SUMMARY PLAN DESCRIPTION

FOR

GREENSTATE CREDIT UNION WELFARE PLAN

Effective as of April 30, 2019

TABLE OF CONTENTS

SECTION 1
INTRODUCTION

INTRODUCTION

GreenState Credit Union (the "Employer") has established a variety of health and welfare benefits plans (each considered a "Component Benefit Plan") for the exclusive benefit of employees and their eligible dependents. These health and welfare benefit plans have been bundled together into a single plan, referred to as the GreenState Credit Union Welfare Plan (the "Plan").

This document, together with the appendices and in conjunction with any applicable enrollment information, schedules of benefits, or separate certificate of coverage booklets issued to you for the Component Benefit Plans (the "Summaries"), make up this document referred to as the Summary Plan Description or "SPD," as required by ERISA.

Please note that this SPD provides only a general summary of the Plan and the benefits offered under the Plan. It is not meant to interpret, extend or change the Plan in any way. In case of any conflict between the Plan Document and this SPD, the terms of the Plan Document will control. In the event of a conflict between either this SPD or the Plan Document and the actual insurance contract, the insurance contract will control.

We recommend that you read this SPD carefully so that you understand the Plan's operation and the benefits available to you. A definition section has been provided within this document to help you better understand the meaning of any capitalized words used within the document.

The Employer and its successor(s) reserve the right to change, amend or discontinue the Plan or any Component Benefit Plan offered under the Plan at any time with or without notice.

SECTION 2
DEFINITIONS

DEFINITIONS

The following capitalized terms are used within this document and have the following meanings:

ACA means the Patient Protection and Affordable Care Act, also known as Health Care Reform.

AD&D means any Accidental Death and Dismemberment insurance offered under this Plan.

Annual Enrollment Period is the enrollment period each year when you may make changes to your benefit elections and/or add or drop dependents.

Beneficiary means an individual you designate, as provided under the terms of each applicable Component Benefit Plan, who is or may become entitled to a benefit under this Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which provides for continuation of health-related coverage in certain circumstances.

Code means the Internal Revenue Code of 1986, as amended from time to time.

Committee means the Administrative Committee, if any, appointed by the Employer to act as the Plan Administrator.

Component Benefit Plan(s) means the Employer-sponsored health and welfare benefit plans that have been wrapped into this Plan, as listed in Appendix A.

Contract Administrator means the third party administrators, if any, who have contracted with the Employer to make determinations on and reimburse claims that have been incurred during the Plan Year.

Dependent means, with respect to any Component Benefit Plan provided under this Plan, the meaning given such term under the applicable Component Benefit Plan to which it relates. If covered Dependents under a medical plan include your dependent children, the medical plan must also cover your adopted children. However, in order to pay the premium cost of any dependent coverage on a pre-tax basis, your dependent(s) must be either your Spouse or Tax Dependent.

Dependent Care FSA means the dependent care flexible spending account, if any, established by the Employer under a separate document as a separate Component Benefit Plan. It is designed to reimburse eligible dependent care-related expenses incurred by qualifying individuals during the Plan Year. It is not a benefit plan subject to ERISA.

Effective Date means April 30, 2019.

Eligible Employee means a common-law employee of the Employer or a Participating Employer who satisfies the eligibility provisions outlined in Section 4 and who is not excluded from participation by the terms of the applicable Component Benefit Plan.

For purposes of this Plan, an Eligible Employee shall not include (1) any employee who is included in a unit covered by a collective bargaining agreement between employee representatives and the Employer unless the bargaining agreement specifically requires participation in this Plan; or (2) any person retained directly or through a third party to perform services for the Employer (for either a definite or indefinite duration) as a temporary or leased employee, independent contractor, consultant or in any similar capacity, even if any such person is or has been determined to be an employee of the Employer for any purpose, including tax withholding, employment tax, employment law or for purposes of any other employee benefit plan of the Employer.

Employer means the Employer named above or its successor(s) that continue to maintain the Plan, and if appropriate, the term Employer shall also mean a Participating Employer that is the employer of a particular Participant.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time.

FMLA or FMLA Leave means a leave of absence provided to an employee of the Employer under the Family and Medical Leave Act of 1993, as amended from time to time.

Health Care FSA means the health care flexible spending account, if any, established by the Employer under a separate document as a separate Component Benefit Plan. It is designed to reimburse eligible health-related expenses incurred by you, your Spouse or your Tax Dependents during the Plan Year.

Health Coverage means any medical, dental, vision, EAP or Health Care FSA coverage extended under the Plan.

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

Insurer means the insurance company who has contracted with the Employer to insure and pay eligible claims incurred by you and/or your Dependents.

IRS means the Internal Revenue Service.

Late Enrollee means an individual who enrolls on a date other than when first eligible, during the Initial Enrollment Period, or during a HIPAA Special Enrollment Period.

Participating Employer means an Employer that adopts this Plan and participates in this Plan for the benefit of its Eligible Employees, pursuant to approval of such participation by the Employer. Any additional Participating Employers will be listed in Appendix C.

Participant means an Eligible Employee, Dependent or Beneficiary who is eligible for or receiving a benefit under this Plan, by virtue of her or his participation in any Component Benefit Plan offered under this Plan.

Plan means this Plan adopted by the Plan Sponsor for the benefit of Eligible Employees and their Dependents, as amended or restated from time to time.

Plan Administrator means the Employer or the individuals or Committee appointed by the Employer to oversee and carry out the administration of the Plan.

Plan Sponsor means the Employer.

Plan Year means each twelve-month period beginning on January 1 and ending on the December 31 that follows.

Spouse means your current, legal spouse of the same or opposite sex.

Tax Dependent means your Spouse and your tax dependents determined under the Code except that an individual's status as a Tax Dependent for purposes of the Plan is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition. See the Plan Administrator or consult your tax advisor for more information about which individuals will qualify as your Spouse or Tax Dependents. Note that some individuals may qualify as your Tax Dependents, but may not be an eligible for coverage as a Dependent under the Component Benefit Plans.

SECTION 3
BENEFITS, CONTRIBUTIONS AND SUBROGATION

BENEFIT PLANS

All of the Component Benefit Plans currently offered under this Plan are listed in the attached Appendix A. For a detailed description of any Component Benefit Plan offered under this Plan, please refer to the actual certificates of coverage booklets, benefit summaries, or other enrollment materials provided by the Insurer or Plan Administrator for the Component Benefit Plans that are incorporated under this Plan by reference. The eligibility and participation rules of the Plan are in addition to and do not supersede any rules imposed by the Insurer.

CONTRIBUTIONS

The Plan Administrator may require you to contribute toward the cost of certain Component Benefit Plans offered under this Plan in order for you to participate in those Component Benefit Plans. Any employee contributions required in order to participate in any Component Benefit Plan offered under this Plan shall be set out in a separate document and made available to you by the Plan Administrator at the time of enrollment, or upon request.

Should a change in the cost of any Component Benefit Plan be required during the Plan Year (for example, due to a change in the overall cost of the coverage paid by the Employer), the amount of your contribution will be adjusted automatically.

The Employer may, from time to time, implement wellness programs or disease management programs that offer you the opportunity to qualify for discounts on the cost of Health Coverage or other financial incentives to participate. Rewards for participating in a wellness program will generally be available to all employees. If you think you might be unable to meet a standard for a reward under a wellness program adopted by the Employer, you might qualify for an opportunity to earn the same reward by different means. If you have a concern about a particular wellness program, contact the Plan Administrator at the address in Section 11 of this SPD. Your Employer and the Plan Administrator will work with you (and, if you wish, with your doctor), if necessary, to find a wellness program with the same reward that is right for you in light of your health status.

FUNDING

The Component Benefit Plans offered under this Plan may be either fully-insured or self-insured by the Employer. If they are fully-insured, it means that an insurance carrier (the "Insurer") has issued a contract with the Employer, and is responsible for financing and administering the Component Benefit Plan, and for guaranteeing payment of eligible claims incurred while covered under the Component Benefit Program. Alternatively, if a Component Benefit Plan is self-insured, it means that the Employer has assumed the risks associated with offering the coverage and that claims will be paid from the Employer's general assets or a trust. The Employer assumes this risk, even if the Employer contracts with a third party or claims payment service to help administer the payment of claims.

