



Welfare Benefits Plan

Medical Benefits

Dental Benefits

Vision Benefits

Prescription Benefits

MILLER & LONG DC, INC. HEALTH AND WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Effective January 1, 2018

ABOUT THIS SUMMARY

The following is a summary of some of the principal features of the Miller & Long DC, Inc. Health and Welfare Benefit Plan (the Plan). We urge you to read this summary carefully.

This summary is the “Summary Plan Description” for the Plan and is meant to summarize the Plan in easy-to-understand language. However, in the event of any ambiguity or any inconsistency between this Summary Plan Description and any formal Plan documents, the Plan documents will control.

Copies of the formal Plan documents for the Plan are on file at Miller & Long DC, Inc. (the Employer) and are available to you for inspection at a time and place mutually agreeable to you and to the Employer.

If anything in this Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator.

MILLER & LONG DC, INC. HEALTH AND WELFARE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION
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GENERAL INFORMATION ABOUT THE PLAN

Name of Plan

Miller & Long DC, Inc. Health and Welfare Benefit Plan

Name and Business Address of Employer

Miller & Long DC, Inc.
4001 Brandywine Street, NW, Suite 400
Washington, DC 20016

Employer's Taxpayer Identification Number

27-5492647

Plan Number

501

Type of Administration

The Plan is administered by the Plan Administrator. Please note that participant benefit accounts under the Plan are merely bookkeeping entries, no assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. Some benefits may be provided through insurance contracts. To the extent that any benefits are not provided through insurance contracts, they are paid from the Employer's general assets.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's discretionary authority includes but is not limited to, discretionary authority to interpret plan provisions and to make all determinations of facts, including factual determinations relating to eligibility for benefits, and to make all determinations that require application of facts to the terms of the Plan. The Plan Administrator's determinations shall be given deference and are final and binding on all interested parties. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Health Coverage Funding Information

Allegeant, 9475 Deereco Road, Suite 408, Timonium, MD 21093 is the claims processor of your medical and dental benefits under the Plan. The Plan's medical and dental benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance carrier.

Affordable Care Act

This Summary includes various provisions that are required to comply with the requirements of the federal health care reform law, (the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010) and with regulations and other guidance issued under that law. Whenever this Summary refers to the “Affordable Care Act” it is referring to the PPACA, as amended, and any applicable regulations. The health care reform requirements of the Affordable Care Act generally apply only to the Plan’s medical coverage. When this Summary refers to coverage that is subject to the Affordable Care Act, it means the Plan’s medical coverage, including any prescription drug or vision benefits that are offered as part of a bundled package with the medical coverage.

Plan Year

The Plan Year for the Plan is the period beginning each September 1 and ending on the next August 31, but for purposes of the Plan’s medical, dental and flexible spending account benefits, references to “Plan Year” mean the calendar year, January 1 through December 31.

Name, Business Address and Telephone Number of Plan Administrator

Miller & Long DC, Inc.
c/o Human Resources Department
4001 Brandywine Street, NW, Suite 400
Washington, DC 20016
(202) 524-4600

Service of Legal Process

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

Type of Plan

This Plan is a form of employee welfare benefit plan called a “cafeteria plan” because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the Employer to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan. For certain benefits, because your salary is reduced before federal taxes (and, in most states, state taxes) are imposed, you pay less in taxes if you participate in the Plan. (Some benefits may require that you make after-tax contributions.)

Eligibility

If you are a full-time regular employee of the Employer (i.e., if you are regularly scheduled to work at least thirty hours per week, as determined by the Employer), you and your eligible dependents are eligible to participate in the Plan beginning on the day on which you complete ninety days of continuous employment with the Employer (your “Participation Date”). For purposes of this continuous employment requirement as it applies to the Plan’s health benefits, if you are absent from work because of a health condition, your absence will not interrupt your completion of the continuous employment requirement. That is, any period of continuous service that you complete before your health-related absence will apply toward the continuous

employment requirement and will be added to any period of continuous service that you complete after you return to work following your health-related absence.

Leased employees, persons classified by the Employer as temporary employees of the Employer (as determined by the Employer), and employees covered by a collective bargaining agreement and their dependents (unless Plan participation is provided for in the collective bargaining agreement) are not permitted to participate in the Plan. A person who is not characterized by the Employer as an employee of the Employer, but who is later characterized by a regulatory agency or court as being an employee, will not be eligible for the period during which he or she is not characterized as an employee by the Employer.

If you are laid-off by the Employer and are rehired within six months, your Participation Date will be your date of rehire. Otherwise, your Participation Date will be the day on which you complete ninety days of continuous employment with the Employer after you are rehired. However, if you are rehired during the same Plan Year and within 30 days after your previous period of eligible employment ended, you generally will not be permitted to make a new election of benefits for that Plan Year, but your previous election of benefits will be reinstated.

Please note that your eligibility for any particular benefit is determined under Plan terms applicable to that benefit. The Benefit Booklets delivered with this Summary include information about any additional or different eligibility requirements that may apply to specific benefits.

Dependent Eligibility

(NOTE: This Dependent Eligibility section does not apply to flexible spending account benefits. For details on whether a family member's expenses can be covered under a flexible spending account, see the separate explanations of those benefits in the "Summary of Available Benefits" section.)

For purposes of all benefits available under the Plan to dependents, your *spouse* is considered an eligible dependent (*spouse* and other *italicized* terms used in this section are defined below).

The Plan's dependent eligibility requirements for children of eligible employees have changed to comply with the requirements of the Affordable Care Act. Your *child* is eligible for coverage offered to dependents under the Plan based on the following rules:

1. Coverage for Children under Age 26. Your eligible dependents include your *child* who is under age 26, regardless of the child's marital status, tax dependent status or student status and regardless of whether the child lives with you.
2. Coverage for Older Children with Disabilities. For purposes of all coverage offered to dependents under the Plan, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable calendar year is an eligible dependent if he or she is physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 26.

The following definitions apply for purposes of this Dependent Eligibility section:

Child means a natural child, a legally adopted child who is under age 18 at the time of the

adoption, a child placed with you for adoption who is under age 18 at the time of the placement, a foster child (if the child is an “eligible foster child”, as defined in the Internal Revenue Code) or a stepchild. *Child* also includes any other person whose welfare is your legal responsibility under a legal guardianship, written divorce settlement, written separation agreement or a court order.

Spouse means a person who is treated as your spouse because of a marriage that is recognized as a marriage for purposes of federal income tax law, which currently includes any marriage that is recognized as a valid marriage in the State, District, territory or foreign jurisdiction in which the marriage occurred.

Dependent for Federal Income Tax Purposes

Whether someone is your *dependent for federal income tax purposes* is determined under IRS rules. For details on the requirements for someone to be your federal income tax dependent, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* under the Plan. However, for purposes of this Plan’s health benefits, note that even if your family member would not qualify as your dependent for federal income tax purposes under the IRS rules solely because (a) you are a dependent of someone else or (b) he or she has gross income for the year greater than the IRS personal exemption amount (this amount is \$4,150 for 2018 and is subject to adjustment for inflation each year), that family member is still considered to be your *dependent for federal income tax purposes* for purposes of the Plan’s dependent eligibility requirements.

Also, in determining if your minor or disabled child is your *dependent for federal income tax purposes*, a special rule applies in cases of divorce or legal separation or if you and your child’s other parent live apart for all of the last six months of the calendar year if either you or the child’s other parent has custody of the child and is actually entitled to claim the child as a dependent for tax purposes. In those cases, as long as at least half of the child’s support for the applicable calendar year is being provided by you and the other parent (and your current spouses, if any) together, the child can be considered your *dependent for federal income tax purposes* for purposes of the Plan’s health benefits.

A person otherwise qualifying as your eligible dependent will not be covered for any coverage providing benefits to dependents unless you have elected to pay and have paid the required additional contributions, if any, for dependent coverage. Also, unless otherwise required by law, note that your spouse or child will not qualify as an eligible dependent while on active duty in the armed forces of any country.

You are responsible for determining if someone qualifies as your spouse or dependent for purposes of the Plan’s dependent eligibility rules, subject to the Employer’s final approval. The Employer may require you to provide proof that an individual satisfies all of the Plan’s eligibility requirements. Also, if at any time during a Plan Year your eligible spouse or dependent becomes ineligible for coverage, you are responsible for notifying the Employer of that change in eligibility.

If you and your eligible spouse or dependent are both employees of the Employer and each of you meets the Plan’s eligibility requirements to participate in the Plan as employees, you may elect employee-only medical, dental or vision coverage or one of you may elect family (or

employee and spouse or dependent) coverage. However, no employee can be covered under the Plan's medical, dental and vision coverage as another employee's spouse or dependent at the same time that he or she is also covered under the Plan as an employee/participant.

For any insured coverage offered under the Plan, the terms of the insurance contract, instead of this "Dependent Eligibility" section, will determine whether any person is your dependent for purposes of that benefit (if there is any difference between the language in this Dependent Eligibility section and the terms of the contract). The Benefits Booklets provided to you with this Summary will include any additional or different dependent eligibility requirements that apply for any insured coverage.

For purposes of the Plan's medical coverage, the Plan will not impose any preexisting condition exclusion on any person (including an employee) who is under 19 years of age.

All Qualified Medical Child Support Orders that require the Plan to provide Plan coverage for so-called "Alternate Recipients" will be honored by the Plan in accordance with applicable law. (These orders are a type of order by a court or by an administrative agency providing coverage for children of Plan participants.) As required by applicable law, the Plan uses procedures to determine whether a medical child support order is a "Qualified Medical Child Support Order" that must be honored by the Plan. Upon request to the Plan Administrator, you may receive, without any charge, a summary of these procedures.

Participation

(a) Initial Election Period. If you are not already a participant in the Plan, to become a participant on your Participation Date, you must be an active employee of the Employer on your Participation Date and you must properly complete and submit an initial Election Form to the Plan Administrator (or complete a designated electronic enrollment process, if available) before your Participation Date and during the period designated by the Plan Administrator as your initial "enrollment period". For purposes of medical benefits only, you will be treated as an active employee on your Participation Date even if you are absent from work if your absence occurs because of a health condition (as determined by the Employer).

Your benefit elections made during your initial enrollment period will be effective from your Participation Date until the last day of the Plan Year in which you change your initial benefit election (see subsection (b) below) or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (see subsections (d) and (e) below).

If you fail to properly complete and submit an Election Form to the Plan Administrator during your initial election period, you will not automatically participate in the Plan.

(b) Election Periods after Initial Election Period. After you complete the initial Election Form, your initial benefit election will remain in effect indefinitely or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (as described in subsections (d) and (e) below) or until you make a new benefit election by requesting, completing and submitting a new Election Form to the Plan Administrator for a future Plan Year during the period preceding the Plan Year that is designated by the Plan Administrator as the Plan's annual "election period". Your new benefit election will be effective from the first day of the Plan Year

following the election period in which you make your new benefit election until you change your election during a later election period, or you experience a Status Change, exercise a Special Enrollment right or otherwise qualify to make an election change that is permitted under the Plan.. However, this automatic carry-over of previous elections does not apply to your elections regarding participation in the Plan's health care flexible spending account or dependent care flexible spending account. If you fail to complete and submit a new Election Form for these benefits, you will not automatically receive coverage.

The Employer, in its discretion, may determine that it will not offer an annual "election period" for a future plan year. If the Employer determines that there will be no annual "election period" or open enrollment for the upcoming year, the elections you made on your most recent Election Form will carry over for the next year. You will still be able to make changes to your election if you or your dependents experience a Status Change, exercise a Special Enrollment Period right or qualify to make a change for certain other reasons, as described below.

Also, although your benefit elections normally will carryover from one Plan Year to the next as described above, the Employer may announce before the start of a Plan Year that new elections will be required for all eligible employees to participate in benefits for that upcoming Plan Year. In such cases, a special required election period will be announced for all eligible employees to make new elections, which will take effect at the beginning of the next Plan Year. An employee who fails to make an election of available benefits for the following Plan Year during that special required election period will cease to participate in the Plan at the end of the Plan Year in which the special required election period occurs.

(c) Changes of Election to Reflect Status Change. If you are currently participating in the Plan, you may, with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, change your elections by filing a Status Change Form within 30 days after a Status Change event. If you are not currently a participant in the Plan but you have satisfied all the requirements to be eligible to participate (except that you do not have a current benefit election in place), with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, you may become a participant by filing an Election Form and a Status Change Form within 30 days after a Status Change event occurs.

Under applicable law, to be permitted to make a change in your benefit elections because of a Status Change event, the Status Change event must result in you or your spouse or dependent gaining or losing eligibility for that coverage or similar coverage under the Plan, a plan sponsored by another employer by whom you are employed or a plan sponsored by the employer of your spouse or other dependent. (For dependent care flexible spending account benefits, you are also permitted to make an election change if a Status Change increases or decreases your eligible dependent care expenses and the election change corresponds to the change in expenses.)

Any change that you wish to make to your benefit elections must be consistent with the Status Change event that occurred. The Employer will determine whether, under applicable law, a requested change (or a new election) is consistent with the Status Change you experience. For example, if you become eligible for health coverage offered by your spouse's employer because you get married or because your spouse changes employers, you may cancel your health coverage under this Plan only if you certify to the Employer that you have actually enrolled or intend to enroll in the other Plan. Under applicable law, it would not be consistent with the Status

Change if you merely dropped coverage under this Plan without enrolling in the other plan.

