sickness until the covered person, or someone legally qualified and authorized to act for the covered person, enters into a written agreement with the Plan regarding its right of recovery. Also, the Plan may suspend payment of Plan benefits if the covered person does not execute such an agreement or does not comply with the terms of such an agreement. Payment of Plan benefits by the Plan before such a written agreement is obtained, or while the covered person is not in compliance with the terms of such a written agreement, shall not constitute a waiver by the Plan of its right of recovery.

The Plan Administrator, in its sole discretion, may waive the Plan's right of recovery. Waivers may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. The Plan's waiver of its right of recovery with respect to one claim shall not constitute a waiver of its right of recovery with respect to another claim; and the Plan's waiver of its right of recovery with respect to one covered person shall not constitute a waiver of its right of recovery with respect to another covered person.

VIII. PPACA COMPLIANCE

Pre-Existing Conditions. Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any limitation or exclusion on coverage of pre-existing conditions for individuals.

Lifetime/Annual Limits. Notwithstanding anything contained in the Plan to the contrary, the Plan does not place any lifetime or annual limits on the dollar value of essential benefits for any individual under the group health plan. “Essential benefits” are those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

Cost Sharing Requirements for Preventive Care Expenses. With regard to non-grandfathered benefits under the Plan, there will be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.

Dependent Definition. The term “Dependent" includes any child of a participant who is covered under an insurance contract, as defined in the contract, or under a self-funded plan, as defined in the plan, to the extent allowed by PPACA and the regulations and guidance issued thereunder.

No Rescission of Coverage. The Plan will not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

Selection of Providers. If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. The plan or issuer must also permit the Participant to designate an in-network pediatrician who is available to accept the participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the participant, beneficiary, or enrollee.

Emergency Services. With respect to non-grandfathered benefits under the Plan, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services.

Cost Sharing Limits. With respect to non-grandfathered benefits under the Plan, this Plan does not impose cost sharing amounts (i.e., copayments, coinsurance, and deductibles, but not premiums) that are more than the maximum allowed for high deductible health plans. In 2022, these limits are $8,700 for an individual and $17,400 for family coverage. After 2022, these amounts will be adjusted for health insurance premium inflation. For these purposes, if the Plan utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums for Essential Health Benefits of a group health plan, the Plan will combine with the annual limitation on out-of-pocket maximums between each provider as an aggregate benefit limit amount.

Clinical Trials. With respect to non-grandfathered benefits under the Plan, this Plan will not deny any “qualified individual,” as set forth in Public Health Service Act §2709, participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. This Plan also will not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. Finally, this Plan will not discriminate against the individual on the basis of the individual's participation in such trial.

Provider Discrimination. With respect to non-grandfathered benefits under the Plan, this Plan will not discriminate with respect to participation under the Plan against any health care provider that is acting within the scope of that provider's license or certification under applicable state law, as required by Public Health Service Act §2706(a).

Applicability. This section will apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.

IX. ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) if any, and updated plan document and summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if any is required by ERISA to be prepared, in which case, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

To the extent applicable under your applicable Welfare Plan options, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage, if available. Review this SPD Supplement and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

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

ASSISTANCE WITH YOUR QUESTIONS

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

APPENDIX A

SUMMARY OF BENEFIT OPTIONS AND PROVIDER CONTACTS

Welfare Program	Insurance Company or Third Party Administrator	Policy or Contract Number	PPACA Applicability
Health Plan (Self-Funded) BCBS of MN Effective Date: 01/01/2017	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	10203994 / 10204015	Applicable
Dental Delta Dental of Minnesota Effective Date: 01/01/2017	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	50964	Applicable
Vision EyeMed Effective Date: 01/01/2017	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	9890864	Applicable
Group-Term Life for Employees Unum Life Insurance Company of America Effective Date: 01/01/2017	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	948945	Applicable
Long-Term Disability (Fully-Insured) Unum Life Insurance Company of America Effective Date: 01/01/2017	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	948945	Applicable
Group-Term Life for Employees Unum Life Insurance Company of America Effective Date: 01/01/2017	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	470744	Applicable
Accident Insurance Unum Life Insurance Company of America Effective Date: 01/01/2017	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	R0661371	Applicable
Critical Illness Insurance Unum Life Insurance Company of America Effective Date: 01/01/2017	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	R0661371	Applicable
Health Flexible Spending Account (FSA) Further Effective Date: 01/01/2018	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	003242	Applicable
Hospital Indemnity UNUM Effective Date: 01/01/2022	CSM Corporation 500 Washington Ave S Suite 3000 Minneapolis, MN 55415	R0661371	Applicable