SUBROGATION

In some cases, another individual, insurance policy or plan – such as an auto or liability insurance policy or another group plan or HMO – may be obligated to pay some or all of your Health Coverage expenses. In these cases, you or your covered Dependents have the right to recover some or all of your eligible expenses from those sources, rather than from the Plan.

In these cases, the Plan is "subrogated' in your or your covered Dependent's right to recover, and has the right to recover these amounts from you or your covered Dependent if such amounts are recovered from the liable third party or its insurer. The Plan may assert this right independently of you or your covered Dependent. You or your covered Dependent may request for the Plan to pay benefits for you or your covered Dependent's covered expenses, but you or your covered Dependent must give written consent for the Plan to recover those expenses from the other insurance policy or plan, and you must agree to pay over to the Plan any amount that you recover from a responsible party.

You or your covered Dependent must also cooperate in all respects with the Plan's effort to recover, including providing the Plan with any relevant information, signing and delivering any documents the Plan

reasonably requests to secure its subrogation claim, and obtaining the Plan's consent before releasing any party from liability for payment of medical expenses.

If you or your covered Dependent receives an amount to compensate you for injuries which the Plan has paid for (even if these injuries are not specifically mentioned), you or your covered Dependent is obligated to repay the Plan. Further, you or your covered Dependent will hold these amounts in trust or a constructive trust for the benefit of the Plan. The Plan does not take into account state law doctrines such as limitations on its rights to recover in cases where you or your covered Dependent has not been fully compensated for your injuries. Furthermore, the Plan will not be responsible for paying any part of your or your covered Dependent's legal fees in connection with recovering any covered expenses.

If another party is legally responsible or agrees to provide any compensation, you or your covered Dependent (or legal representatives, estate, heirs or trusts established on behalf of either you or your covered Dependent), must promptly reimburse the Plan for any benefits it paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your covered Dependent have been made whole). The Plan may reduce or deny current or future benefits on the basis of the compensation received or constructively received by you, your covered Dependent(s) or representative(s).

In order to secure the rights of the Plan under this section, you or your covered Dependents:

- Grant to the Plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by you, your covered Dependent or representative;
- Assign to the Plan any benefits you or your covered Dependent may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement; and
- Agree that you, your covered Dependent, or representative will hold any compensation in constructive trust for the benefit of the Plan and all its participants who have contributed to the funding of the Plan.

The Plan may reduce or deny current or future benefits on the basis that you or your covered Dependent has refused to sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement or refused to reimburse the Plan from the proceeds of your settlement verdict. If you or your covered Dependent enter into litigation or settlement negotiations regarding the obligations of other parties, you or your covered Dependent must not prejudice, in any way, the subrogation rights of the Plan under this section.

In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

The provisions of this section apply to the parents, guardian, or other representatives of a Dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

SECTION 4
ELIGIBILITY AND PARTICIPATION

To become a "Participant" in the Plan, you and your Dependents must meet certain eligibility and enrollment requirements, which are summarized below. You should also refer to any Component Benefit Plan Summaries (e.g., certificate of coverage booklet, benefit summary, etc.) which are incorporated by reference into this Plan.

ELIGIBILITY REQUIREMENTS

To participate in any of the Component Benefit Plans offered under this Plan, you must be and remain either an Eligible Employee or the Dependent of an Eligible Employee. Please refer to Appendix B for specifics on any hours or other requirements necessary to be considered eligible for coverage under the Component Benefit Plans offered under this Plan.

No individual may participate whose participation has been terminated for cause or for any other reason listed in the "Termination of Coverage" section of this document.

INITIAL ENROLLMENT

You will become a Participant in the Plan automatically when you enroll or begin participating in any Component Benefit Plan offered under this Plan. However, participation in some Component Benefit Plans is not automatic. In order to participate in those Component Benefit Plans, you may be required to complete and submit written election forms to the Plan Administrator or enroll electronically before becoming a Participant. For those Component Benefit Plans requiring a written or electronic election, your initial election to participate must be made and submitted to the Plan Administrator not later than 30 days after first becoming eligible to participate. If you do not timely make and submit any written or electronic election to the Plan Administrator within the 30-day period, you will be deemed to have elected not to participate in the Component Benefit Plan. You must then wait until the next Annual Enrollment Period to elect coverage, unless you qualify for a mid-year enrollment opportunity, as described below under the HIPAA Special Enrollment Period or Other Mid-Year Enrollment Change Period.

ANNUAL ENROLLMENT PERIOD

If you did not apply for coverage during the Initial Enrollment Period or a HIPAA Special Enrollment Period, you may apply for coverage during any Annual Enrollment Period. The Plan Administrator must receive the enrollment or change notice through the methods approved by the Plan Administrator within the specified time period. This is an enrollment period which occurs annually, during which time you may enroll (if otherwise eligible) or make election changes to your coverage under the Component Benefit Plans offered under this Plan for yourself or your eligible Dependents. Any election changes made during this Annual Enrollment Period become effective the first day of the following Plan Year. If you do not enroll or change your coverage selections during the Annual Enrollment Period, you must wait until the next Annual Enrollment Period, unless you are eligible to become enrolled due to special circumstances, as outlined below.

HIPAA SPECIAL ENROLLMENT PERIOD

HIPAA Special Enrollment Periods apply only to group "Health Coverage," and not to any other Component Benefit Plan offered under this Plan (e.g., life, disability, etc.). If you, your Spouse and/or eligible Dependents are entitled to special enrollment rights, you may change your group Health Coverage elections to correspond with the special enrollment right. For example, if you declined enrollment in the

medical plan offered under this Plan for yourself or your eligible Dependents because you or they had other medical coverage and eligibility for such other coverage is subsequently lost (for example, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA coverage), you may be able to elect medical coverage (and if applicable, dental and/or vision coverage) under the Plan for yourself and your eligible dependents who lost such coverage. You must request enrollment in writing within 30 days after your or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, you may make a change to your Health Coverage due to your marriage or the birth, adoption or placement for adoption of a child with you. Written requests received within 30 days of the birth of a child or adoption or placement for adoption of a child with you will permit you, your child(ren) and your Spouse, if elected, to be covered retroactively to the date of birth, adoption or placement for adoption. Written requests received within 30 days of your marriage will permit you, your Spouse and your Dependent children, if elected, to be added to your coverage prospectively on the first day of the month following the date of your written request.

You may also cancel or modify your medical insurance during the current Plan Year if the reason for canceling or modifying your election is on account of your, your Spouse and/or your eligible Dependent (i) losing coverage under a Medicaid Plan under Title XIX of the Social Security Act; (ii) losing coverage under a State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (iii) becoming eligible for group health plan premium assistance under Medicaid or SCHIP. However, to cancel or modify your medical insurance, you must make a written election to the Plan Administrator no later than 60 days after the loss of coverage or eligibility for premium assistance.

An individual who loses coverage as a result of either a failure to pay premiums on a timely basis or for cause (such as for making a fraudulent claim or an intentional misrepresentation of a material fact in connection with prior health coverage) does not have the right to enroll under this Subsection.

OTHER MID-YEAR ENROLLMENT CHANGES PERIOD

Generally, you cannot change the enrollment elections you have made after the beginning of the Plan Year, other than during an Annual Enrollment Period or HIPAA Special Enrollment Period. However, there are certain other limited situations when your enrollment elections may be changed during the Plan Year, such as if you experience a change in your employment or family status. Please review your Section 125 Cafeteria Plan, if any, for a more information regarding the events that may permit a mid-year enrollment change under this Plan.