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the elections are approved by the Plan Administrator, and will be effective, for health care flexible spending account or dependent care flexible spending account coverage, for the balance of the Plan Year in which the new election is made or, for all other coverage, until you change your elections according to the Section entitled “Election Periods After Initial Election Period” or you experience another Status Change.

You will experience a Status Change if:

- (1) your legal marital status changes including changes because of marriage, the death of your spouse, divorce or legal annulment;
- (2) there is an event which causes you to gain or lose a dependent;
- (3) you, your spouse or your dependent terminates or begins employment;
- (4) there is an increase or reduction in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or the beginning or ending of an unpaid leave of absence) by you or your spouse or other dependent;
- (5) you, your spouse or your dependent becomes eligible or loses eligibility for coverage under a plan offered by that person’s employer because of a change in employment status (for example, if your dependent switches from hourly to salaried employment and the dependent’s employer’s medical plan covers only salaried employees);
- (6) an event happens that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or similar circumstance;
- (7) there is a change in location of the residence or worksite of you or your spouse or other dependent;
- (8) for purposes of dependent care flexible spending account benefits, there is an event that changes the number of your dependents who are under the age of 13 or mentally or physically incapacitated; or
- (9) for any election made on an after-tax basis, you experience any event which, in the Administrator’s sole discretion, qualifies as a Status Change.

(d) Changes of Election Because of Changes in Cost or Coverage. You may make certain changes, as described below, because of changes in cost or coverage of benefits available under the Plan. You must request such an election change within a reasonable time after your right to change your election arises (as determined by the Plan Administrator, in its discretion). Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the Election Form, if required, and the elections are approved by the Plan Administrator, and will be effective, for dependent care flexible spending account coverage, for the balance of the Plan Year in which the new election is made or, for all other coverage, until you change your elections according to the Section entitled “Election Periods After Initial Election Period”.

The rights described in paragraphs (i)-(iv) below are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan. Also, the rights described in (i)-(iv) below do not apply to elections involving a health care flexible spending account. You may not change the amount you contribute to a health care flexible spending account because of a change in cost or a change in coverage of another benefit option and you may not make an election change for any other benefit option because of a change in the cost or coverage under your health care flexible spending account or the health care flexible spending account of your spouse or dependent.

(i) Significant Cost Changes. If the cost that you are required to pay for a benefit option significantly increases (as determined by the Employer) while you are covered under that benefit, you may elect to revoke your election for that benefit and elect another similar benefit option, if one is available (as determined by the Employer). If no similar benefit option is available, you may elect to drop your coverage because of the increased cost.

If the cost that you are required to pay for a benefit option significantly decreases (as determined by the Employer) during the Plan Year, you may elect that benefit option for yourself or an eligible spouse or dependent.

Ordinarily, you may change the amount you contribute to a dependent care flexible spending account because of a significant increase or decrease in cost. However, under applicable law, if the dependent care provider who is imposing the increased cost is a close relative of yours, you cannot change your election. For this purpose, a close relative includes your parent, grandparent, child, grandchild, brother, sister, niece, nephew, stepparent, stepchild, stepbrother, stepsister, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law or brother-in-law.

You may change your elections because of a significant cost change, as described above, regardless of the reason for the increase or decrease in your cost. It does not matter whether the change in cost results from an action taken by the Employer or if it occurs because of something you do (such as switching from part-time to full-time employment if that changes the amount you have to pay for coverage).

(ii) Coverage Changes. If your coverage under a benefit is significantly curtailed during the Plan Year, you may revoke your election of that benefit and elect another benefit option that offers similar coverage (as determined by the Employer), if any. Coverage is significantly curtailed only if there is an overall reduction of the coverage provided to all participants (as determined by the Employer).

If your coverage under a benefit is significantly curtailed during the Plan Year (as determined by the Employer), and the significant curtailment amounts to a complete loss of coverage (as determined by the Employer), you may change your elections as described in the previous paragraph. In addition, if you experience a complete loss of coverage and no other benefit option that provides similar coverage is available, you may drop the coverage entirely. A loss of coverage includes, for example, the elimination of a benefit option, the loss of availability of an HMO option in the area where you or your dependent reside, or a loss of coverage for you or a dependent under a health plan option because your expenses exceed an annual limit. The Employer, in its discretion, will determine when a curtailment of a benefit amounts to a complete loss of coverage.

If the Employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year (as determined by the Employer), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

(iii) Changes in Coverage of Dependents Under Other Plans. You may also change your elections to correspond to certain changes that your spouse or a dependent makes to his or her benefit elections under a benefit plan offered by his or her employer. For example, if your spouse's employer has a cafeteria plan with an election period that is different from this Plan's election period, you may change your benefit elections to correspond to the changes elected by your spouse during his or her employer's annual election period. Also, if your spouse's employer has a cafeteria plan that allows participants to make changes during a Plan Year, such as the ones permitted by this Plan, and your spouse makes one of those permitted changes, you may elect changes to your coverage under this Plan, as long as your change corresponds with the change made by your spouse. For example, if your spouse revokes a benefit election for a health plan offered by his or her employer because of the increase in cost, you could change your election under a health plan offered by this Plan to elect coverage for your spouse.

(iv) Loss of Other Group Health Coverage. If you or your eligible spouse or dependent loses coverage for any group health coverage sponsored by a governmental entity or an educational institution (as determined by the Employer), you may change your election of benefits to elect coverage for the affected individual.

(e) Other Election Changes. Except as otherwise provided below, if you are entitled to an election change described below, you must request the change within 30 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

(i) Orders Requiring Coverage. If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical coverage for your child, you, or, if required by the order, the Plan Administrator, may change your health coverage elections (to the extent permitted by the Plan Administrator, in its discretion) to provide such coverage and you, or if required by the Order, the Plan Administrator, may change the amount of your salary reduction contributions to cover the cost of such coverage. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order and you provide evidence to the Employer that such coverage is actually being provided, subject to the Employer's approval, you will be permitted to change your election to stop providing medical coverage for your child.

(ii) Medicare or Medicaid Enrollment. If you or your spouse or dependent becomes enrolled in Medicare or Medicaid, subject to the Employer's approval, you may change your election to cancel or reduce medical coverage for that individual. If you or your spouse or dependent loses eligibility for Medicare or Medicaid, again subject to the Employer's approval, you may change your election to commence or increase medical coverage for that individual.

(iii) Paying for COBRA Coverage. If you or your spouse or dependent becomes eligible for continued health coverage under the Employer's health plan as provided under COBRA or any similar state law, you may change your election to pay for that COBRA coverage with salary reduction contributions.

(iv) FMLA Leave. If you take leave under the Family and Medical Leave Act of 1993 (FMLA), you may make certain election changes that are permitted by the Employer in accordance with the FMLA.

(f) Special Enrollment Periods for Employees and Dependents. If you decline enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption (90 days in the case of the addition of a spouse or child that does not result in an increase in your contribution).

If you or your eligible dependent are covered under Medicaid or a State Children's Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and any affected dependent in this Plan's medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. Also, if you or your eligible dependent become eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days after the date a government agency determines that you are eligible for that financial assistance.

To request special enrollment or obtain more information, contact the Plan Administrator at the address provided in this Summary.

Termination of Participation

Except as otherwise provided below, coverage for a participant generally terminates on the earliest of the following dates:

- (a) The day on which the participant terminates employment.
- (b) Except for certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant.
- (c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.
- (d) Except to the extent required by law, the day on which the participant reports for active duty as a member of the armed forces of any country.
- (e) The day on which all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of

contributions by an Employer.

Coverage for an eligible dependent of a participant generally terminates on the earliest of the following dates:

- (a) The day on which the participant terminates employment.
- (b) Except for certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant.
- (c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.
- (d) Except to the extent required by law, the day on which the eligible dependent reports for active duty as a member of the armed forces of any country.
- (e) The day on which all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.
- (f) The day on which the eligible dependent ceases to be an eligible dependent.

Coverage under the Plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.

For coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may occur in only two situations. First, as indicated above, if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with respect to the Plan, or makes an intentional misrepresentation of a material fact. In that case, the Plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

Coverage under the Plan may be extended after the date that the participant would otherwise cease to be a participant because of any of the preceding provisions if, on that date, the participant is totally disabled from a sickness or injury and is under a doctor's care. However, this coverage extension applies only to the disability and any related sickness or injury (as determined by the Employer). Any such extended coverage is subject to all of the terms of this Plan. In such cases, the extended coverage will end on the earliest of (i) the date the participant is no longer totally disabled, (ii) the date the participant becomes eligible for other health coverage under another group health plan or Medicare or (iii) 90 days from the date the participant would otherwise cease to be a participant based on the Termination of Participation events listed above.

In addition, if your employment is terminated due to a layoff, you will continue to be a participant in the Plan for an additional 30 days after the date your participation would otherwise terminate.

If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the Plan. See the “Continuation and Conversion Rights” and “COBRA Notice” sections of this Summary for more details.

Also, if you take a leave of absence from employment with the Employer because of military service and your coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in the COBRA notice section of this Summary and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the last day of the 24-month period beginning on the date your military leave of absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer. Please contact the Employer if you have questions about coverage during periods of military service.

Summary of Available Benefits

The following benefits are available under the Plan. Any salary reduction contributions you will be required to make to obtain any elected benefit will be determined by the Employer, and will be communicated to you from time to time. Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect you or require a change to your elections or benefits, you will be notified.

Medical and Prescription Drug Coverage. If you are eligible to participate in the Plan, you may purchase medical and prescription drug coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time. Medical coverage under the Plan will comply with the reconstructive surgery requirements of the Women’s Health and Cancer Rights Act of 1998.

Dental Coverage. If you are eligible to participate in the Plan, you may purchase dental coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Life Insurance/AD&D Coverage. If you are eligible to participate in the Plan, you will receive at the Employer’s sole expense life insurance/accidental death and dismemberment (AD&D) coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Long Term Disability Coverage. If you are a salaried employee and you are eligible to participate in the Plan, you will receive at the Employer's sole expense long term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

If you are eligible for long-term disability coverage, you have the option of receiving coverage as an employer-paid tax-free benefit or treating it as an after-tax benefit. If you elect to receive the coverage as a tax-free benefit, that means that you do not have to pay federal income and payroll tax (and you may not have to pay state taxes) on the amount that the employer pays for the coverage. However, if you become eligible for disability benefits during the coverage period, you generally will be subject to tax on those benefit payments. Under the other option, if you elect to receive the coverage as an after-tax benefit, you will be treated as receiving the value of the coverage as a taxable benefit, so you will be subject to income and payroll tax on the amount the Employer pays for the coverage. However, if you become eligible for disability benefits during that coverage period, any benefit payments you receive would generally not be subject to tax. You should consult with a financial advisor if you have questions about how you should pay for long-term disability coverage.

Short Term Disability Coverage. If you are an hourly employee and you are eligible to participate in the Plan, you will receive at the Employer's sole expense short term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Health Care Flexible Spending Account. Flexible spending account elections are administered based on a calendar year Plan Year. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed \$2,650 (for the 2018 calendar year). The Plan's maximum contribution amount is required by federal law. The maximum amount is adjusted by the IRS each year based on inflation. The Plan's maximum contribution amount will also be automatically adjusted each year based on the new maximum announced by the IRS.

Beginning with the 2018 calendar year, the Employer also may make contributions to a Health FSA for each employee who enrolls in medical coverage under the Plan during the Plan's annual open enrollment period. For the 2018 Plan Year, the Employer will automatically make Employer contributions to a Health FSA equal to \$100 for any Employee who is enrolling in individual medical coverage for the Plan Year or \$300 for any Employee who enrolls in family coverage under the Plan. For later years, the Employer reserves the right to contribute different amounts or no amount at all, as communicated to eligible Employees during each annual open enrollment period. Employer contributions to your Health FSA are credited even if you do not elect to make your own contributions to the Health FSA. If you do elect to make your own contributions, the Employer contribution simply increases the amount available under the Health FSA and does not reduce the amount you may contribute. Employer contributions are subject to all of the rules that apply to employee salary reduction contributions under the Health FSA, as described in this section and in other documents available to employees. Employer contributions are provided only for eligible Employees who enroll in medical coverage during the applicable open enrollment period and are not made for any Employee who enrolls in the Health FSA after the start of the calendar year.

If you do not use up your entire Health FSA balance with expenses incurred by the

end of the Plan Year, there is also a “grace period” that lasts two and one-half months after the end of the Plan Year (that is, until March 15th of the next calendar year). Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Health FSA on the last day of the Plan Year. You will still be treated as participating in the Health FSA for this purpose if you elected COBRA continuation coverage under the Health FSA and that COBRA coverage is in effect on the last day of the Plan Year. If your participation in the Health FSA ends before the end of the Plan Year, there is no grace period.

Generally, eligible medical expenses are expenses that you or your dependent (determined as described below) have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code’s definition of medical expenses (including legally obtained prescription drugs or insulin), and that have not been taken as a deduction in any year. As required by law, the Health FSA does not reimburse expenses for over-the-counter medicine (other than insulin), unless the medicine has been prescribed by a physician or another qualified health care provider.

Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

For purposes of Health FSA reimbursements, “dependent” includes:

- (1) your spouse;
- (2) your biological, adopted or step-child or your eligible foster child if the child will be younger than 27 on the last day of the calendar year in which the expense is incurred, (even if the child is not your dependent for tax purposes); and
- (3) any person who is expected to be your *dependent for federal income tax purposes* (as defined below) for the calendar year in which the expense is incurred.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Health FSA benefits. However, for purposes of the Health FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) he or she files a joint income tax return with another person for the current year or (2) has gross income for the year greater than the IRS personal exemption amount (this amount is \$4,150 for 2018 and is subject to adjustment for inflation each year), that family member is still considered to be your *dependent for federal income tax purposes* for Health FSA benefits. The Plan Administrator always has the right to require documentation that an individual qualifies as your spouse or dependent for health FSA purposes and to deny benefits if you fail to provide adequate documentation when required. If you have any question about whether someone qualifies as your dependent for purposes of the Health FSA, you should consult a tax advisor.

To be reimbursed from your Health FSA, you must submit to the Plan Administrator a request for reimbursement on a form provided by the Plan Administrator. You

also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than the next April 15th following the end of the calendar year (or grace period) in which the expenses were incurred. However, if you cease to be a participant in the Health FSA (because your employment terminates or for any other reason) before the end of the Plan Year, you must submit all requests for reimbursement to the Plan Administrator no later than 60 days after you cease to be a participant in the Health FSA.

Please note that amounts held in your Health FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Health Savings Account Eligibility

You should be aware that, if you or your spouse or any eligible dependent wishes to be eligible to make Health Savings Account (HSA) contributions, your participation in the Health FSA (including automatic participation based solely on Employer contributions) could make you or your spouse or dependent ineligible to make HSA contributions. To avoid that issue, you have two options:

(1) You can elect on your Election Form to exclude your spouse from eligibility for Health FSA reimbursements, which would simply mean that you could not use the Health FSA to reimburse any expenses incurred by your spouse; or

(2) You can elect on your Election Form for the Health FSA to be treated as a “limited-scope” Health FSA. If you choose that option, that choice will apply to you and any other eligible dependents under your Health FSA. The amount contributed to your limited-scope Health FSA (including any Employer contributions) generally would be available to pay only eligible dental or vision care expenses. You could not use the Health FSA to pay or be reimbursed for any other types of expenses.

Qualified Reservist Distributions

If you are called or ordered to active duty in a United States reserve component for a period of 180 days or longer or for an indefinite period (or for a shorter period that is later expanded to 180 days or longer), and the amount you have received in reimbursements from your Health FSA for the Plan Year is less than the amount you have contributed, you may request a Qualified Reservist Distribution of your unused balance (the difference between what you have contributed and the amount of reimbursements you have received). The distribution generally would be treated as taxable compensation to you. You must request the distribution before the end of the grace period for the Plan Year during which you are called or ordered to active duty. If you request a distribution, you may continue to submit claims for expenses incurred before you made your request, but you may not submit claims for expenses incurred after that date. Your request must include a copy of the document that orders or calls you to active duty (if not already provided to the Employer). If you qualify for a Qualified Reservist Distribution, the distribution will be made within a reasonable period (no later than 60 days) after you request it. Once you receive a distribution equal to your entire unused balance, you will no longer be a participant in the Health FSA for that Plan Year and will not be able to submit or be reimbursed for any additional claims for eligible medical expenses. To request a Qualified Reservist Distribution or for more information, you should contact the Plan Administrator at the address provided in this Summary.

Dependent Care Flexible Spending Account. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed \$5,000 per calendar year or, for married participants filing separately, \$2,500 per calendar year, credited to your dependent care flexible spending account (Dependent Care FSA). You can receive amounts from this Account, in cash, as reimbursement for Employment Related Expenses incurred during the Plan Year and while you are a participant in the Dependent Care FSA. However, if you do not use up your entire Account balance with expenses incurred by the end of the Plan Year, there is also a “grace period” that lasts two and one-half months after the end of the Plan Year (that is, until March 15 of the next Plan Year). Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Dependent Care FSA on the last day of the Plan Year. If your participation in the Dependent Care FSA ends before the end of the Plan Year, there is no grace period.

The amount of any reimbursement for Employment Related Expenses may not exceed the amount credited to your Account at the time of your reimbursement request. Generally, under federal law, Employment Related Expenses are expenses for household services and expenses related to the care of a “Qualifying Individual”, which you incur to enable you to work.

“Qualifying Individual” is defined under federal law and currently means someone who is:

- (1) your child (including a stepchild), brother, sister, stepbrother or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13, who has the same principal residence as you for at least half of the calendar year and who does not provide at least half of his or her own support for the current calendar year,
- (2) your spouse who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year or
- (3) your *dependent for federal income tax purposes* (as defined below) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Dependent Care FSA benefits. However, for purposes of the Dependent Care FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) he or she files a joint income tax return with another person for the current year or (2) has gross income for the year greater than the IRS personal exemption amount (this amount is \$4,150 for 2018 and is subject to adjustment for inflation each year), that family member is still considered to be your *dependent for federal income tax purposes* for Dependent Care FSA benefits.

The Plan Administrator always has the right to require documentation that an individual qualifies as a Qualifying Individual under the above rules and to deny benefits if you

fail to provide adequate documentation when required or if the Administrator determines that expenses for any person are not eligible for reimbursement. If you have any question about whether someone qualifies as your dependent for purposes of the Dependent Care FSA, you should consult a tax advisor. Also, note that the determination of whether someone is a Qualifying Individual must be made each time expenses are incurred. For example, if your child is age 12 at the start of the calendar year, otherwise eligible expenses for that child can be reimbursed under the Dependent Care FSA only for services provided before the child's 13th birthday (unless the child is mentally or physically incapable of taking care of himself or herself).

The amount of reimbursements that you may receive from your Dependent Care FSA on a tax-free basis in a calendar year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. Thus, for example, if you have \$5,000 in your Dependent Care FSA and you and your spouse have Earned Income of \$20,000 and \$4,000, respectively, you can receive \$4,000 worth of reimbursement from the Account on a tax-free basis, and you will be taxed on \$1,000 worth of the reimbursement you receive. If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have Earned Income for each month that he or she is a full-time student or incapacitated. The amount of deemed earnings will be \$250 a month, if you provide care for one Qualifying Individual, or \$500 a month, if you provide care for more than one Qualifying Individual.

Employment Related Expenses that are incurred for services outside your household may be reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under thirteen years of age (category (1) in the above definition of Qualifying Individual), or (ii) another Qualifying Individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center (as defined below), the Center must comply with applicable laws and regulations of a state or local government. A "Dependent Care Center" is any facility that provides care for more than six individuals who do not reside at the center and receives a fee, payment or grant for providing services for any of the individuals.

No reimbursements will be made for Employment Related Expenses for services rendered by any person for whom you or your spouse is entitled to a deduction on your federal income tax return for the applicable calendar year or who is your child (including a stepchild or a foster child) who will be under the age of 19 at the end of the year.

To be reimbursed from your Dependent Care FSA, you must submit a reimbursement request to the Plan Administrator on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than the next April 15th following the end of the calendar year (or grace period) in which the expenses were incurred. However, if you cease to be a participant in the Dependent Care FSA (because your employment terminates or for any other reason) before the end of the Plan Year, you must submit all requests for reimbursement to the Plan Administrator no later than 60 days after you cease to be a participant in the Dependent Care FSA.

Please note that amounts held in your Dependent Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts which you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the tax credit available. Attached as an Exhibit is a notice which further explains the dependent care tax credits and the income exclusions. The notice also provides a worksheet to help you determine which tax reduction method is more beneficial for you.

Dependent Care FSA benefits are not subject to the federal law known as ERISA, so the “Your Rights under ERISA” section of this Summary does not apply to these benefits.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your health care continuation or conversion rights, please contact the Plan Administrator. Also, please review the next section regarding continuation coverage under the federal law known as “COBRA”.

Continuation Coverage Under COBRA (COBRA Notice)

This “COBRA Notice” section of your Summary Plan Description applies to employees and covered spouses and dependents who have health coverage under the Plan. For purposes of this notice, “Plan” refers only to the medical, prescription drug, dental and health care flexible spending account benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

You are receiving this notice because you are covered under a group health plan offered under the Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice 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.** Both you and your spouse (if you are married and your spouse is covered by the Plan) should take the time to carefully read this notice.

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 at the address provided in this notice.

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 period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health coverage under the Plan 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 COBRA continuation coverage.

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

- 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 happens:

- 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 happens:

- 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 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 the employee and 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 later of (1) the date the qualifying event occurs or (2) the date coverage would end because of the qualifying event. This notice

must be provided, along with any required documentation to:

Miller & Long DC, Inc.
c/o Human Resources Department
4001 Brandywine Street, NW, Suite 400
Washington, DC 20016

Your notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- Your name, address, phone number and health plan ID number.
- The name, address, phone number and health plan ID number for any dependent or spouse whose eligibility is affected by the qualifying event.
- A description of the qualifying event and the date on which it occurred.
- The following statement: “By signing this letter, I certify that the qualifying event described in this letter occurred on the date described in this letter.”
- Your signature.

You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided in this notice.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, you may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. (NOTE: The rest of this paragraph applies to health plans other than a health care flexible spending account plan. For the rules that apply for a health care flexible spending account, see the “*Special Rules for Health Care Flexible Spending Accounts*” section below.) 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 employment terminates, COBRA continuation coverage for his 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, as described in the next two sections of this Notice.

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 a disability determination, you should follow the same procedures described above under "*You Must Give Notice of Some Qualifying Events*". Your notice must include documentation of the Social Security Administration's decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event.

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 (following the same procedures described above under "*You Must Give Notice of Some Qualifying Events*"). 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.

Special Rules for Health Care Flexible Spending Accounts

For a health care flexible spending account (Health FSA), COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs (plus any grace period that applies after the end of that Plan Year (as described in this Summary Plan Description), but only if the qualified beneficiary keeps COBRA coverage in effect through the last day of the Plan Year). COBRA continuation coverage for the Health FSA cannot be extended beyond that time for any reason.

EXAMPLE: Assume that an employee elected to contribute a total of \$1,200 to her Health FSA account for a Plan Year and then her employment terminates six months after the start of that Plan Year. By that time, she has contributed \$600 to her FSA account through payroll deductions. Assume that she has already received \$800 in reimbursements from her account for eligible expenses she paid before her

employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is \$400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of \$600 (plus about \$12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about \$612) is more than the maximum that she would be eligible to receive in reimbursements (\$400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of \$588 or less before her employment terminated, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay (\$612).

Any filing deadlines or other rules (including any grace period rules) for filing a request for reimbursement under the Health FSA, as described earlier in this Summary Plan Description, will continue to apply if you elect continuation coverage under the Health FSA.

Additional Continuation Coverage Election Period for “TAA-Eligible Individuals”

In addition to the other COBRA rules described in this section of your Summary Plan Description, there are some special rules that apply if you are classified as a “TAA-eligible individual” by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.)

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than 6 months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this Notice, your coverage period will be measured from the date of your TAA-related loss of coverage.

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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (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 EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

If you have questions or need more information about COBRA continuation coverage under the Plan, please contact the Plan Administrator at the address or phone number provided in this Summary.

Emergency Medical Care

If you believe you need emergency medical care, you should not forego that care because you believe it will not be covered by the Plan.

Patients to Evaluate Care

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any practitioner. Each patient should evaluate the quality of care and act accordingly. No Plan provision expressed in this Summary or the Plan documents should be interpreted to restrict the access to or delivery of medically necessary services. A patient's decision to forego such care should not be based on his or her interpretation of this Summary Plan Description or the Plan documents.

Health Information Privacy

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. If you are an employee and you are covered under any of the Plan's health benefit options, you should have received a copy of the Plan's Privacy Notice with this Summary (if you did not previously receive one). In addition, a copy of the Plan's current Privacy Notice is always available upon request. Please contact the Plan Administrator at the address indicated later in this Summary if you would like to request a copy of the Notice or if you have questions about the Plan's privacy policies.

Medical Benefits Following Childbirth

The Plan and any health insurance company insuring health benefits under the Plan, 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 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 and/or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, the Plan and any health insurance company may not, under federal law require that a provider obtain authorization from the Plan or health insurance company, if any, for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

Claims Procedures

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and for certain medical benefits, the applicable requirements of regulations issued under the Affordable Care Act and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures generally will apply instead of the claims procedures described in this Summary. This Claims Procedure section includes descriptions of the minimum requirements for claims procedures that apply to insured benefits, but full details of claims procedure rules for insured benefits are described in the insurer's Benefit Booklet that describes the specific insured benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims, including claims for dependent care flexible spending account or short term disability benefits, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator (or an insurer) provide notice to a claimant about any right under ERISA will not apply to such a claim.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

For purposes of these procedures, "health benefit" or "health claim" refer to benefits or claims involving medical, dental, vision or health care flexible spending account coverage. Also, a benefit or claim is considered a "disability benefit" or "disability claim" for purposes of these procedures if the benefit or claim, including claims for accidental death and dismemberment benefits, requires that the Plan or an Insurer make a determination of whether a claimant has experienced a disability.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act, "adverse determination" also includes any rescission of coverage. A

rescission of coverage generally is a retroactive termination of coverage because of fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a “rescission” and is therefore an adverse determination that is subject to these claims procedures will be determined by the Reviewer based on applicable law.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term “Reviewer” to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. Claims should be submitted promptly after an expense is incurred. Unless a later deadline expressly applies in this Summary or under a benefits booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred. (For deadlines for submitting flexible spending account reimbursement requests, see the “Summary of Available Benefits” section of this Summary.)