Employer Requirements for Medicare Modernization Act

1. Must identify who is Medicare Eligible Individual, including their dependents;
    - Active Medicare eligible Employees or their Medicare eligible dependents
    - Medicare eligible Cobra Participant, or their Medicare eligible dependents
    - Medicare eligible Disabled Individual covered under the RX Plan
    - Medicare eligible Retirees or their dependents who are covered under the RX Plan
2. Determine if Group Health Plan or RX benefit is "Creditable"
3. Provide the disclosure notices to Medicare Eligible individuals (as noted above), at minimum
    - prior to individuals initial enrollment period for Medicare RX drug benefit
    - prior to the effective date of enrolling in the sponsors plan & upon any change that affects whether coverage is creditable RX benefit
    - prior to the commencement of annual election period that begins on 10/15 of each year
    - and upon beneficiary request
4. Complete Online Questionnaire (link below) within 60 days of the beginning of the Plan year or within 30 days of a plan termination or change

    https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose

This notice is intended to inform you of the privacy practices followed by the Company's group health Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor we often need access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as an merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you $0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within our records is incorrect or missing, you have a right to request that we correct the incorrect or missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Information

The Company is required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our current notice at any time. For more information about our privacy practices, contact the person listed below:

CSM Corporation

500 Washington Ave S Suite 3000
Minneapolis, MN 55415

If you have any questions or complaints, please contact the Plan Administrator listed under the Article titled: "General Information About Our Plan".

Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit *www.hhs.gov/ocr* for further information.

Employer Requirements for Distributing ERISA Documents

ThePlan Administrator/Employer is responsible for preparing the Summary Plan Description ("SPD") and **AFFIRMATIVELY DELIVERING** it to certain persons:

- Covered Employees
- Terminated Cobra Participants
- Parents or guardians of children covered under a qualified medical support order
- Dependents of a deceased participant
- Guardians of an incapacitated person

An employer should be prepared to prove it furnished the SPD in a way "reasonably calculated to ensure actual receipt" using a method "likely to result in full distribution".

I.E., first class mail, hand-delivery, and electronically, if the employees have access to computers in the workplace and can print a copy easily.

Electronic Distribution of ERISA Documents

Employees with work-related computer access

The employee has the ability to access documents at any location where they perform employment duties. Access to Employer’s electronic information system must be an integral part of their normal duties.

- Electronic materials prepared and furnished in accordance with applicable requirements
- Notice is provided to each recipient when furnished, detailing the document
- Notice advises participant of their rights to access the document and how to request a paper copy
- Employer must take steps to ensure the electronic transmittal will result in actual receipt
- If disclosure includes PHI, steps are taken to safeguard the confidentiality of the information

Requirements for Employees with Non-work related computer access or non-employees

May include COBRA participants, dependents or disabled participants.

- Affirmative consent required; Pre-Consent must be obtained, which include details of types of document to be provided, right to withdraw consent, including procedures and updating of information (new email), right to request a paper version and if any cost, and the hardware and software requirements to access the electronic document.
- Pre-Consent statement can be sent electronically if have a reliable e-mail address
- If system hardware or software requirements change, a revised statement must be provided and consent from each individual must be obtained.
- If documents provided on Internet, Consent must be given in a manner that illustrates the individual’s ability to access the information along with a current email address.
- Employer must keep track of individual email addresses for delivery, the consents and actual receipt of emailed documents by recipients.
- These requirements along with the five steps outlined for Employees with work-related computer access above.

ERISA Required Documents for Participants

- SPD - Summary Plan Description
- Restatement of SPD due to Plan Modifications
- SBC - Summary of Benefits and Coverage
- SAR - Summary Annual Report
- Plan Documents

Document	Distribution Instructions
SPD	To Participants within 90 days of coverage on existing plan; within 120 days for new plan. Every 5 years if plan amended or every 10 years if no changes made.
Restatement of SPD	To Participants no later than 210 days after end of the plan year in which change is adopted.
SBC	To participants with enrollment materials, at renewal or reissue of coverage. Special enrollees no later than 90 days from enrollment. Otherwise, within 7 days of written request.
SAR	To participants within 9 months after plan year end if Employer is required to file Form 5500 for the benefit plan.
PLAN DOCUMENT	Copies must be furnished no later than 30 days after written request.

- Other Group Health Plan Notices

There are notices required under other provisions in ERISA (i.e., the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Newborns’ and Mothers’ Health Protection Act (Newborns’ Act), and the Women’s Health and Cancer Rights Act (WHCRA)). Some of these notices may be included in the SPD and others must be provided separately due to the timeframes for when they are required to be provided.

Please be sure to check for current laws and regulations on the reporting and disclosure provisions included in the publication on EBSA’s Website at http://dol.gov/ebsa.