PARTICIPATION DURING MILITARY LEAVE OF ABSENCE

When you or your covered family member would otherwise lose coverage under the Plan due to leave for full-time active duty in the US military, you may ask to extend coverage, including dependent coverage, for up to 24 months or the length of your military service, whichever is shorter, as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). The Plan's policies and procedures require that you provide notice of any military service within a reasonable period of time in order to be eligible for USERRA continuation coverage. You should provide written notice to your employer as soon as possible, however, in some circumstances, oral notice will be sufficient. This entitlement will end if you provide written notice of your intent not to return to work following the completion of military leave.

If you elect to continue Health Coverage under the Plan due to military leave, you may be required to pay up to 102% of the full contribution under the Plan, except that if you are on active duty for 30 days or less,

you cannot be required to pay more than the active employee share of the premium, if any, for the coverage. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of your military leave.

Questions concerning your Plan or your USERRA continuation coverage rights should be addressed to the individual(s) identified in the Plan Information Section of this SPD. For more information about your rights under USERRA, contact the Regional or District Office of the U.S. Department of Labor's Veterans' Employment and Training Service (VETS) in your area or contact VETS at 1-866-4-USA-DOL or visit their website at http://www.dol.gov/vets.

PARTICIPATION DURING FMLA LEAVE

Under FMLA, you are entitled to continue any Health Coverage during the period of leave if Health Coverage was in effect prior to the date on which the leave began. However, you have different options with regard to your Health Coverage, depending upon whether the FMLA Leave is paid leave or unpaid leave. For information regarding continuation of coverage under Component Benefit Plans other than Health Coverage during FMLA Leave, contact the Plan Administrator.

If FMLA Leave is Paid Leave

If you commence FMLA Leave that is paid leave, you will be required to continue without interruption any existing Health Coverage for yourself and your Dependents during your period of paid leave. Any Employee contributions applicable to your Health Coverage (and that of your Dependents) that would normally be deducted through salary reduction when you are regularly scheduled to work will continue to be deducted from your pay while on paid FMLA leave to the same extent as would be deducted for any other paid leave (e.g. on a pre-tax salary reduction basis).

If FMLA Leave is Unpaid Leave

If you commence FMLA Leave that is unpaid leave, you may either (a) continue your existing Health Coverage during your period of leave, or (b) elect to revoke or terminate your Health Coverage during your period of unpaid FMLA leave.

If you continue your Health Coverage during your leave, any required contributions due and payable during your period of leave must be paid to your Employer on a "pay-as-you-go" basis with after-tax monthly payments.

If you revoke or terminate your and your Dependents' Health Coverage during your leave, or if coverage is cancelled during your leave due to nonpayment of premiums, upon return from leave you may either:

1. reinstate your prior elections; or
2. make new elections if permitted under the terms of the Employer's cafeteria plan.
3. If Health Care FSA coverage (if any) is terminated during your leave, either because you revoked your election or it was terminated due to nonpayment of premiums, such coverage may be reinstated upon return from your FMLA leave. However, you will not be entitled to receive reimbursements for claims incurred during the period when coverage was terminated.

General Rules Applicable to FMLA Leaves (Whether Paid or Unpaid)

If an Annual Enrollment Period occurs while you are on FMLA leave, you must be provided with any applicable enrollment materials and extended the opportunity to elect any change in benefits during your leave to the same extent as any similarly situated active employee.

PARTICIPATION UPON REHIRE

If you terminate your employment with the Employer and are then rehired, you may be permitted to resume participation in the Component Benefit Plans, if and when you satisfy the eligibility requirements applicable to those Component Benefit Plans. Please check with the Plan Administrator for more information.

TERMINATION OF PARTICIPATION IN THIS PLAN

Participation in this Plan will end on the earliest of:

- The date your employment with the Employer terminates; (or, if provided by the terms of the Component Benefit Plan, the last day of the month in which you terminate employment);
- The date you cease to be an eligible Employee under the terms of any Component Benefit Plan;
- The date of your death; or
- The date the Plan is terminated by the Employer.

If your employment with the Employer ends, or you cease to meet the eligibility requirements of the Plan, your participation in the Plan will be terminated and typically, your contributions (whether pre-tax or after-tax) will continue through your last regular payroll period. If the Employer terminates the Plan, your coverage under the Plan will end effective the date of termination.

Suspension of or disqualification, denial, loss or forfeiture of any benefits under any Component Benefit Plan will be specified within the certificate of coverage booklets, benefit summaries, etc. provided for each Component Benefit Plan.

Termination of participation in the Plan will not affect any rights you or your Spouse and/or eligible Dependents may have to continue participation in certain Health Coverage. Please see the COBRA Continuation Coverage section that appears later in this document.

NONDISCRIMINATION REQUIREMENTS

To the extent that any Component Benefit Plan provides health coverage, such group health plan and issuer may not establish rules for eligibility of any individual (including continued eligibility) to enroll under the terms of the health plan based on any "health status-related factors." In other words, the group health plan may not deny your eligibility to participate on the basis of factors such as your medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. Additionally, you cannot be required to pay a greater premium or contribution than that of similarly situated individuals just because of your health-status (except for premium discount programs under a bona fide wellness program).

ACA PROTECTIONS

Adult Children Are Covered Until Age 26. You can cover your adult children (regardless of financial dependency, student status or residence) under the medical coverage offered through this Plan until they reach age 26 (please see the applicable certificate of coverage (or plan document, if self-insured) to

determine whether coverage ends on the child's 26th birthday or at the end of the month or calendar year in which the child reaches age 26, and whether any special rules apply as to the child's eligibility for another employer-sponsored plan). You are also eligible for reimbursement from your health care flexible spending account ("FSA"), if any, for eligible medical expenses incurred by these adult children.

No Exclusion of Pre-Existing Conditions. No exclusions of pre-existing conditions of any individual will apply under medical coverage provided by Component Benefit Plans offered under the Plan.

No Lifetime or Annual Limit. No lifetime or annual limit applies to your medical coverage provided by Component Benefit Plans offered under the Plan, as described in the applicable certificate of coverage or plan document for the coverage.

Primary Care Provider Designations. To the extent that any Component Benefit Plan that provides medical coverage requires or allows for the designation of primary care providers by participants or beneficiaries, you have the right to designate any primary care provider who participates in-network and who is available to accept you or your family members; and to the extent that any Component Benefit Plan that provides medical coverage requires or allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider for the child. (Not applicable to Grandfathered Plans)

OB/GYN Designations. To the extent that any Component Benefit Plan that provides medical coverage provides coverage for obstetric or gynecological care and requires the designation by a participant or beneficiary of a primary care provider, you do not need prior authorization from the Plan's network provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in-network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. (Not applicable to Grandfathered Plans)

No Co-Pay for Preventative Services and Wellness Care. You are not required to pay a co-payment or other cost-sharing under the medical coverage offered through this Plan for preventive services and wellness benefits (as defined in the law), such as routine exams, immunizations, mammograms, and routine baby care. Please see the schedule of benefits in the applicable certificate of coverage (or plan document, if self-insured) for more information. (Not applicable to Grandfathered Plans)

Emergency Services. You may seek emergency medical services at an in-network or out-of-network provider under Component Benefit Plans providing medical coverage under this Plan without having to obtain prior authorization. Any out-of-network emergency medical services are subject to the same co-payments and deductibles as in-network emergency services, and the out-of-network provider will be paid at the same level as an in-network provider for the same service. Note, however, that the out-of-network provider may balance bill you for the difference between its charge for the emergency services and the amount paid by this Plan. Balance billing is prohibited under some state laws and you should confirm whether you are responsible for these additional costs prior to payment. Please see the applicable certificate of coverage (or plan document, if self-insured) for more information. (Not applicable to Grandfathered Plans).

SECTION 5
CLAIMS AND APPEALS PROCEDURES

The following claims procedures shall apply, but only to the extent not otherwise provided under the applicable Component Benefit Plans. If the claim and appeal rules in this document apply, they shall be construed and applied in a manner consistent with Department of Labor regulation § 2560.503-1 as in effect

on the date the claim was received. To the extent that a conflict exists in the insurance contracts or administrative agreements, the provisions of the foregoing regulations will control.