The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, following the following procedures. (For purposes of these procedures, “health benefits” or “health claims” refers to benefits or claims involving medical, dental, vision or health care flexible spending account coverage.)

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the Claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan’s benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan’s determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan’s receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the

time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. The Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

(A) For any pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(B) For any post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will

specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services or other benefits already provided (or any other health benefit claim that is not a pre-service claim).

(c) Disability Benefit Claims. For any disability benefits claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

- (i) A description of the specific reasons for the denial;
- (ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;
- (iii) A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed);
- (iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;
- (v) A statement of the Claimant's right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial and a description of any time limit that would apply under the Plan for bringing such an action.

In addition, for a denial of health benefits or disability benefits, the following will be provided to the Claimant:

- (i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and
- (ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or

clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).

For an adverse determination concerning a health claim involving urgent care, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

Reviews of Initial Adverse Determinations

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

(a) Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after you receive notice of the initial denial of the claim. The decision on review will be made within a reasonable time but no later than 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records 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.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a

particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) For purposes of any medical coverage, the Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:

(A) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by or on behalf of the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(B) For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within a reasonable time but not later than 45 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

- (i) a description of its decision;
- (ii) a description of the specific reasons for the decision;
- (iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;
- (iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claim for benefits;
- (v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA section 502(a) and a description of any time limit that applies under the Plan for bringing such an action;
- (vi) if applicable, a statement describing any voluntary appeal procedures offered by the Plan and about the Claimant's rights to obtain information about such procedures
- (vii) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and
- (viii) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

Additional Requirements for Medical Plans

For any adverse determination involving medical coverage, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

- (1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);
- (2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
- (3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Also, for all claims involving coverage that is subject to the Affordable Care Act, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Additional Requirements for Out-of-Network Claims for Medical Coverage

Out-of-Network Medical claims submitted to the Plan must comply with billing standards established by the United States Department of Health and Human Resource Centers for Medicare and Medicaid Services for the purpose of Medicare claims processing. Claims submitted on behalf of members who sought care outside the network of health care providers with negotiated rates through the Plan's Network or other specific negotiated contractual arrangements will be subject to the Medicare-Based Reasonable Reimbursement Rates or Reference-Based Rate Reimbursement. The Reference-Based Rate Reimbursement will be based on Medicare allowable fee schedules listed by geographical region, published and publicly available fee and cost lists and comparisons, any resources listed, rate or any combination of such sources that result in the determination of reasonable expense under the Plan, within the range of what is accepted as fair payment. If you are balance billed for covered services with a facility or institution, (hospital, rehabilitation facility, etc.) you should contact the Customer Service Number located on your ID Card.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the determination will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits other than health benefits, the period for making the determination on appeal will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant's Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any

legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan's Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim for benefits under coverage that is subject to the Affordable Care Act, you are deemed to have exhausted the Plan's internal claims and appeals process if the Plan fails to strictly adhere to the applicable requirements of the U.S. Department of Labor's claims procedure regulations (or corresponding regulations issued by the Department of the Treasury or the Department of Health and Human Services), except for certain minor violations. For this purpose, the Plan's failure to comply with the claims procedure regulations is considered a minor violation if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred as part of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this "minor violation" exception applies, you may request a written explanation of the violation from the Plan and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the Plan's internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run when you receive the notice.

In cases where you are deemed to have exhausted the Plan's internal claim procedures, you have the right to pursue any available remedy under ERISA and, if the claim involves coverage that is subject to the Affordable Care Act, you have the right to pursue any remedy under any available external review process provided under federal or state law in accordance with the Affordable Care Act.

External Review

(a) External Review Process. For purposes of any coverage that is subject to the Affordable Care Act, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with the interim procedures for federal external review in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance. The Plan will begin complying with any new requirements for external review guidance on or before the date that those requirements become applicable to the Plan.

(b) Availability of External Review. External review is not available for all adverse

determinations. For example, external review is not available for an adverse determination based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan. External review is available only for:

(i) any final internal adverse determination (or an initial internal adverse determination on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal adverse determination that involves a rescission of coverage; or

(iii) Any other final adverse determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

(c) Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives notice of an adverse determination for which external review is available.

(d) Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the time the health care item or service was provided;

(ii) The adverse determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe the reasons external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the Claimant receives the notice.

(e) Referral to Independent Review Organization. External reviews are conducted by

independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan will contract with at least three different IROs. The Plan will take action against bias and to ensure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Under a contract between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving any information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- (A) The Claimant's medical records;
- (B) The attending health care professional's recommendation;
- (C) Reports from appropriate health care professionals and other

documents submitted by the Plan, the Claimant, or the Claimant's treating provider;

(D) The terms of the Plan, unless the terms are inconsistent with applicable law;

(E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(G) The opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.

(vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.

(vii) The IRO's notice will include:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;

(F) A statement that judicial review may be available to the Claimant; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA.

(viii) The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make

such records available for examination by the Claimant, Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(e) Effect of External Review Decision. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse determination, the Plan will provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

(a) Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an adverse determination that otherwise qualifies for external review (as described above) and that is:

(i) An adverse determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under the Plan's normal procedures for urgent care claims would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final adverse determination, if the Claimant has a medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(b) Procedures for Expedited External Review.

(i) In General. The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review. The Plan will immediately send the Claimant a notice of its eligibility determination that meets the preliminary review notice requirements described above.

(iii) Referral to IRO. Upon a determination that a request is eligible for external review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide review as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that

notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

Insured Benefits and State Law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Termination or Amendment of Plan

The Employer expects to maintain the Plan indefinitely as a program of employee benefits. However, the Employer has the right, in its sole discretion, to terminate or amend any provision of the Plan at any time. Therefore, no Plan participant (including any future retiree or retiree who has already retired) has a right to the continued enjoyment of any particular benefit under the Plan after a Plan termination or amendment affecting those benefits.

No Right to Continued Employment

No provision of the Plan or this Summary shall be interpreted as giving any employee any rights of continued employment with the Employer or in any way prohibiting changes in the terms of employment of any employee covered by the Plan.

Non-Assignment of Benefits; Payments to Providers

Except as otherwise expressly provided in this Summary or in an applicable Benefits Booklet, no participant or beneficiary may transfer, assign or pledge any Plan benefits and no benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. Also, no benefit under the Plan will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

The Administrator may, in its discretion, elect to make a direct payment to a provider of services for which benefits are available under a Component Plan and such direct payment to the provider by the Plan shall not be considered an assignment or alienation under the Plan or any Component Plan, and neither the direction by a Plan participant, or any eligible or covered dependent to make such payment nor the payment itself shall be construed as an assignment of benefits or as a recognition by the Administrator of the validity of any attempted alienation or assignment of benefits under the Plan nor will any such payment confer on the payee any rights besides the right to receive the payment in the amount of that specific payment.

No Covered Person may, at any time, either while covered under the Plan or following termination of coverage, assign his or her right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its

fiduciaries.

The Plan will honor any Qualified Medical Child Support Order (QMCSO) that provides for Plan coverage for an Alternate Recipient, in the manner described in ERISA §609(a) and in the Plan's QMCSO Procedures.

Coordination of Benefits

The coordination of benefits provisions described in the Benefits Booklets delivered to you with this Summary, as interpreted by the Plan Administrator (or insurer, if applicable) in its discretion, control all coordination of benefits situations involving the Plan and other payers.

Subrogation/Right of Reimbursement

As a condition of receiving medical, dental, vision, disability or any other benefits under the Plan, all covered persons, including all covered dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person, organization or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to the "make whole" doctrine, the "common-fund" doctrine or other similar common-law subrogation rules or legal theories.

Also, each participant and each covered person, as a condition for and consequence of receiving medical, disability or any other benefits under the Plan with respect to any amount that is subject to this subrogation provision, agrees as follows:

(1) The participant and each covered person (or their attorneys or other authorized representatives) will promptly inform the Plan of any settlement agreement and to provide reasonable advance notice of any plans for the disbursement of any settlement funds to the Participant or covered person (or to any other person on behalf of the covered person);

(2) The participant and each other covered person (or their attorneys or other authorized representatives) will hold any settlement funds received with respect to a claim that is subject to the Plan's subrogation rights in trust for the benefit of the Plan until all obligations to the Plan under this subrogation provision are satisfied (or to disburse such funds to the Plan to satisfy any obligations to the Plan under this subrogation provision);

(3) The participant and each other covered person (or their attorneys or other authorized representatives) will maintain and treat any settlement funds received by or on their behalf, as Plan assets, to the full extent of any benefits paid by the Plan with the Participant or other covered person being a trustee of Plan assets with respect to such amounts until the covered person's obligations under this subrogation provision are satisfied; and

(4) The participant and each other covered person (or their attorneys or other authorized representatives) agree that the Plan has an equitable lien on any settlement funds payable to or on behalf of the Participant to the full extent of any benefits paid by the Plan amounts until the covered person's obligations under this subrogation provision are satisfied in full.

Insurance Contracts

The Employer may contract with one or more insurance companies for insured benefits to be provided under the Plan. The Employer has the right to replace any such insurance companies from time to time for any reason. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any insurance contract used to provide benefits are the property of the Employer, except to the extent, if any, that the Plan Administrator determines that a portion of the amount payable is required to be treated as an asset of the Plan. Any portion of such a payment that is required under applicable law to be treated as a Plan asset may be used to provide or pay for benefits for eligible employees or to pay reasonable Plan expenses or may be used or paid in any other manner that is consistent with applicable law regarding the use of Plan assets.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA):

- You can examine, free of charge, at the Plan Administrator's office and at other locations, all of the Plan documents, including insurance contracts, if any, collective bargaining agreements and copies of all documents filed by the Plan (such as detailed annual reports) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You can obtain copies of all Plan documents governing the operation of the Plan, by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.
- In some cases, the law may require the Plan Administrator to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. As described above, if your claim for a Plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision, without charge and have the Plan review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials 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 until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied after review and reconsideration by the Plan or is ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof considering the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse Plan funds, if any, 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.

You may have the right to continued health 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. You should review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage.

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

EXHIBIT: Dependent Care Tax Credit vs. Dependent Care FSA

If you have qualifying dependent care expenses, you may be able to choose one or both of two ways to reduce your taxes. You may be able to obtain a tax credit (which is a direct reduction in the amount of taxes you otherwise would owe) or you may be able to reduce your taxable income by contributing to a dependent care flexible spending account (FSA). This worksheet will help you decide which is better for you.

DEPENDENT CARE TAX CREDIT

If you qualify for the tax credit, you are allowed to deduct from the taxes you owe a percentage of the lesser of (1) your actual qualifying dependent care expense or (2) \$3,000 if you have one dependent or \$6,000 if you have two or more dependents. The percentage is based on your adjusted gross income for the year. The following chart will help you determine your percentage.

If your adjusted gross income is		The percentage of the cost of dependent care you can deduct from your taxes is:
over	to	
\$0	\$15,000	35%
\$15,000	\$17,000	34%
\$17,000	\$19,000	33%
\$19,000	\$21,000	32%
\$21,000	\$23,000	31%
\$23,000	\$25,000	30%
\$25,000	\$27,000	29%
\$27,000	\$29,000	28%
\$29,000	\$31,000	27%
\$31,000	\$33,000	26%
\$33,000	\$35,000	25%
\$35,000	\$37,000	24%
\$37,000	\$39,000	23%
\$39,000	\$41,000	22%
\$41,000	\$43,000	21%
\$43,000		20%

Example: An employee's adjusted gross income for the year is \$34,000 and the employee spends \$2,600 each year for day care for one dependent. When you compare \$2,600 with the \$3,000 allowed for one dependent, the lesser of the two amounts is \$2,600. To find the employee's allowable percentage, you use the above chart. Since the employee's adjusted gross income is \$34,000, the employee's percentage will be 25%. Therefore, the amount the employee will be able to deduct from his or her taxes will be $\$2,600 \times 25\%$ or \$650.

INCOME EXCLUSION (DEPENDENT CARE FSA CONTRIBUTIONS)

Instead of the Dependent Care Tax Credit, each year you may elect to have a designated amount taken out of your paycheck before taxes and put into your Dependent Care FSA. This amount must be used during the year to pay for qualifying dependent care expenses. You will not have to pay taxes on the amount you put into the FSA that will be used to pay your qualifying dependent care expenses. If, however, either you or your spouse has Earned Income (as defined in the Plan) of less than \$5,000, your income exclusion will be limited to the Earned Income of you or your spouse, whichever is less. Note that your maximum dependent care FSA contribution for any calendar year is \$5,000 (\$2,500, if you are married but file a separate federal income tax return), regardless of the number of qualifying dependents.

Example: The following is an example of an employee's comparison of the Dependent Care Tax Credit and the Dependent Care FSA. Assume the employee is married and the employee and spouse together expect to have \$70,000 in adjusted gross income (AGI), and they expect to have \$2,800 in qualifying dependent care expenses for the year for one qualifying child. They plan to file a joint federal income tax return. After taking the standard deduction (\$12,700) and 3 exemptions (\$4,050 X 3), their federal taxable income would be \$45,150. Assume they live in a state that uses the same definition of taxable income as the IRS and a 5% tax rate. (Note that state income tax rates vary from zero to about 9.0% and states may use different definitions of taxable income. The federal tax rates and standard deduction and exemption amounts in this example are for the 2017 tax year.)