An individual making a claim for benefits under the Plan ("the Claimant"), at all steps of the claims process, may be represented by another person, who may be, but is not required to be, a lawyer. The Claimant will be responsible for paying the fees and expenses of his or her representative. The Plan Administrator may require evidence that it considers reasonable to establish that an individual is actually the authorized representative of the Claimant.

Except for claims decisions that it delegates to a Claims Administrator, the Plan Administrator has exclusive responsibility for deciding claims for benefits under the Plan and for deciding any appeals of denied claims. The Plan Administrator has the authority, in its complete discretion, to interpret the terms of the Plan, including any insurance policies, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Plan Administrator shall be final and binding on the Claimant to the fullest extent permitted by law.

The following definitions apply to this Claims and Appeals Procedures Section:

"Adverse Benefit Determination" means a denial, reduction, or termination of a benefit, including a failure to pay all or part of a benefit claim, whether based on a determination that the Claimant is ineligible to participate in the Plan or based on a utilization review. In addition, any rescission of coverage under the Plan, other than a rescission attributable to a failure to timely pay required premiums or contributions towards the cost of coverage, will be treated as an "adverse benefit determination." Rescission of coverage generally means a cancellation of coverage or discontinuance of coverage that has retroactive effect. Adverse Benefit Determination also includes failure by the Plan to cover an item or service for which benefits are otherwise provided because it is found to be experimental or investigational, or because it is found not to be medically necessary or appropriate.

"Claimant" means any Participant, Beneficiary or Dependent who is making a claim for a benefit.

"Claims Administrator" means a Contract Administrator, Insurer or the Plan Administrator, if applicable.

"Concurrent Claim" means any benefit claim for medical, dental or vision benefits where the Claims Administrator has approved an ongoing course of treatment over a set period of time, or a set number of treatments, but the Claims Administrator cancels the treatment before the end of that time period or reduces the number of treatments.

"Grandfathered Health Plan" means a group health plan and/or health insurance coverage that was in existence on March 23, 2010, and that had at least one participant on that date. Grandfathered Health Plans are excused from some of the health care reform requirements enacted under the Public Health Service Act (PHSA). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. The medical group health plans offered under this Plan are not "Grandfathered Health Plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act) as of the Effective Date of this Plan.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at www.dol.gov/ebsa/healthreform/consumer.html or by calling 1-866-444-3272. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

"Post-Service Claim" means any benefit under the Plan that is not a Pre-Service Claim and does not involve urgent care.

"Pre-Service Claim" means any benefit claim on account of which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"Urgent Care" or "Urgent Care Claim" means any claim for medical care or treatment under the Plan if application of time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the Claimant to regain maximum function; or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Claims Administrator or the Plan Administrator will determine if a claim involves Urgent Care by applying the judgment of a prudent layperson possessing an average knowledge of health and medicine. Nevertheless, if a physician with knowledge of the Claimant's medical condition determines that the claim involves Urgent Care, this decision will control.

CLAIMS PROCEDURES FOR HEALTH COVERAGE BENEFITS

Urgent Care Claims

If a Claimant submits a claim for Urgent Care, the Claims Administrator shall notify Claimant of its determination on the claim as soon as possible, but no later than seventy-two (72) hours after the claim is filed. If the Claimant does not provide the Claims Administrator with enough information to decide the claim, the Claims Administrator shall notify the Claimant within twenty-four (24) hours after it receives the claim of the further information that is needed. The Claimant shall have forty-eight (48) hours to provide that information. If the needed information is provided, the Claims Administrator shall notify the Claimant of its decision within forty-eight (48) hours after the Claims Administrator received the information. If the needed information is not provided, the Claims Administrator shall notify the Claimant of its decision within one hundred twenty (120) hours after the claim was received. The Claims Administrator may notify the Claimant of its decision by phone and later mail a written notice if the claim is denied.

Concurrent Care Claims

If the Claimant wants to extend the course of a treatment beyond the initial time period or increase the number of treatments and the claim involves Urgent Care, the Claims Administrator shall notify the Claimant of its decision within 24 hours of receipt of the claim, provided that the claim has been made by the Claimant at least 24 hours prior to the end of the treatment time period. If the Claimant wants to extend the course of treatment beyond the initial time period or increase the number of treatments and the claim is not urgent, then the Claims Administrator must notify the Claimant of its decision within 30 days after a request is made. If special circumstances require more time, the Claimant shall be informed in writing

(before the end of the 30-day period) of the reason for the delay and the date a decision will be made. In no case will the extension exceed 45 days after the claim is filed.

Pre-Service Claims

If a Claimant submits a Pre-Service claim, the Claims Administrator shall notify the Claimant of its determination on the claim within a reasonable period, but no later than fifteen (15) days after the claim is filed. If an extension of this 15-day period is required due to matters beyond the control of the Plan, the Claims Administrator shall notify the Claimant in writing, prior to the end of the 15-day period, of the circumstances requiring the extension and the date that the Claims Administrator expects to make a decision. The extension period will be no longer than 15 days. If such an extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Claimant will have at least 45 days from the receipt of the notice within which to provide the necessary information.

Post-Service Claims

If a Post-Service Claim is filed, the Claims Administrator shall have a reasonable period of time, up to 30 days, in which to review the claim and to notify the Claimant of its decision on the claim. If an extension of this 30-day period is required due to matters beyond the control of the Plan, the Claims Administrator shall notify the Claimant in writing, prior to the end of the 30-day period, of the circumstances requiring the extension and the date that the Claims Administrator expects to make a decision. The extension period will be no longer than 15 days. If such an extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Claimant will have at least 45 days from the receipt of the notice within which to provide the necessary information. If the Claimant or the medical care provider made a mistake in filing the claim, the notice shall tell the Claimant how to correct it.

Rules Applicable to All Claims for Health Coverage Benefits

If the claim is denied, the Claimant shall receive a written notice from the Claims Administrator that will explain the reason for the denial, specify the Plan provisions on which the denial was based, describe the benefit claims procedure and the time limits to appeal the claim, and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied. The notice shall also inform the Claimant if the Claims Administrator relied on any internal rule or guideline when it made its decision, and that a copy of the rule or guideline will be provided to the Claimant free of charge, upon request. If the Claims Administrator denies the claim because it determines that the claim is not medically necessary or that the treatment used is experimental or investigational, the notice will specify what Plan provision(s) the decision is based on as well as explain any scientific judgments the Claims Administrator made.

If the claim is denied in whole or in part, the Claimant shall be permitted to review his or her claim file, and may appeal the Adverse Benefit Determination using the procedures described below.

Non-Grandfathered Health Plans offering Medical Coverage are also subject to an additional, external level of review. For more information regarding this external level of review, please contact the applicable Insurer providing the Medical Coverage.

CLAIMS FOR LIFE INSURANCE OR AD&D BENEFITS

In the case of claims for life insurance benefits, the Claims Administrator shall notify the Claimant of its determination on the claim no later than 90 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing the claims is required, the Claimant shall be provided with written notice of the extension (of no more than 90 days) prior to the expiration of the initial 90-day period. In no case will the extension exceed 180 days after the date the claim was filed.

If the claim for life insurance benefits under the Plan is partly or entirely denied, the Claimant will receive written notice from the Claims Administrator. The notice will explain the reason for the denial, specify the Plan provisions on which the denial is based, describe the appeals procedure and the time limits to appeal the claim, and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied.

If the claim is denied in whole or in part, the Claimant is entitled to appeal the Adverse Benefit Determination using the procedures described below.

CLAIMS FOR LONG-TERM DISABILITY BENEFITS FILED PRIOR TO APRIL 1, 2018

In the case of claims for long-term disability benefits that are filed prior to April 1, 2018, the Claims Administrator shall notify the Claimant of its determination on the claim no later than 45 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that an extension (not to exceed 30 days) is required due to matters beyond the control of the Plan. If the Claims Administrator determines that additional time is required to process the claim, the Claimant must be provided with written notice of the extension prior to expiration of the initial 45-day period. The notice will explain the circumstances requiring an extension.

If prior to the end of the first 30-day extension period, the Claims Administrator determines that due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the Claims Administrator may have an additional 30 days to make a decision. The Claimant will be provided written notice prior to the end of the initial 30-day extension period, explaining the circumstances requiring the additional extension (not to exceed 30 more days) and the date as of which the Claims Administrator expects to render a decision. The extension notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The Claimant will be given at least 45 days within which to provide the information specified in the notice. If the Claimant does not provide additional information within the time specified, the determination will be made based solely on the available information previously provided. In no case will the extensions exceed 105 days after the date the initial claim was filed.

If the claim is denied, the Claimant will receive a written notice from the Claims Administrator that will explain the reason for the denial; specify the Plan provisions on which the denial was based; describe the benefit claims procedures and the time limits to appeal the claim; and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied. The notice will also inform the Claimant if the Claims Administrator relied on any internal rule or guideline when it made its decision, and a copy of the rule or guideline will be provided to the Claimant free of charge, upon request.

If the claim is denied in whole or in part, the Claimant is entitled to appeal using the procedures described below.

APPEALING A CLAIM DENIAL

In the case of claims involving Health Coverage or long-term disability claims that are filed prior to April 1, 2018, the Claimant has 180 days to appeal following the date on which he or she receives notice of an Adverse Benefit Determination. In the case of claims involving life insurance or AD&D, the Claimant has 60 days to appeal following the date on which he or she receives notice of an Adverse Benefit Determination.

The Claimant will be provided, upon request and free of charge, with copies and/or reasonable access to all documents, records and other information relevant to his or her appeal. The Claims Administrator's review must take into account all comments, documents, records, other evidence and testimony, and other information submitted by the Claimant relating to the claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Claims Administrator's review must not give any deference to the initial Adverse Benefit Determination. No individual who took part in the initial Adverse Benefit Determination, nor a subordinate of anyone who took part in the initial Adverse Benefit Determination, may participate in the appeal decision.

If an appeal is based in whole or in part on a medical judgment, including a determination with regard to whether a treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the judgment. This professional may not be an individual who was consulted in connection with the initial Adverse Benefit Determination, nor the subordinate of anyone consulted in connection with the initial Adverse Benefit Determination, and no individual who reviews and decides appeals shall be compensated or promoted based on the individual's support of a denial of benefits. The Claims Administrator shall identify and disclose to the Claimant any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, regardless of whether the advice was relied upon in making the determination. The Claims Administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination; any new rationale for an adverse benefit determination prior to making a final benefit determination and will provide required notices in a culturally and linguistically appropriate manner, as directed by the Claims Administrator.

CLAIMS FOR DISABILITY-RELATED BENEFITS FILED ON AND AFTER APRIL 1, 2018

Effective for claims filed on or after April 1, 2018, the Plan is providing enhanced claims procedures for disability-related decisions, including expanding the types of disability claims that qualify to encompass all disability-related benefits and not just LTD claims. Rescissions of coverage, except those due to non-payment of premiums, such as rescissions due to an alleged misrepresentation of fact, shall be treated as adverse benefit determinations. The Claims Administrator shall notify the Claimant of its determination on the claim no later than 45 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that an extension (not to exceed 30 days) is required due to matters beyond the control of the Plan. If the Claims Administrator determines that additional time is required to process the claim, the Claimant must be provided with written notice of the extension prior to expiration of the initial 45-day period. The notice will explain the circumstances requiring an extension.

If prior to the end of the first 30-day extension period, the Claims Administrator determines that due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the Claims Administrator may have an additional 30 days to make a decision. The Claimant will be provided written notice prior to the end of the initial 30-day extension period, explaining the circumstances requiring the additional extension (not to exceed 30 more days) and the date as of which the Claims Administrator expects to render a decision. The extension notice will explain the standards on which entitlement to a

benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The Claimant will be given at least 45 days within which to provide the information specified in the notice. If the Claimant does not provide additional information within the time specified, the determination will be made based solely on the available information previously provided. In no case will the extensions exceed 105 days after the date the initial claim was filed.

If the claim is denied, the Claimant will receive a written notice from the Claims Administrator that will explain the specific reason or reasons for the denial and the standards used in making the decision, including an explanation for disagreeing with or not following any views presented by the Claimant, medical or vocational experts, or the Social Security Administration regarding the Adverse Benefit Determination. The notice will be provided in a culturally and linguistically appropriate manner; specify the Plan provisions on which the denial was based; include a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits; describe the benefit claims procedure and the time limits to appeal the claim; and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied. The notice will also inform the Claimant if the Claims Administrator relied on any internal rule, guideline, protocol, standard or similar criteria when it made its decision, and include either a copy of the criteria or a statement that no such criteria were used.

If an Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the Claims Administrator's notice will include 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 an explanation will be provided upon request free of charge. No individual who reviews and decides long-term disability claims shall be compensated or promoted based on the individual's support of a denial of benefits.

If the claim is denied in whole or in part, the Claimant is entitled to appeal using the procedures described below. However, if it is determined that the Plan failed to adhere to the claims and appeals procedures for long-term disability claims described in this section, then the Claimant will be deemed to have exhausted his or her administrative remedies available under the Plan and the Claimant may immediately pursue his or her claim in court. Notwithstanding the prior sentence, the Claimant will not be deemed to have exhausted his or her administrative remedies available under the Plan if (1) the error is minor and (2) the Plan demonstrates that the violation (A) was for good cause or due to matters beyond its control and (B) occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. If a court of competent jurisdiction rejects Claimant's request for review due to a failure to exhaust administrative remedies, the Plan shall treat the claim as re-filed on appeal.

APPEALING A CLAIM DENIAL FOR A DISABILITY CLAIM FILED ON OR AFTER APRIL 1, 2018

In the case of disability-related claims filed on or after April 1, 2018, the Claimant has 180 days to appeal following the date on which he or she receives notice of an Adverse Benefit Determination. The Claimant will be provided, upon request and free of charge, with copies and/or reasonable access to all documents, records and other information relevant to his or her appeal. The Claims Administrator's review must take into account all comments, documents, records, other evidence and testimony, and other information submitted by the Claimant relating to the claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Claims Administrator's review must not give any deference to the initial Adverse Benefit Determination. No individual who took part in the initial Adverse Benefit Determination, nor a subordinate of anyone who took part in the initial Adverse Benefit Determination, may participate in the appeal decision.

If an appeal is based in whole or in part on a medical judgment, including a determination with regard to whether a treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the judgment. This professional may not be an individual who was consulted in connection with the initial Adverse Benefit Determination, nor the subordinate of anyone consulted in connection with the initial Adverse Benefit Determination, and no individual who reviews and decides appeals shall be compensated or promoted based on the individual's support of a denial of benefits. The Claims Administrator shall identify and disclose to the Claimant any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, regardless of whether the advice was relied upon in making the determination. The Claims Administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination; any new rationale for an adverse benefit determination prior to making a final benefit determination; and, if the final benefit determination concerns the denial of a disability based on such new evidence or rationales, a fair opportunity to respond prior to the determination date. Required notices will be provided in a culturally and linguistically appropriate manner, as directed by the Claims Administrator.

SPECIAL TIMING RULE GOVERNING APPEALS OF HEALTH COVERAGE BENEFIT CLAIMS

In the case of a claim involving Urgent Care under the Plan, the Claims Administrator shall allow the Claimant to submit an expedited appeal either orally or in writing. If an expedited appeal is requested, all necessary information, including the Claims Administrator's determination on review, will be transmitted between the Claims Administrator and the Claimant by telephone, facsimile or other expeditious method.