	Using the Tax Credit	Using the FSA
Federal Taxable Income (without Dependent Care FSA)	\$45,150	\$45,150
Subtract: Dependent Care FSA contribution	(0)	(2,800)
Federal Taxable Income	\$45,150	\$42,350
Taxes		
Federal (10% of first \$18,650 of taxable income + 15% of amounts from \$18,650 up to \$75,900)	\$5,840	\$5,420
Social Security and Medicare (7.65% of AGI (minus Dependent Care FSA contributions))	5,355	5,141
State (5.0% of taxable income)	2,258	2,118
Total	\$13,453	\$12,679
Subtract: Tax Credit (20% of \$2,800)	(560)	(0.00)
Total Taxes	\$12,893	\$12,679

In this example, the employee would pay less in taxes by using the Dependent Care FSA. Of course, this is just one example. Other employees might pay lower taxes using the tax credit, so you should perform the calculations using your own estimated income, qualifying expenses and filing status.

CALCULATE YOUR TAX CREDIT

Use the following chart to determine whether you should use the Dependent Care Tax Credit or the Dependent Care FSA.

	Using the Tax Credit	Using the Income Exclusion (FSA)
Federal Taxable Income (before Dependent Care FSA)	\$ _____.	\$ _____.
Subtract: Dependent Care FSA contribution		(\$ _____.)
Taxable Income	\$ _____.	\$ _____.
Taxes		
Federal* (_____ %)	\$ _____.	\$ _____.
State* (_____ %)	_____.	_____.
Social Security (generally 7.65% of total wages B remember to subtract FSA contributions for the second column)	_____.	_____.
Total	\$ _____.	\$ _____.
Subtract: Tax Credit (% from chart on previous page based on your adjusted gross income X your expected qualifying dependent care expenses)	(\$ _____.)	
Total Taxes	\$ _____.	\$ _____.

*Federal and state tax rates vary depending upon your taxable income and filing status. Estimate your tax liability or check with your tax consultant. Also, note that Pennsylvania and New Jersey, unlike other states, do not exclude Dependent Care FSA contributions from state income tax.

USE OF BOTH DEPENDENT CARE TAX CREDIT AND INCOME EXCLUSION

You may use both the Dependent Care Tax Credit and the Dependent Care FSA (although not for the same qualifying dependent care expenses.) However, any amounts that you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the \$3,000 or \$6,000 Dependent Care Tax Credit figure, whichever is applicable.

Example: An employee's adjusted gross income for the year is \$35,000 and the employee spends \$2,600 during the year for qualifying day care for one dependent. The employee elects to place \$1,200 into a Dependent Care FSA to pay for a portion of the dependent care expenses. When you compare the employee's remaining dependent care expenses of \$1,400 with \$1,800 (\$3,000 - \$1,200), the lesser of the two amounts is \$1,400. Given the employee's adjusted gross income of \$35,000, the employee's percentage from the chart is 25%. Therefore, the amount the employee may deduct from the employee's taxes will be \$1,400 x 25% or \$350.

ALWAYS DISCUSS THESE ISSUES WITH YOUR TAX ADVISOR.

DEFINITIONS

Accident

An unforeseen and unplanned event or circumstance resulting in an Injury.

Ambulatory Surgical Center

A clinic or other establishment licensed and approved by Medicare (where applicable) to perform outpatient surgery, diagnosis and treatment of Illness or Injury on an outpatient basis.

Birthing Facility

A specialized free-standing facility for child-birth which is licensed under applicable law.

Claim Processor

The person or entity, if any, to whom the Plan Administrator delegates claim administration including, but not limited to responsibility for:

- receiving and reviewing claims for Plan benefits;
- determining benefit amounts payable;
- disbursing benefit payments;
- reviewing denied claims; and
- processing appeals under applicable law as described in the Summary Plan Description

under the terms and conditions of a written agreement with the Plan Administrator.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Copayment

The amount the Covered Person is required to pay toward the payment of expenses for which coverage is available under the Plan as specified in the Schedule of Benefits. A Copayment is expressed as a flat dollar amount.

Coinsurance

The amount the Covered Person is required to pay toward the payment of expenses for which coverage is available under the Plan as specified in the Schedule of Benefits. Coinsurance is expressed as a percentage of covered charges.

Covered Expenses

The Plan's Allowable Amount for Medically Necessary healthcare services or supplies provided under the Plan. Covered Expenses are limited to actual expenses incurred for a healthcare service or supply after application of any discounts or adjustments from preferred providers. For expenses incurred at Out-of-Network Providers, except as otherwise expressly provided under the Plan, Covered Expenses will be determined based on Reference-Based Reimbursement Rates, as detailed within this Schedule of Benefits, as determined under the Plan's Claim Review and Audit Program.

Covered Person

A person who has satisfied the requirements for becoming a Participant and such person's eligible Dependents, in each case on and after Plan participation has become effective for each such person. Covered Person includes individuals who are covered under a COBRA continuation provision.

Deductible

The Deductible is the amount a Covered Person must pay to service providers out of his or her own funds before certain benefits under the Plan begin. Some benefits require no Deductible while other benefits are subject to Deductibles.

Patient Copayments and Coinsurance payments (i.e., your percentage or share of expenses) do not apply toward the Deductible.

Dependent

See Eligibility section.

Durable Medical Equipment

Medical equipment (e.g., hospital beds, wheelchairs, etc.) which:

- is prescribed by a licensed Physician
- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose, such as treatment of an illness or injury, improvement of a malformed body member, or prevention of deterioration of the patient's medical condition;
- is generally not useful to a person in the absence of an illness or injury;
- is appropriate for use in the home; and
- is not primarily for the convenience of the patient.

All requirements of the definition must be met before an item can be considered Durable Medical Equipment.

Emergency Accident/Illness

Facility and Professional Provider services and supplies for treatment of a sudden and serious onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the

absence of immediate medical attention, as a prudent layperson would determine under similar circumstances, could reasonably result in:

1. permanently placing the Covered Person's health in jeopardy, thereby causing other serious medical consequences, or
2. causing serious impairment to bodily functions, or
3. causing serious permanent dysfunction of any body organ or part

Employer/Plan Sponsor

The term “Plan Sponsor” refers to Miller & Long DC, Inc., which sponsors the Plan. The term “Employer” refers to the Plan’s other participating employers.

Experimental or Investigational

A drug, device, medical treatment or procedure is experimental or investigational:

1. If the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure.

FAIR Health Database

A database made up of de-identified data from billions of privately billed medical claims submitted by healthcare professionals to health insurers across the nation. The database includes over 18 billion billed procedures, from 2002 to present. The FAIR Health database includes billed charges from all geographic areas in the United States and its territories.

Fee Schedule

Reimbursement determined and used by the Network for their Providers.

Freestanding Dialysis Facility

A Freestanding Dialysis Facility which is licensed and approved by Medicare (where applicable) and which is primarily engaged in providing dialysis treatment to patients on an out-patient or home care basis.

Home Health Care

Services and supplies provided in the Covered Person's home ordered by a Physician, in lieu of hospitalization, and provided by someone other than a relative or by someone living in the Covered Person's household. The Claim Processor will determine on a case-by case basis whether services and supplies qualify as Medically Necessary Home Health Care expenses by qualifying as one of the following:

1. Brittle diabetics or complications of diabetes requiring professional assessment.
2. Post-operative with sutures, dressings, or complex treatments requiring professional assessment every 24 hours.
3. Receiving chemotherapy as an alternative to hospitalization.
4. Respiratory therapy - including positive pressure or oxygen (not self-administered) requiring professional assessment.
5. Suctioning/Posturing requiring professional assessment.
6. Receiving intravenous fluid or IV drug therapy as an alternative to hospitalization.
7. Decubitus care and other special skin treatment that require professional assessment every 24 hours.
8. Intensive physical/occupational therapy as an alternative to Skilled Nursing Facility care until such time the patient is able to receive services in an outpatient facility.
9. Special observation, frequent monitoring and administration of medications requiring professional assessment.
10. Acute special health monitoring, e.g. uterine monitoring.

11. Terminal, comatose or dehydrated patient, e.g. Hospice.
12. Intravenous feedings.
13. Tracheotomy care.
14. Professional assessment and instruction related to:
 - Medication compliance
 - Home equipment instructions
 - Evaluation of home environment for safety issues
15. Other Illnesses not mentioned above but requiring skilled nursing for homebound patients.

A simple Home Health Care visit shall not exceed 4 hours in duration. Please refer to the Covered Medical Expenses section in the Schedule of Benefits.

Hospice

A special program of care for a terminally ill patient diagnosed to have six months or less to live.

Hospice Care

Healthcare services or supplies provided to a terminally ill Covered Person in the Covered Person's home, a Hospital, a Skilled Nursing Care Facility or other licensed institution to provide Home Health Care, Hospital Care, medical care, nutrition counseling and specialty foods. Hospice Care also shall include bereavement counseling sessions for immediate family member provided by a licensed Mental Health Provider or pastoral counselor. The prognosis by the patient's physician for the life expectancy must be 6 months or less.

Hospital

Any institution for care of the sick or injured which is licensed to operate as such, and which has nurses on duty 24 hours a day, a Physician on call at all times, and facilities for diagnosis of sickness and for major surgery.

Hospital does not include a home for long-term, convalescent, nursing, custodial or domiciliary care; and infirmary, orphanage, or sanatorium, school, home for the needy or aged, or similar institution, a health resort or residential treatment center.

Illness

A sickness or disease including all related conditions and recurrences. Illness also includes pregnancy, miscarriage, childbirth and all related conditions, chemical detoxification and psychiatric conditions.

Injury

An Accident to the body by external force which requires medical or surgical treatment.

Medically Necessary (or Medical Necessity)

A Medically Necessary item or service is an item or service which:

1. provides for the diagnosis, prevention, or care of a covered medical condition; and
2. is appropriate for the symptoms and provides for the diagnosis or treatment of the Covered Person's medical condition; and
3. is supplied or performed in accordance with current standards of medical practice within the United States of America; and
4. is not primarily for the convenience of the Covered Person or the Covered Person's facility or Professional Provider; and
5. is the most appropriate supply or level of service that safely can be provided; and
6. is recommended or approved by the attending Professional Provider.

Medically Necessary items or services do not include Experimental/Investigational items or services.

For diagnostic services to be considered Medically Necessary, the results must be used in making treatment decisions or directing further diagnostic work up.

Mental Health Provider

An individual:

1. licensed or certified to practice psychiatry or clinical psychology; or
2. with a master's degree in social work who is duly licensed as a clinical social worker;
or
3. licensed or certified as an addiction counselor, professional counselor, or nurse specialist; or
4. a social worker if a Physician has referred the Covered Person for such treatment; or
5. licensed in a state where he or she is practicing to perform individual/group counseling.

Mental Health Treatment

Healthcare services and supplies provided by a Mental Health Provider to treat a clinically significant mental or emotional disease or disorder that is identified in the most recent edition of the International Classification of Diseases or the Statistical Manual of the American Psychiatric Association.

Morbid Obesity

A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or has a body mass index (BMI) of 40 or more (35 with certain comorbid conditions). The excess weight must cause a condition such as physical trauma, pulmonary, and circulatory insufficiency, diabetes, or heart disease.

Network

A system of care consisting of Professional Providers and facilities who have agreed with the Employer Plan Sponsor, Plan Administrator or Claim Processor to provide care to Covered Persons in a manner that seeks to ensure quality of care and appropriateness and cost-efficiency of the care's delivery.

Network Provider

A Professional Provider classified by the Plan as a Network Provider and which may be included in the most current Provider Directory or Addendum. The Plan Administrator is not responsible for any Covered Person's decision to receive treatment, services or supplies from a Network Provider, nor does the Plan Administrator make any warranties or representations regarding the quality of treatment, services or supplies provided by a Network Provider.

Out-of-Pocket Maximum ("OOP")

The annual limit of a Covered Person's out-of-pocket payments for Covered Expenses in a "Benefit Year" (i.e., a time period to be determined by the Plan Administrator) under the Medical Plan, as specified in the Schedule of Benefits. In addition, any expenses in excess of the Usual and Customary allowable fees, expenses which are not Medically Necessary, and all expenses which are excluded from coverage by the Plan will not apply towards the OOP. Upon attaining this OOP limit, the Plan will pay 100% of all other Covered Expenses incurred during the "Benefit Year". Refer to "Other Important Information concerning the applicability of certain provisions of the Plan" in this Summary Plan Description for details on how the OOP applies to the specific Plan selected.

Out-of-Network Provider

An Out-of-Network Provider is a Professional Provider who is not a Network Provider.

Physician

A person licensed to practice medicine or perform surgery or a licensed practitioner (including a nurse practitioner or Physician assistant) providing healthcare services or supplies if such services are directed and supervised by a Physician.

Plan Allowable Amount

The Amount of charges upon which the Plan's payment (for otherwise eligible expenses) is based. In determining the Allowable Amount for reimbursement under the Schedule of Benefits, the Plan will consider the lesser of: (1) the usual and customary rate, (2) the allowable charge specified under the terms of the plan, (3) the negotiated rate established in a contractual

arrangement with a provider or provider network, or (4) the actual billed charges for the covered services. An amount is considered within the Plan's Allowable Amount only to the extent that the amount is within the contracted PPO Network Rates, if applicable, or if Network Rates are not applicable, within the FAIR Health Database or Medicare-Based Reasonable Reimbursement Rates or Reference Based Rate Reimbursement.