HOW LONG MAY IT TAKE TO DECIDE AN APPEAL

The Claims Administrator will decide an appeal from a denied life insurance or AD&D claim no later than 60 days after receipt of the Claimant's request for appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If special circumstances require a further extension of time for processing a claim, the Claims Administrator must provide the Claimant written notice of the extension prior to the termination of the initial 60-day period. This written notice must describe the special circumstances requiring the extension and the date upon which the appeal will be decided. In no case will the extension exceed 120 days after the appeal is filed.

The Claims Administrator will decide an appeal from a denied disability-related claim no later than 45 days after receipt of the Claimant's request for appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If special circumstances require a further extension of time for processing the claim, the Claims Administrator must provide the Claimant written notice of the extension prior to the termination of the initial 45-day period. This written notice must describe the special circumstances requiring the extension and the date upon which the appeal will be decided. In no case will the extension exceed 90 days after the appeal is filed.

If the appeal involves an Urgent Care Claim for Health Coverage benefits under the Plan, the Claims Administrator will notify the Claimant of its decision on appeal as soon as possible taking into account pertinent medical matters and considerations, but in no event later than 72 hours after receipt of the request for appeal.

If the appeal involves a Pre-Service Claim for medical, dental or vision benefits under the Plan, the Claims Administrator will notify the Claimant of its decision on appeal within a reasonable period of time appropriate to the medical circumstances. This period will not exceed 30 days after the date upon which the Claims Administrator received the request for appeal.

If the appeal involves a Post-Service Claim for medical, dental, vision or health care flexible spending account benefits under the Plan, the Claims Administrator will notify the Claimant of its decision on appeal within a reasonable period of time, which will not exceed 60 days after the date upon which the Claims Administrator received the request for appeal.

CONTENTS OF THE APPEAL DECISION

The Claims Administrator's decision will be furnished to the Claimant in writing within the time periods described above. If an appeal is denied in whole or in part, the notice of decision shall set forth, in a manner calculated to be understood by the Claimant, the specific reason or reasons for the denial; reference to the specific plan provisions upon which the denial was based; a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claim for benefits; and a statement describing any voluntary dispute resolution options.

If an internal rule, guideline, protocol or other similar criterion was relied upon in denying an appeal, the Claims Administrator must either furnish the Claimant with a copy of the specific rule, guideline, protocol or other criterion, or provide the Claimant with a statement that the rule, guideline, protocol or criterion was relied upon in making the Adverse Benefit Determination, and that a copy of these materials will be provided to the Claimant free of charge. If the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, the Claims Administrator must either furnish the Claimant with an explanation of the scientific or clinical judgment upon which the decision was based, applying the terms of the Plan to the Claimant's case, or a statement that this explanation will be provided free of charge upon request. The decision by the Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. These claims procedures must be exhausted before any legal action is commenced and any legal action must be filed within one year of the date the Claims Administrator issues its final decision on appeal.

SECTION 6
COBRA CONTINUATION COVERAGE

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of Health Coverage under the Plan. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group Health Coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group Health Coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Health Coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for any COBRA continuation coverage elected.

If you are an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happen:

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

If you are the Spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of you and your Spouse, or a Dependent child's losing eligibility for coverage as a Dependent child), ***you must notify the Plan Administrator within 60 days*** after the qualifying event occurs (within 30 days of loss of Social Security disability status).

An untimely Qualifying Event Notice is considered to have no effect and shall be rejected.

The Plan requires that you provide a Qualifying Event Notice in writing by mail to the Plan Administrator. Under no circumstances will an oral notice be effective.

In the Qualifying Event Notice, you are required to provide certain information regarding the qualifying event such as identification of the type of event, the date the event occurred and the name of the individual to whom the event is applicable. The qualifying events listed below require specific documentation attached to the Qualifying Event Notice:

Qualifying Event	Documentation Required with Notice
Divorce or legal separation	Certified copy of the court order granting the divorce or legal separation
Death of covered employee	Copy of death certificate
Qualification for Social Security Disability	Copy of the Social Security Administration determination
Loss of Social Security Disability Status	Copy of Social Security Administration final determination

To be considered valid, the notice must be completed in full and all required enclosures must be supplied. However, the Plan's Policy provides that a Qualifying Event Notice otherwise received timely, but which does not contain all required information or enclosures will not be considered untimely if the Plan Administrator is able to identify the Plan, identify the covered employee or qualified beneficiary, identify the qualifying event or disability, and identify the date on which the qualifying event occurred. The Plan Administrator, in such event, may require additional supplementary information from the covered employee or qualified beneficiary. The completed Qualifying Event Notice must be mailed to the Plan Administrator. It is recommended that you send the completed Qualifying Event Notice by registered mail, return receipt requested, but this is not required. When you submit a completed Qualifying Event Notice, you need to retain a copy (including copies of all enclosures) and any proof of mailing. If you do not receive a response from the Plan Administrator within 14 days of mailing the notice, you must contact the Plan Administrator immediately in writing to determine the status of your COBRA claim.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage may be offered to each of the qualified beneficiaries, each of whom has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his or her

spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To notify the Plan Administrator of the determination by the Social Security Administration that you, your Spouse or your Dependent child is eligible for disability, the Qualifying Event Notice must be completed and returned to the Plan Administrator as described in the section "You Must Give Notice of Some Qualifying Events." A copy of the determination by the Social Security Administration must be attached to the Qualifying Event Notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

COBRA Coverage for Employees Participating in a Health Care Reimbursement Plan

The COBRA continuation coverage period that applies to certain health care reimbursement plans may not be the same as the COBRA continuation period that applies to other health care benefits as described above, but may end as of the last day of the Plan Year in which the qualifying event occurs.

If you are an employee participating in a health care reimbursement plan, such as a flexible spending arrangement (or health reimbursement FSA, which is funded in whole or in part through pre-tax payroll deductions) or a health reimbursement arrangement (or HRA, which is funded solely through employer contributions), COBRA continuation coverage may apply to you and may apply to your qualified beneficiaries.

Generally, most health FSA plans meet certain conditions with respect to maximum benefits and benefit availability and are "excepted" from certain COBRA requirements. If your FSA is an "excepted" plan, you, or your qualified beneficiaries, may have limited COBRA continuation coverage with respect to the health FSA. Your eligibility for this limited COBRA continuation coverage will be determined based on how much of your annual reimbursement amount has been distributed to you as of the date of the qualifying event. COBRA coverage will not be offered to you if you have "overspent" your excepted health FSA as of the date of your qualifying event. Also, for excepted health FSAs, the limited health FSA COBRA continuation coverage period available to qualified beneficiaries who have not overspent their health FSA ends as of the end of the Plan Year in which the qualifying event occurs.

A health FSA is an excepted health FSA if health plan eligibility, the benefits paid to participants and the cost of these benefits to the participants meet three requirements. First, the maximum benefit payable to each participant (the total amount of reimbursement available for the year) cannot exceed the greater of (a) the participant's salary reduction amount for the year times two, or (b) the salary reduction amount for the year plus $500. Second, the employer must offer other major medical plan coverage and this other coverage must be consistently available to all employees who are eligible to participate in the health FSA. Third, the maximum COBRA premium amount for a year must equal or exceed the maximum benefit available under the health FSA for the year.

Health care reimbursement plans that do not meet the conditions listed in the preceding paragraph are "non-excepted" plans. Non-excepted plans include most HRA plans and certain health FSA plans. If you are a participant in a "non-excepted" health care reimbursement plan, you, or your qualified beneficiary, will be eligible for COBRA continuation coverage for the entire applicable COBRA period.

If you have any questions concerning your COBRA continuation coverage with respect to the health care reimbursement plan in which you are participating, you should contact the Plan Administrator."

IF YOU HAVE QUESTIONS

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in your address or the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. Please also refer to Section 11 – General Plan Information for more information concerning the Contract Administrator for COBRA claims.

SECTION 7
HIPAA PRIVACY AND SECURITY

HIPAA PRIVACY RULES APPLICABLE TO HEALTH COVERAGE UNDER THE PLAN

This Section 7 describes only the health information privacy and security practices of any Component Benefit Plan offered under this Plan that is subject to HIPAA Privacy and Security rules. For a more complete explanation, please see the individual Notices of Privacy Practices.

The Plan is committed to protecting medical information about you. The Plan may disclose protected health information (PHI) to the Employer under limited circumstances, although this information will be disclosed only upon the receipt of a certification by the Employer that the Plan documents have been amended to incorporate the privacy provisions, and that it will abide by them. The Plan may disclose summary health information to the Employer for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the Plan.

The Plan may disclose protected health information to carry out plan administration functions that are consistent under applicable law. The Plan may not disclose PHI to the Employer for the purpose of employment-related actions or decisions in connection with other benefits or employee benefit plans of the Employer. A limited number of employees of the Employer will have access to PHI for the purposes of carrying out plan administration functions in the ordinary course of business.

The following categories describe different ways that the Plan uses and discloses PHI. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

For Treatment. The Plan may use or disclose medical information about you to provide you with medical treatment or services by providers. The Plan may disclose PHI about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital.

For Payment. The Plan may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Health Care Operations. The Plan may use and disclose PHI about you for other Plan operations which are necessary to run the Plan. For example, the Plan may use PHI in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As Required By Law. The Plan will disclose PHI about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To Facilitate Claims Under Employer Plans. Your health information may be disclosed to another health plan maintained by the Employer for purposes of paying claims under that plan. In addition, medical information may be disclosed to the Employer to administer benefits under the Plan, such as to determine a claims appeal.

Provide You With Information. The Plan or its agents may contact you to remind you about appointments or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplants, or to an organ donation bank to help with organ or tissue donation.

Military and Veterans. If you are a member of the armed forces, the Plan may release PHI about you as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks. The Plan may disclose PHI about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if the Plan believes a participant has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose PHI about you in response to a court or administrative order. The Plan may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement; about a death the Plan believes may be the result of criminal conduct; about criminal conduct at the hospital; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release PHI about you to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

You have the following rights regarding PHI the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. If you request a copy of the information, the Plan may charge a fee for the cost of copying, mailing, or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. The Plan is not required to agree to your request however.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You will not be retaliated against for exercising the privacy rights described above.

Other uses and disclosures of medical information not covered by the above discussion or the laws that apply to the Plan will be made only with your written authorization. If you provide the Plan permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures the Plan has already made with your permission, and that the Plan is required to retain its records of the benefits that the Plan provided to you.

HIPAA SECURITY RULES APPLICABLE TO HEALTH COVERAGE UNDER THE PLAN

The Employer will put into place and follow administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any ePHI (electronic protected health information) that the Employer creates, receives, maintains or transmits on behalf of the Plan, except as stated below.

The Employer will put into place and follow reasonable and appropriate security measures to ensure that access to and use of ePHI is restricted to its employees or group of employees who are required to access or use such ePHI for the proper administration of the Plan, or for such other reasons as may be proper under the HIPAA Security Rules. The Employer will provide an effective mechanism for resolving any issues of non-compliance with such security measures by ensuring that appropriate sanctions are imposed against any employee who violates or fails to follow them. The Employer will require that any of its agents or subcontractors to whom it provides ePHI relating to the Plan agrees to implement reasonable and appropriate security measures to protect the ePHI. The Employer will report to the Plan any security incident of which it becomes aware.

The terms of this section shall not apply if ePHI is disclosed to the Employer pursuant to an authorization which meets the requirements of the HIPAA Privacy Rule, or if the ePHI is summary health information which the Employer has requested in order (a) to obtain premium bids from health insurers for providing health insurance coverage under the Plan; or (b) to amend or terminate the Plan. In addition, the terms of this section shall not apply if the ePHI disclosed to the Employer is information concerning whether an individual is participating in the Plan.

SECTION 8
PLAN ADMINISTRATION

RESPONSIBILITIES FOR PLAN ADMINISTRATION

The Plan is administered by the Employer, which may in its discretion appoint one or more individuals or a Committee, to act as the Plan Administrator under the Plan. The Plan Administrator is the named fiduciary of the Plan. The Plan Administrator has the power and authority to manage the operation and administration of the Plan and to take all actions it deems necessary to carry out the provisions of the Plan. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the Plan, make findings of fact, determine the eligibility, rights and status of participants and others under the Plan, and resolve disputes under the Plan. To the extent permitted by law, such interpretations, findings, determinations, and decisions shall be final and conclusive on all persons for all purposes of this Plan. The Plan document, which is the legal document that governs the Plan, is available for review and inspection during regular office hours at the address indicated in the Plan Information section of this document.

AMENDMENT OR TERMINATION OF THE PLAN

The Employer has established this Plan with the bona fide intention and expectation that it will be continued indefinitely, but has no obligation whatsoever to maintain this Plan for any given length of time.

The Employer, as the Plan Sponsor, reserves the right to amend or terminate the Plan at any time for any reason, and may do so retroactively, with or without prior notice to Participants or Beneficiaries. Any such action will be taken only after careful consideration, and shall be by a written instrument duly adopted by the Employer or any of its delegates. Therefore, there is no guarantee that you will be eligible for the benefits described in this document for the duration of your employment.

Upon termination of this Plan, all elections and reductions in compensation relating to the Plan will terminate. However, neither amendment or termination of this Plan will diminish or eliminate any claim for any benefit to which you may have become entitled prior to the amendment or termination, unless necessary in order for the Plan to comply with the law.

SECTION 9
MISCELLANEOUS PROVISIONS

NO GUARANTEE OF EMPLOYMENT

Nothing contained in the Plan will be construed as a contract of employment between the Employer and any employee, or as the right of any employee to be continued in the employment of the Employer or as limitation of the right of the Employer to discharge any of its employees with or without cause.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

A "qualified medical child support order" ("QMCSO") is any court judgment, decree, or administrative order (including a court's approval of a domestic relations settlement agreement) that either creates or recognizes the right of an alternate recipient—or assigns to the alternate recipient the right—to receive benefits for which a Participant or other Dependent is entitled under this Plan. An "alternate recipient" is any child of a Participant or Spouse who is recognized under a medical child support order as being entitled to enrollment in the Plan.

A QMCSO must include: (1) the name and last known mailing address of the Participant; (2) the name and address of each alternate recipient; (3) a reasonable description of the type of coverage to be provided by this Plan or the manner in which such coverage is to be determined; (4) the period of which coverage must be provided; and (5) each plan to which the order applies.

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

To the extent that any Component Benefit Plan provides health benefits in connection with childbirth, please note that 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 issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

For any Component Benefit Plan that offers mastectomy coverage, such group health plans, insurance companies and health maintenance organizations (HMOs) must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce symmetry, and prostheses and treatment of physical complications at all

stages of the mastectomy, including lymphedemas. Any applicable co-payments and/or co-insurance provisions will still apply.

MENTAL HEALTH PARITY ACT

Pursuant to federal law, if a Component Benefit Plan provides coverage for mental health benefits, such group health plan, insurance company or HMO may not set annual or lifetime dollar limits on mental health or substance use disorder benefits that are lower than any such dollar limits for medical and surgical benefits. If a health plan imposes no annual or lifetime dollar limit on medical and surgical benefits, such health plan may not impose an annual or lifetime dollar limit on mental health or substance use disorder benefits.

For example, a group health plan that includes medical/surgical benefits and substance use disorder benefits must ensure that the financial requirements and treatment limitations that apply to substance use disorder benefits are no more restrictive than those that apply to substantially all medical/surgical benefits. Specifically, the group health plan may not impose separate cost-sharing requirements (such as separate deductibles, co-pays or co-insurance) or treatment limitations (such as providing out-of-network coverage for medical/surgical benefits without providing the same out-of-network coverage for mental health or substance abuse disorder benefits) on mental health or substance use disorder benefits as opposed to those provided for medical/surgical benefits.

SECTION 10
STATEMENT OF 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) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the Summary Annual Report.

COBRA RIGHTS

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. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the 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 (Form 5500) from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day, for each day after 30 days that you did not receive the materials, until you receive the materials, unless the requested materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. No action at law or in equity may be brought to recover under this Plan document until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have 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 (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW., 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.