Plan Administrator

The Plan Administrator is the Employer.

Pre-Authorization

A written authorization stating if a procedure/service is approved or disapproved for benefits based on Medical Necessity. Pre-Authorization may also include specific allowances for the services and contractual limitations. It does not meet Pre-certification requirements.

Pre-certification

A reference used for pre-admission.

A cost containment program that requires specified services to be certified in advance for Medical Necessity. This should not be used as a Pre-Authorization for Surgical Procedures.

Preferred Provider Organization (PPO)

See Network and Network Provider definitions.

Prescription Drug means:

1. legend proprietary (brand name) and generic drugs; and
2. other state-controlled drugs, which, by law, must be Physician-prescribed.

Preexisting Condition

The Miller & Long DC, Inc. plans do not have a limitation on a pre-existing condition.

Primary Care Physician ("PCP")

Any duly licensed doctor who is engaged in the practice of family medicine, general practice, internal medicine, pediatric medicine and geriatric medicine and/or who is classified as a Primary Care Physician by the Plan.

Professional Provider

Any Hospital, Skilled Nursing Facility, individual, organization or agency licensed to provide professional services within the scope of that license or certification. Professional Provider includes, but is not limited to:

1. acupuncturist
2. certified addiction counselors
3. certified registered nurse practitioner
4. chiropractor
5. clinical laboratory
6. clinical licensed social worker (ACSW, LCSW, MSW)
7. clinical psychologist
8. dentist
9. midwife
10. nurse
11. occupational therapist
12. optometrist or optician
13. physical therapist
14. Physician
15. podiatrist
16. respiratory therapist
17. speech therapist
18. Physician's assistant
19. ophthalmologist

All of the above Providers may not be covered by the Plan. Check the Plan Limitations and Exclusions section.

Prosthetics and Orthopedic Braces

Rigid or semi-rigid devices to support or replace all or part of a body function or organ in connection with an Injury or Illness.

Provider Directory

A list of Primary Care Providers and specialty Network Providers that participate in the Network.

Qualified Medical Child Support Order ("QMCSO")

A judgment, decree or order (including approval of a spousal separation agreement) issued by a court of competent jurisdiction or by an administrative process having the force and effect of state law which provides for medical coverage under the Plan with respect to a child of a Team Member and which is made pursuant to a state domestic relations law.

Reasonable and Customary

Refer to Usual and Customary.

Referral

When a Primary Care Physician is managing a Covered Person's health needs, the PCP may make Referrals to other providers and specialists for additional care, as needed.

Rehabilitation

The restoration to a condition of health not to exceed a Covered Person's former level of function or useful and constructive activity.

Rehabilitation Facility

A facility licensed to provide comprehensive Rehabilitation services to patients recovering from an Accident or an Illness, and for evaluation and treatment of individuals with physical disabilities with emphasis on education and training. The program must be coordinated and provided by or under the supervision of Physicians who are qualified and experienced in Rehabilitation.

Second Surgical/Medical Opinion

A Medical Opinion provided by a Physician, with prior authorization from [Plan], to assure the appropriateness of an elective Surgical Procedure or other course of treatment.

Skilled Nursing Facility

An institution which is:

1. accredited as a Skilled Nursing Facility by The Joint Commission or Accreditation on Health Care Organizations;
2. recognized and eligible for payment under Medicare as a Skilled Nursing Facility; and
3. recognized by the Plan as a Skilled Nursing Facility.

Substance Abuse Treatment

Treatment including, but not limited to, healthcare services and supplies, detoxification and Rehabilitation services provided by a Mental Health Provider in a Hospital or other institution licensed by the appropriate governing regulatory authority to treat alcohol addiction or other chemical dependency. Check the Schedule of Benefits and Plan Limitations and Exclusions section for covered services.

Surgical Procedure

Physician-provided services performed in a Hospital, Ambulatory Surgical Center or Physician's office, including, but not limited to:

1. a cutting operation;
2. treatment of a fracture;
3. reduction of a dislocation;
4. an endoscopic procedure; and
5. any other procedure considered surgery by the American Medical Association.

Urgent Care Center

A facility licensed to provide medical services for unexpected Illnesses or Injuries that require prompt medical attention but are not life- or limb-threatening.

Usual and Customary

The usual charge for medical services and/or supplies which is not higher than the usual charge made or accepted by the provider of the care or supply and does not exceed the usual charge made or accepted by most providers of like services in the same area. The term *area* as it would apply to any particular service, medicine or supply means a zip code or such greater area as is necessary to obtain a representative cross-section of the level of charges as determined by the Plan.

The Plan uses Medicare Reference Based Reimbursement or the Fair Health Database when there is no negotiated rate. If there are insufficient charges for a service in a geographic area the Plan uses standard relative value methodology to determine the range and usual and customary allowance for the charge submitted.

The Plan will not cover any expenses that are in excess of Usual and Customary expenses. Charges in excess of Usual and Customary expenses are the responsibility of the member unless otherwise indicated and do not apply to the Out-of-Pocket Maximum.

MILLER & LONG DC, INC.
MEDICAL PLAN
SCHEDULE OF BENEFITS
Effective January 1, 2018

Maximum Plan Benefit – There is no lifetime maximum per covered individual on total Plan benefits. However, benefit-specific maximums apply as indicated on the following chart. CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
MEDICAL DEDUCTIBLE, PER CALENDAR YEAR:		
Per individual	\$500.00	\$800.00
Per family	\$1,500.00	\$2,400.00
OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR:		
Individual	\$2,000.00	\$3,200.00
Family	\$6,000.00	\$9,600.00
Deductible payments count toward the Out-of-Pocket Maximum. There is no carryover provision for the deductible or Out-of-Pocket Maximum. In-Network and Out-of-Network deductible and out-of-pocket amounts off set each other.		
FACILITY CHARGES:		
Inpatient Hospital (Semiprivate) <i>If the hospital has only private rooms, the allowed amount for room charge is 90% of the lowest private room charge.</i> Precertification Required	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Nursery Room Charges	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Emergency Room Accident	80% of Plan's Allowable Amount after deductible.	80% of Plan's Allowable Amount after deductible.
Emergency Room Illness	80% of Plan's Allowable Amount after deductible.	80% of Plan's Allowable Amount after deductible.
Urgent Care	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Telemedicine Services	100% of Plan's Allowable Amount through Teledoc	Not Applicable
Pre-admission Testing <i>Testing must be performed within 10 days of the surgical procedures</i>	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Outpatient Surgery	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Outpatient Diagnostic X-Ray and Laboratory	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Extended Care Facility (Semiprivate)	90% of Plan's Allowable Amount after deductible, maximum 180 days per lifetime.	70% of Plan's Allowable Amount after deductible, maximum 180 days per lifetime.

TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospice Care	90% of Plan's Allowable Amount after deductible, lifetime maximum 180 days.	70% of Plan's Allowable Amount after deductible, lifetime maximum 180 days.
Outpatient Hospice Care	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Hospice Counseling	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Bereavement	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Outpatient Therapy • Chemotherapy • Radiation • Physical • Speech • Occupational • Renal Dialysis	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
PROFESSIONAL CHARGES:		
Emergency Room Physicians Accident	80% of Plan's Allowable Amount after deductible.	80% of Plan's Allowable Amount after deductible.
Emergency Room Physicians Illness	80% of Plan's Allowable Amount after deductible.	80% of Plan's Allowable Amount after deductible.
Second Surgical Opinion	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Inpatient Surgery	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Outpatient Surgery	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Inpatient Assistant Surgeon	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Outpatient Assistant Surgeon	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Inpatient Hospital Visits by Physicians	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Inpatient Hospital Consultations by Physicians	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Outpatient Therapy • Chemotherapy • Radiation • Physical • Speech • Occupational • Renal Dialysis	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Inpatient Anesthesia	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Outpatient Anesthesia	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.

TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
Physician Office Visits	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Injections	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Chiropractor	90% of Plan's Allowable Amount after deductible, maximum 30 visits per calendar year per illness.	70% of Plan's Allowable Amount after deductible, maximum 30 visits per calendar year per illness.
Podiatrist	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable amount after deductible.
Well Adult Preventive Services • Examination • X-Ray and Lab • Immunizations	100% of Plan's Allowable Amount.	100% of Plan's Allowable Amount.
Routine Gynecological Examination	100% of Plan's Allowable Amount.	100% of Plan's Allowable Amount.
Norplant	100% of Plan's Allowable Amount.	100% of Plan's Allowable Amount.
Screening Mammogram One baseline mammogram for women age 35-39. Yearly for women age 40+	100% of Plan's Allowable Amount.	100% of Plan's Allowable Amount.
Routine Pap Smear	100% of Plan's Allowable Amount.	100% of Plan's Allowable Amount.
Women's Preventive Services: • Well women preventive care to obtain recommended preventive services • Human papillomavirus (HPV) testing • Counseling for sexually transmitted infections (STI) • Counseling and screening for human immune-deficiency virus (HIV) • Contraception: FDA approved contraceptive methods, sterilization procedures, education and counseling • Prenatal office visits (not billed with delivery services) • Breastfeeding support and counseling, access to equipment • Screening and counseling for interpersonal and domestic violence	100% of Plan's Allowable Amount.	100% of Plan's Allowable Amount.

TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
Well Child Preventive Services • Examination • X-Ray and Lab • Immunizations	100% of Plan's Allowable Amount.	100% of Plan's Allowable Amount.
X-Ray, Outpatient Diagnostic X-Ray or Laboratory	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Professional Component • Inpatient X-Ray or Lab Interpretation • Outpatient X-Ray or Lab Interpretation	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
X-Ray or Lab Interpretation Outpatient Surgery	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
OTHER FACILITY AND/OR PROFESSIONAL CHARGES:		
Home Infusion	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
In Vitro	Same benefits as for other conditions.	Same benefits as for other conditions.
Artificial Insemination	Same benefits as for other conditions.	Same benefits as for other conditions.
Home Health Care	90% of Plan's Allowable Amount after deductible, maximum 100 visits per calendar year.	70% of Plan's Allowable Amount after deductible, maximum 100 visits per calendar year.
Organ Transplants	Organ Transplant coverage is provided under a fully insured policy issued by Optum/United Healthcare. For information about Organ Transplant coverage, see the separate benefit booklet concerning that coverage. Coverage under the Optum policy for transplant-related services begins on the day before the transplant is performed and continues through the 365 th day after the transplant. Transplant-related services received before or after the Optum benefit period are covered for the same benefits as are other medical conditions. Experimental procedures are not covered.	Organ Transplant coverage is provided under a fully insured policy issued by Optum/United Healthcare. For information about Organ Transplant coverage, see the separate benefit booklet concerning that coverage. Coverage under the Optum policy for transplant-related services begins on the day before the transplant is performed and continues through the 365 th day after the transplant. Transplant-related services received before or after the Optum benefit period are covered for the same benefits as are other medical conditions. Experimental procedures are not covered.

TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment/Prosthetic Devices	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Private Duty Nursing	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Disposable Medical Devices	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
TMJ Facility/Professional Charges	Covered for the same benefits as are other medical conditions.	Covered for the same benefits as are other medical conditions.
TMJ Appliance	Covered for the same benefits as are other medical conditions.	Covered for the same benefits as are other medical conditions.
Ambulance Service	80% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Acupuncture	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
MENTAL AND NERVOUS BENEFITS:		
Inpatient Hospital (Semiprivate) <i>If the hospital has only private rooms, the allowed amount for room charge is 90% of the lowest private room charge.</i> Precertification Required	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Hospital Visits by Physicians	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Outpatient Therapy	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Psychological Testing	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
Psychiatric Partial Hospitalization	90% of Plan's Allowable Amount after deductible.	70% of Plan's Allowable Amount after deductible.
SUBSTANCE ABUSE (DRUG AND ALCOHOL): No Benefit Available		
Detoxification	No Benefit Available.	No Benefit Available.
Detoxification – Inpatient Visits by Physicians	No Benefit Available.	No Benefit Available.
Residential Rehabilitation (Semiprivate)	No Benefit Available.	No Benefit Available.
Intermediate Care Facility	No Benefit Available.	No Benefit Available.
Outpatient Therapy	No Benefit Available.	No Benefit Available.
Substance Abuse Partial Hospitalization	No Benefit Available.	No Benefit Available.

PLEASE NOTE THAT THIS SCHEDULE IS MERELY A SUMMARY OF SOME FEATURES OF THIS PLAN. ALSO, PLEASE NOTE THAT THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO ANY SERVICES WHICH ARE NOT MEDICALLY NECESSARY, AS DETERMINED BY THE PLAN ADMINISTRATOR. IN ADDITION, THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO SERVICE COSTS WHICH ARE NOT THE PLAN'S ALLOWABLE AMOUNT, AS DETERMINED BY THE PLAN ADMINISTRATOR. CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

MEDICAL PLAN

Medical Plan coverage is a valuable part of your benefits program because maintaining your overall good health is important. The Plan helps pay the medically necessary costs of eligible medical services, supplies, and treatment of a sickness or injury.

Eligible network and non-network reimbursements are based on the applicable network fee schedule or the Plan's Allowable Amount. Plan benefits are based on whether you use network or out-of-network providers.

The highest level of benefits will apply when you select a Network provider. Network providers have agreed to accept direct payment from the Plan for covered medical services. Providers submit claims directly to the Plan for reimbursement on your behalf, so there's minimal paperwork involved on your part. The lower level of benefits will apply when you select an Out-of-Network provider.

To take advantage of the network benefits, be sure to present your Plan membership card each time you seek health care services from a network provider.

If you need help finding a network provider in your area you can obtain the name of one by logging onto www.myCigna.com. If you wish network benefits it's very important that you verify with the provider you select that they are participating in the network before treatment is received.

For more information concerning participating providers in the Cigna PPO, contact Miller & Long at 301-951-8690.

In most cases it's your choice whether to use an In-Network or Out-of-Network provider for a particular service, depending on your preference. If you choose to use an out-of-network provider, you may be responsible for paying your provider in full, and then you are reimbursed directly based on the Plan's Allowable Amount for the services rendered.

If there is no network provider available within 50 miles of the patient's home, charges will be considered as if in-network, subject to the Plan's Allowable Amount if approved by the claims processor. In addition, if care is rendered at an in-network facility charges made by a non-network provider (i.e., emergency room physicians, anesthesiologist, radiologists, pathologists and consulting physicians) will be considered as if in-network, subject to the Plan's Allowable Amount. If you are taken by ambulance to a non-network facility, the facility and any non-network providers that treated you will be paid as if in-network subject to the Plan's Allowable Amount. Emergency ambulance services are paid as if in-network subject to the Plan's Allowable Amount.

Out-of-Network Providers

As noted above, if you use Out-of-Network Providers, you usually will pay more (sometimes, much more) of the cost of your medical care. So, you should carefully consider that possibility when you consider whether to use an Out-of-Network Provider. The following rules apply to payments to Out-of-Network Providers.

Any charges billed by an Out-of-Network Providers for any covered service in excess of Medicare-Based Reasonable Reimbursement or Reference-Based Reimbursement or the FAIR

Health schedules are the responsibility of the Participant. You are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered.

Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds the discounted fee. For purposes of payable benefits under this Plan, any Provider who is not part of the Plan's Network is considered an "Out-of-Network Provider".

Plan payments for services provided by Out-of-Network Providers shall be limited as follows:

- In-patient Services: No more than the Medicare Based Reasonable Reimbursement or Reference Based Reimbursement or the FAIR Health database pricing (see Definitions) paid at the Percentage Payable for Out-of-Network provider services for all non-Medical Emergencies.
- All other non-Network provider services: No more than the Medicare Based Reasonable Reimbursement or Reference Based Reimbursement Rate or the FAIR Health database pricing paid at the Percentage Payable for non-Network provider services for all non-Medical Emergencies.

Amounts charged by Out-of-Network providers in excess of the Medicare-Based Reasonable Reimbursement or Reference-Based Reimbursement Rate or the FAIR Health database pricing, are not part of the Plan's Allowable Amount and will not be paid by the Plan. You may be responsible for those excess amounts.

Medicare-Based Reasonable Reimbursement or Reference-Based Reimbursement Rates

- If you use Out-Of-Network Providers, covered medical expenses are subject to certain limits under the Plan and you are responsible for paying any charges above this limit. The maximum benefit payable is based on the Plan's Allowable Amount, which is determined by the Plan to be the prevailing charge for a covered service or supply. Determination of the prevailing charge is based on the:
 - the complexity or severity of treatment;
 - the level of skill and experience involved;
 - fees usually charged by providers;
 - fees generally accepted by providers;
 - statistically credible healthcare services data that is updated annually;
 - median cost to deliver care for comparable providers and similar services;
 - prevailing provider rates adjusted to the geographical area in which the services were rendered; and
 - other factors that determine the value of the service.
- Claims submitted for payment must comply with the billing standards established by the Centers for Medicare and Medicaid Services for purpose of Medicare claim processing. Claims submitted on behalf of Plan members who sought care outside the Plan's Network of providers will be subject to a Medicare-Based Reasonable Reimbursement. The Plan will pay based on Medicare allowed fee schedule (by geographical region), published and publicly available fee and cost list and comparisons, any resources listed, rate or any combination of such resources that results in the determination of reasonable expense under the Plan, within the range of what is accepted as a fair payment.

- Eligible medical expenses are the Negotiated Rate, Medicare-Based Reasonable Reimbursement Rates or Reference-Based Reimbursement or FAIR Health Database pricing when there is no Negotiated Rate for charges incurred by an eligible Covered Person, subject to the Definitions, General Exclusions and all other provisions of the Plan. With respect to any service covered under the Plan for which Medicare has not established an allowable charge, the Plan's payment may be determined at the Plan Administrator's discretion, using normative data such as, but not limited to:
 - the fee which the provider most frequently charges the majority of its patients for the service or supply;
 - a percentage of the charges billed for the service or supply;
 - amounts the provider agrees to accept as payment in full either through a Network agreement or through direct negotiation;
 - The average wholesale price (AWP) or manufacturer's retail price; and
 - the prevailing range of fees charged in the same area by providers of a similar training and experience for the same or substantially similar service or supply.
- Medicare Rates are determined from information provided by the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory in the Medicare Cost Report, the Outpatient Prospective Payment System (OPPS) for services in geographical areas. For Ambulatory Surgery Centers, Medicare Rates are based on the Medicare allowed amount for services in the geographical region, and for services not otherwise specified, should be calculated based on industry-standard resources, that include, but are not limited to, CMS Cost Ratios, Medicare allowed fees (by geographical region), published and publicly available fee and cost list and comparisons, any resources listed in the categories above, or any combination of such resources that results in the determination of reasonable expense under the Plan, plus a higher percentage set due to the business commitment and agreement to which a Provider is willing to be contractually bound.
- The Plan Administrator reserves its right, in its sole discretion, to determine any Referenced-Based Rate for certain conditions, services and supplies using industry-standard documentation, uniformly applied without discrimination to any Covered Person.

Medical Plan Deductible

The Deductible is a specified dollar amount that must be paid for eligible expenses each calendar Year, before the Plan will provide benefits. Under the Plan, expenses for certain covered medical services as described in the Schedule of Benefits apply to the Deductible. Prescription drug services do not apply to the deductible. In-Network and Out-of-Network deductibles will offset each other.

Individual Deductible - Each Participant's annual deductible is shown in the applicable Schedule of Benefits. This deductible must be met once each calendar year and applies to Covered Services indicated in the Schedule of Benefits.

Family Deductible - Under Family Coverage, when the deductible amounts accumulated by the members of a family reach the total shown in the applicable Schedule of Benefits during a calendar year, no further deductibles will apply to any family members for the rest of that calendar year. No individual member of the family will be required to satisfy more than the individual deductible maximum.

Out-of-Pocket Limit

The Out-of-Pocket Limit is the amount you are responsible for paying for a covered service. This includes the deductible, applicable copays (not including prescription copays) and coinsurance. Non-covered services and charges in excess of Plan's Allowable Amount do not apply toward the Out-of-Pocket Limit. In-Network and Out-of-Network Out-of-Pocket limits will offset each other.

Individual Coverage Out-of-Pocket Limit – The Individual Coverage Out-of-Pocket Limit includes the medical deductible, applicable copays and coinsurance. After a Participant with Individual Coverage meets the amount shown in the Schedule of Benefits, the Plan will pay 100% of the Plan's Allowable Amount for all eligible expenses for the remainder of the calendar Year except as noted above and in the Schedule of Benefits.

Family Coverage Out-of-Pocket Limit - The Family Out-of-Pocket Limit includes the medical deductible, applicable copays and coinsurance expenses incurred by three or more members of the family. After the family's total Out-of-Pocket expenses reach the maximum amount shown in the Schedule of Benefits, the Plan will pay 100% of the Plan's Allowable Amount for all eligible expenses for all family members for the remainder of that calendar year except as noted above and in the Schedule of Benefits. No individual member of the family will be required to satisfy more than the individual Out-of-Pocket maximum.

Other Important Information

Copay - The dollar amount (shown in the Schedule of Benefits) a Participant is required to pay for a covered service. A copay is expressed as a flat dollar amount.

Maximum Benefits - Benefit specific maximums apply as indicated on the Schedule of Benefits and are offset by In-Network and Out-of-Network services.

There is no carry over deductible or out-of-pocket feature.

CARE MANAGEMENT AND ASSISTANCE PROGRAM

One of the features of the Plan is a Care Management and Assistance program provided by nurses from Inetico. This program can help Covered Persons participating in the program learn more about how to use their health care benefits and make informed decisions about their medical treatment.

The Plan encourages you and your Dependents to seek the best and most appropriate health care services. Because most of us are unfamiliar with the health care environment, we may not feel comfortable enough to make an informed decision about our medical treatment, or know how to arrange for a prescribed treatment plan, or know the kinds of questions to ask. The Care Management and Assistance program acts as a patient resource to help answer your questions and help you through what is sometimes referred to as the "health care maze."

You begin to become involved with the program if you:

- are admitted to the Hospital;
- become pregnant;
- become aware that an organ or transplant may be needed;
- need specific services as identified below; or
- need Case Management services if diagnosed with a serious illness or condition; or
- are diagnosed with or at risk for developing certain chronic medical conditions.

Case Management

Through the case management program, you receive appropriate health care services for serious or catastrophic medical conditions. The Plan Administrator may arrange for review and/or case management from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through the Plan under special circumstances.

While many diagnoses may require special attention, the Plan may use case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- burns;
- cancer;
- coma;
- hemophilia;
- inpatient confinement expected to exceed 14 days;
- multiple sclerosis/Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
- neonatal birth;
- organ transplant;
- progressive neurological debilitative disease;
- certain psychiatric conditions;
- quadriplegic/paraplegic conditions;
- renal dialysis;

- stroke; and
- multiple traumas from a vehicular accident.

Benefits provided under the program are subject to all other Plan provisions. Alternative treatments will be determined on the merits of each individual case and will not be considered as setting any precedent or creating any future liability with respect to any participant. Case management will be involved for in-network and out-of-network services that meet the established criteria.

In addition to the Case Management provided through this Plan, additional services are available for catastrophic medical management referral services. The following services are available to assist employees with catastrophic medical conditions and/or procedures. These services are provided at no cost to employees and their dependents who are eligible and currently have medical benefits under the group health plan. The following services are available:

Managed Care – Pre-certification

PRE-CERTIFICATION/CONTINUED STAY REVIEW. A Covered Person must call at least 72 hours prior to a planned Hospital admission or within 48 hours of an emergency admission. Pre-authorization must be obtained by calling (877) 608-2200.

Disease and Condition Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
 - education about the specific disease and condition,
 - medication management and compliance,
 - reinforcement of on-line behavior modification program goals,
 - preparation and support for upcoming Physician visits,
 - review of psychosocial services and community resources,
 - caregiver status and in-home safety,
 - use of mail-order pharmacy and Network providers

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact Inetico by calling (877) 608-2200.

COVERED MEDICAL EXPENSES

The Plan's medical benefit level depends on the type of expense. Refer to the Schedule of Benefits section for details on specific benefit levels. Specific expenses not described in the Schedule of Benefits are not covered by the Plan.

Plan benefits also may be subject to limitations and exclusions contained in this Summary.

A. Inpatient Hospital

Inpatient hospital expenses (including inpatient rehabilitation) are eligible for Inpatient Hospital coverage under the Plan, as specified in the Schedule of Benefits.

Effective November 1, 1998, Federal law prohibits the Plan from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections. In addition, on such date, Federal law prohibits the Plan from requiring that any provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

B. Outpatient Hospital

Outpatient hospital expenses are eligible for Outpatient Hospital coverage under the Plan, as specified in the Schedule of Benefits.

C. Physician Charges

Physician charges incurred at a facility are eligible for coverage under the Plan, as specified in the Schedule of Benefits. Second surgical opinions received from a physician prior to an elective surgical procedure are covered, although second surgical opinions are not mandatory.

Note that although surgeon's fees are eligible for Plan coverage, as specified in the Schedule of Benefits, if two or more surgical procedures are performed in the same operative field, the Plan will consider 100% of the Allowable Amount for the most expensive procedure only. If surgical procedures are performed at the same time in different operative fields, benefits will be paid as follows: 100% of the Allowable Amount for the highest billed procedure, 75% of the Allowable Amount for the second highest billed procedure, and 50% of the Allowable Amount for all remaining billed procedures.

Assistant surgeon's fees are eligible for Plan coverage, as specified in the Schedule of Benefits, up to 20% of the allowable fee schedule charge for the primary surgeon.

Chiropractic treatment and podiatrist treatment (except routine foot care) are eligible for coverage under the Plan, as specified in the Schedule of Benefits. A new maximum of 30 visits per calendar year for chiropractic treatment is available if the new condition is entirely unrelated to any other condition for which benefits were paid.

D. Specialized Care

Extended Care Facility: A physician may recommend continuing care in a convalescent hospital, which can offer quality care at rates generally below those charged by hospitals.

The Plan covers all eligible charges. However, to receive benefits, the patient must:

- (1) enter the convalescent hospital within 15 days following a stay of at least 3 days in a regular hospital;
- (2) be confined for the same or related condition which caused the hospital confinement;
- (3) be under the continuous care of a doctor; and
- (4) require 24-hour nursing care which is recommended by a doctor.

Confinements separated by less than 7 days are considered one confinement.

For the purpose of Plan coverage, a convalescent hospital may not be used mainly as a place for rest, the aged, custodial treatment, or the treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis.

Eligible expenses include charges for semiprivate room and board, X-rays and laboratory services, specialized treatment rooms, and drugs and other medication. Personal items are not covered.