SECTION 11
GENERAL PLAN INFORMATION

Plan Name:

GreenState Credit Union Welfare Plan

Plan Number:

520

Plan Sponsor and Plan Administrator:

GreenState Credit Union
2355 Landen Rd. 52317
N. Liberty, IA 52317
(319) 341-2106

Plan Sponsor's Employer Identification No. (EIN):

42-0804594

Plan Year:

The Plan's fiscal records are kept on a Plan Year basis beginning on January 1 and ending on the following last day of December.

Agent for Service of Legal Process:

Service of process may be made upon the Plan Administrator to the address above.

Type of Plan:

This Plan is a welfare benefit plan providing for the benefits listed on Appendix A as well as the pre-tax payment of health care premiums and reimbursement of eligible Health Care Expenses and Dependent Care Expenses.

Type of Administration:

The Plan utilizes Insurers and Contract Administrators to administer the payment of all insured and self-insured claims. The Insurers and Contract Administrators for the various Component Benefit Programs are listed in the applicable benefit summaries for each Component Benefit Program. However, all correspondence related to eligibility or enrollment should be sent to the Plan Administrator at the address above.

COBRA Continuation Coverage

Contract Administrator:
The Taben Group
10875 Benson #130
Overland Park, KS 66210
(800) 675-7341, ext. 130

Type of Funding:

The Plan has fully-insured contracts with select insurance carriers, which means all claims for reimbursement are paid by the Insurer. The Plan also has self-insured contracts, which means that claims for reimbursement are paid from the general assets of the Employer. Premiums for the plan coverage are funded with both Employer and Employee Contributions, and to the extent applicable, may be paid by Employees on a pre- or post-tax basis. Any such Employee cost-sharing provisions will be provided in a separate document by the Employer.

Grandfathered Plan Status:

The Medical plan offered under this Plan is not a grandfathered plan under the Patient Protection and Affordable Care Act (the Affordable Care Act).

APPENDIX A

Component Benefit Plans Included in This Plan

The following Component Benefit Plans have been incorporated into this Plan as of April 30, 2019:

- Medical Insurance (Self-insured)
- Dental Insurance (Self-insured)
- Vision Insurance (Fully-insured)
- Group Life and AD&D Insurance (Fully-insured)
- Group LTD Insurance (Fully-insured)
- Voluntary Critical Illness Insurance (Fully-insured)
- Voluntary Accident Insurance (Fully-insured)
- Voluntary Cancer Insurance (Fully-insured)
- GreenState Credit Union Cafeteria Plan which includes:
    - Pre-Tax Premium Payment of eligible Welfare Programs
    - Health Flexible Spending Account Plan (Self-insured)
    - Dependent Care Flexible Spending Account Plan (Self-insured)

APPENDIX B

Eligibility Provisions

GENERAL ELIGIBILITY RULES: You are eligible for coverage if you are classified as a regular full-time employee of the Employer and any Participating Employer. Full-time generally means you are regularly scheduled to work at least 30 hours per week. However, to satisfy the ACA requirement to offer "full-time employees" an opportunity to enroll in adequate and affordable health coverage, your status as a full-time employee for group health plan eligibility is determined under the ACA rules summarized below.

Additional limitations on eligibility may also apply under each of the Component Benefit Plans, including "actively at work" requirements and evidence of insurability. To the extent that any specific eligibility requirements conflict with the general eligibility rules described below, the specific eligibility requirements in the insurance documents or benefit summaries for the Component Benefit Plans will control.

Except as provided below, if you are a full-time employee, you will be eligible to enroll in the Component Benefit Programs effective as of the first day of the month following completion of 60 consecutive days of full-time employment.

SPECIAL ELIGIBLITY RULES FOR HEALTH FLEXIBLE SPENDING ACCOUNTS: If you are a full-time employee, you will be eligible to enroll in the Health Flexible Spending Account under the GreenState Credit Union Cafeteria Plan effective as of the first day of the month following completion of one-year of consecutive full-time employment.

SPECIAL ELIGIBLITY RULES FOR MEDICAL: The following special rules apply for determining full-time status and eligibility for medical benefits:

- ACA LOOK BACK MEASUREMENT AND STABILTIY PERIOD METHOD: To determine the eligible full-time employees of the Plan for medical benefits, the Plan Administrator has established guidelines that incorporate and follow the ACA look-back measurement and stability provisions of Treasury Regulation Section 1.4980H-3(d) (the "Look Back Policy"). Under the Look Back Policy, your eligibility for coverage as a full-time employee during the Plan Year (or other "stability period" described below) is generally determined based on the number of hours you worked in a prior 12-month "measurement period" as follows:

    - NEW FULL-TIME EMPLOYEES: If you are reasonably expected to work at least 30 hours per week upon hire, you will be eligible on the 1st day of the month following completion of 60 consecutive days of employment. Your status as a full-time employee will be measured monthly until you qualify as an "ongoing" employee as described below.

    - NEW PART-TIME, VARIABLE HOUR OR SEASONAL EMPLOYEES: If you are hired as a part-time employee regularly scheduled to work fewer than 30 hours per week or as a "seasonal employee" of the Employer or Participating Employer, you are not eligible for benefits. In addition, if at your date of hire, it cannot reasonably be determined whether you will work at least 30 hours a week (a "variable hour employee"), you are not eligible to participate. However, you may become eligible for benefits at a later date if you transfer to a full-time position or average 30 hours per week during the "initial measurement period", which is the 12 month period beginning on the first day of the month following your date of hire.

EXAMPLE: If you are hired on June 14, 2019 as a new part-time, variable hour, or seasonal employee, the Plan Administrator will measure your hours over the 12 month initial measurement period beginning July 1, 2019 and ending June 30, 2020. If you average at least 30 hours per week during the initial measurement period, you will be eligible for benefits during the 12 month stability period beginning July 1, 2020 and ending June 30, 2021. In addition, your hours will be measured under the rules for ongoing employees as described below once you have worked an entire standard measurement period. In this example, the standard measurement period would be November 1, 2019 through October 31, 2020. If you worked at least 30 hours per week during this standard measurement period, you will be eligible for coverage during the standard stability period beginning January 1, 2021 and ending December 31, 2021, even if you did not qualify as a full-time employee during your initial measurement period.

- ONGOING EMPLOYEES: For all employees who have been employed for the 12 month period beginning November 1 and ending on the following October 31 (the "standard measurement period"), your eligibility for coverage will depend on whether you averaged part-time or full-time hours during the standard measurement period. If you average at least 30 hours per week during the standard measurement period under the Look Back Policy, you will be eligible for benefits during the following Plan Year beginning January 1 and ending December 31 (the "standard stability period").

- REHIRED EMPLOYEES: If you terminate employment and are rehired after 13 weeks, you will be treated as a new employee under the Plan for purposes of the look-back measurement method under the Plan. In some cases, if your initial period of employment is less than 13 weeks, you may be treated as a new employee if your break in service is longer than your initial period of employment. Your eligibility for benefits upon rehire can vary depending on your particular situation, and you should contact the Plan Administrator for more information regarding benefits eligibility if you terminate employment and are rehired.

Eligibility under the Look Back Policy is governed by the ACA guidance issued by the federal agencies responsible for enforcing the ACA, which is interpreted by the Plan Administrator in its discretion and applied uniformly to all similarly-situated employees. The rules for determining an employee's status as a full-time employee under the ACA guidelines are very complex and your status as a full-time employee is influenced by many factors, including leaves of absence and breaks in service. This summary of the Look Back Policy is only a general overview of the rules and cannot address every situation. If you have questions or need additional information regarding your status as a full-time employee, you should contact the Plan Administrator at the address listed in the General Plan Information section of this SPD.

APPENDIX C

Participating Employers

Currently there are additional Participating Employers:

GreenState Insurance Services, LLC

APPENDIX D

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext. 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MONTANA – Medicaid	OREGON – Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)