Hospice Care: The Plan pays eligible inpatient and outpatient hospice care expenses. A hospice is a special program of care for a terminally ill patient diagnosed to have six months or less to live. A team of professionals and volunteer workers cares for the patient, and generally includes a doctor and a registered nurse, and may include a dietary counselor, home health aide, medical social worker, or others.

The goals of the hospice are to provide an alert and pain-free existence for the patient and to keep the family actively involved in the care.

Eligible expenses also include bereavement and counseling services.

Home Health Care: While you or a dependent are under a doctor's care, the Plan provides benefits for charges made by a licensed home health care agency. The doctor must submit a written treatment plan approximately every three months indicating the patient would otherwise need to be confined in a hospital or convalescent facilities if home care were not provided.

Services and supplies must be provided by a licensed health care organization and may not be performed by a relative or anyone living in your household.

Non-covered home health care services include:

- (1) domestic or housekeeping service
- (2) rental or purchase of equipment or supplies
- (3) meals-on-wheels or other similar food arrangements
- (4) home care provided in a nursing home or skilled nursing facility
- (5) home care for mental and nervous conditions

E. Other Eligible Medical Charges:

In addition to the inpatient, outpatient, physician and specialized care coverages noted above, the Plan provides coverage, as specified in the Schedule of Benefits, for the following:

- (1) oxygen and its administration
- (2) outpatient chemotherapy and radiotherapy
- (3) outpatient renal dialysis
- (4) approved durable medical equipment considered medically appropriate/ necessary, up to the purchase price of the equipment rented
- (5) prosthetic devices
- (6) casts, splints
- (7) diabetic supplies (are covered under the Prescription Drug Card Plan)
- (8) outpatient occupational or speech therapy if rendered by a qualified provider and prescribed by a physician.
- (9) outpatient physical therapy
- (10) cosmetic surgery for the repair of an injury, the reconstruction required by surgery from a sickness or illness, and the correction of a congenital defect that results in a functional defect of the insured's child
- (11) voluntary sterilization
- (12) elective abortion
- (13) non-experimental organ transplants. (Organ Transplant coverage is provided under a fully insured policy issued by Optum/United Healthcare and is described in the separate benefit booklet for the Optum organ transplant coverage. Coverage under the Optum policy for transplant-related services begins on the day before the transplant is performed and

continues through the 365th day after the transplant. Transplant-related services received before or after the Optum benefit period are covered for the same benefits as are other medical conditions.)

- (14) accidental injury to natural teeth or jaw (if treatment is rendered within 12 months of accident)
- (15) treatment of temporomandibular joint syndrome (TMJ)--the same as any other medical condition.
- (16) blood plasma, if not replaced
- (17) professional nursing services by a registered graduate nurse (R.N.), Licensed Practical Nurse (L.P.N.) as long as the individual is not a relative or living in the home of the patient.
- (18) Norplant
- (19) ambulance service to and from the nearest hospital where necessary care and treatment can be provided
- (19) acupuncture by a licensed physician or licensed acupuncturist for the purpose of pain relief or anesthesia only
- (20) Coverage for Individuals Participating in Approved Clinical Trials

Qualified individual. A qualified individual is defined under the plan as an individual who is enrolled or participating in the health plan and who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. To be a qualified individual, there is an additional requirement that a determination be made that the individual's participation in the approved clinical trial is appropriate to treat the disease or condition. That determination can be made based on the referring health care professional's conclusion or based on the provision of medical and scientific information by the individual.

Approved clinical trial. The term "approved clinical trial" is defined as a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or life threatening disease or condition and is one of the following:

1. A federally funded or approved trial.
2. A clinical trial conducted under an FDA investigational new drug application.
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Covered Services - Routine patient costs. With some important exceptions, routine patient costs generally include all items and services consistent with the coverage provided under the plan for a qualified individual (for treatment of cancer or another life-threatening disease or condition) who is not enrolled in a clinical trial. However, costs associated with the following are excluded:

1. The cost of the investigational item, device or service.
2. The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management.
3. The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(21) other necessary services and supplies as specifically provided in the Schedule of Benefits

F. Preventive Services

The Medical Plan includes benefits for adult and children preventive services as outlined by the Patient Protection Affordable Care Act (PPACA). Under the new rules preventive health services recommended by the U.S. Preventive Services Task Force (USPSTF) will generally be required to be provided without cost sharing when delivered by an in-network provider. Recommendations of the USPSTF for Grade A and B preventive health services can be found in a chart on the USPSTF web site (www.ahrq.gov).

Generally the preventive health services are listed in three broad categories:

- Covered Preventive Services for Adults
- Covered Preventive Services for Women, including Pregnant Women
- Covered Preventive Services for Children

These benefits can help you and your Dependents remain healthy and productive. It is important for you to understand that when you see your primary care physician (family doctor) for your annual visit that you discuss with him or her that you are there for your annual “wellness exam”. The doctor codes your encounter based on the general purpose of your visit. If it is a wellness visit then your doctor will code the encounter as a “wellness” visit and the health plan will pay any of the preventive health services at 100%.

On the other hand, you may see your doctor for a particular problem and even though some services provided may be similar to “preventive health services” the encounter is “diagnostic” in nature and the office visit and other services will be subject to co-pays, coinsurance and deductibles as listed in the Schedule of Benefits.

Well care services based on age and sex include but are not limited to:

- periodic physicals
- prostate screenings
- routine gynecological visits
- mammography screenings

- routine PAP smears
- well child care
- immunizations and inoculations
- fecal occult screenings

G. Mental and Nervous Treatment

Inpatient Treatment: Certain in-hospital mental illness expenses are covered. Eligible expenses include certain charges for semiprivate room and board, and all medically necessary medical services and supplies. Certain inpatient doctor visits are also covered.

Psychiatric Partial Hospitalization: Psychiatric Partial Hospitalization is considered the same as inpatient care.

Outpatient Treatment: Certain outpatient expenses are covered. Eligible expenses include those of a physician, psychiatrist, psychologist, or licensed certified social worker. See Schedule of Benefits for network and non-network benefits.

H. Substance Abuse Treatment is not a covered benefit.

I. Plan Limitations and Exclusions

The Medical Plan **does not** cover charges for the following:

- (1) substance abuse treatment
- (2) custodial care, residential care or rest cures
- (3) services and supplies not recommended and approved by a physician
- (4) a private room beyond the amount normally paid for a semiprivate room
- (5) cosmetic surgery, unless resulting from an accidental injury or sickness or because of a congenital malformation of a child
- (6) treatment received in a government hospital or at government expense
- (7) reversal of sterilization
- (8) routine foot care (such as corns, calluses, or toenails)
- (9) medical services for dietary control
- (10) hearing aids or corrective lenses or the examinations for their fitting or prescription, except when necessary after cataract surgery

- (11) education, research, or training programs including vision (except for Diabetic counseling/training)
- (12) experimental or investigational treatment, including transplants using non-human organs
- (13) claims filed more than one year after the expenses were incurred
- (14) charges for personal hygiene and convenience items such as air conditioners, humidifiers, or physical fitness equipment
- (15) charges for telephone consultations, missed appointments, or for completion of claim forms
- (16) charges in connection with (1) an injury arising out of, or in the course of any employment for wage or profit, or (2) a disease covered with respect to such employment, by any Workers' Compensation law, occupational disease law, or similar legislation.
- (17) treatment of any injury sustained or disease resulting from war, act of war, riot, rebellion, civil disobedience, or from military service in any country
- (18) charges reimbursable by no-fault auto insurance, or any other federal or state mandated law
- (19) charges which you or a dependent are not legally required to pay
- (20) charges that would not be made if no coverage existed
- (21) charges by a provider who is a member of your immediate family (spouse, child, brother, sister, or parent)
- (22) charges otherwise payable as described under the Coordination of Benefits provision (see below)
- (23) dental charges, except as indicated
- (24) full body scans (virtual physicals)
- (25) organ transplants and transplant-related services covered under the fully insured policy issued by Optum/United Healthcare.
- (26) services not considered medically necessary or appropriate
- (27) services not listed or described in this Summary Plan Description.

PRESCRIPTION DRUG PLAN
SCHEDULE OF BENEFITS
Effective January 1, 2018

CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY

TYPE OF PRESCRIPTION	COPAYMENT
Retail: Name Brand	\$25.00 per 30 day supply
Retail: Generic	\$15.00 per 30 day supply
Mail Order: Name Brand	\$50.00 per 90 day supply
Mail Order: Generic	\$30.00 per 90 day supply
Specialty Drugs	One fill allowed at retail with additional fills through Accredo, Express Scripts Specialty Pharmacy
Contraceptive Methods under expanded Women's Preventive Services including oral, injections and devices; includes all Generic and certain Brand Name Drugs and approved over-the-counter contraceptives	\$0 copayment
Certain Preventives OTC and Prescription Drugs under the Patient Protection and Affordable Care Act (ACA). Drugs such as Aspirin, Iron Supplements, Oral Fluorides, Folic Acid, Smoking Cessation and Vaccines based on age, sex and diagnosis are covered	\$0 copayment
PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR:	
Individual	\$4,700.00
Family	\$7,500.00

PLEASE NOTE THAT THE PLAN WILL NEVER PAY FOR ANY SERVICES THAT ARE NOT MEDICALLY NECESSARY, AS DETERMINED BY THE PLAN ADMINISTRATOR. IN ADDITION, THE PLAN WILL NEVER PAY FOR SERVICE COSTS BEYOND THOSE THAT ARE THE PLAN'S ALLOWABLE AMOUNT, AS DETERMINED BY THE PLAN ADMINISTRATOR. EXPRESS SCRIPTS ADMINISTERS THE PRESCRIPTION DRUG COVERAGE.

PRESCRIPTION DRUG PLAN

The prescription drug plan helps you pay for prescription drugs and medicines.

When you have a prescription filled at any participating pharmacy, you pay a \$15.00 copay per prescription (for a (30) day supply) for generic drugs and a \$25.00 copay per prescription (for a thirty (30) day supply) for brand name drugs. One fill is allowed at retail for specialty drugs with additional fills through Accredo, Express Scripts Specialty Pharmacy. Copayments are applied to the Prescription Drug out-of-pocket maximum (OOP). The Prescription Drug OOP maximum is \$4,700.00 per individual per calendar year. The maximum family OOP is \$7,500.00 per calendar year. This means that once 2 or more family members satisfy, in the aggregate (together) a total of \$7,500.00, the family Prescription Drug OOP maximum is satisfied for the rest of the calendar year. However, no one individual may satisfy more than \$4,700.00 of the family OOP. There is no carryover out-of-pocket feature.

Once your share of the covered expenses reaches the OOP maximum level, Plan benefits are 100% of the remaining covered expenses for the rest of that calendar year.

When you use a non-participating pharmacy, you pay the same amount as the retail.

The drug program covers drugs and medicines generally prescribed by a physician.

However, the prescription plan **does not** cover:

- (1) charges for the administration of any medication
- (2) therapeutic devices or appliances (e.g. support garments and other non-medical substances)
- (3) charges for a prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the order of the physician
- (4) immunization agents, biological sera, blood or blood plasma
- (5) drugs or medicines not legally dispensed under federal and/or state law
- (6) any medication taken or administered at the place where it is dispensed (i.e. hospital, rest home, extended care facility, nursing home, etc.)
- (7) drugs and medicines which can be obtained without a doctor's prescription
- (8) experimental drugs
- (9) prescription drugs which may be obtained without charge under local, state, or federal programs
- (10) drugs purchased outside the United States that are not legal inside the U.S.
- (11) norplant
- (12) medication used for cosmetic purposes

Mail Order Program

When you have a prescription filled by mail order, you pay a \$30.00 copay per prescription for generic drugs and a \$50.00 copay per prescription for brand name drugs. The Mail Order Program covers up to a 90-day supply or 100-unit doses, whichever is greater.

Contact Express Scripts or Miller & Long for mail order envelopes.

DENTAL PLAN

SCHEDULE OF BENEFITS

CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

TYPE OF EXPENSE	BENEFITS
MAXIMUM BENEFITS PER INDIVIDUAL:	
Preventive and Diagnostic, General and Major Services	\$1,750 per calendar year.
Orthodontic Services	\$2,500 per lifetime.
DEDUCTIBLE:	
Per Individual Diagnostic, Preventive and General Services	\$50.00 per lifetime (out-of-network only).
Per Individual Major Services	None
Per Individual Orthodontic Services	None
Per Family Diagnostic, Preventive and General	Each family member must satisfy the above individual deductible, if applicable.
COPAYMENT:	
Diagnostic, Preventive and General Services	100% in network, 80% of Plan's Allowable Amount out-of-network.
Major Services	50% of Plan's Allowable Amount
Orthodontic Services	50% of Plan's Allowable Amount
NOTE: Certain limitations apply to dental benefits. See the following sections for details	

PLEASE NOTE THAT THE PLAN WILL NEVER PAY FOR ANY SERVICES THAT ARE NOT MEDICALLY NECESSARY, AS DETERMINED BY THE PLAN ADMINISTRATOR. IN ADDITION, THE PLAN WILL NEVER PAY FOR SERVICE COSTS BEYOND THOSE THAT ARE THE PLAN'S ALLOWABLE AMOUNT, AS DETERMINED BY THE PLAN ADMINISTRATOR.

DENTAL PLAN

Your dental coverage is a valuable part of your benefits program since having healthy teeth and gums is important to your overall well being. The Plan encourages good dental health by reimbursing preventive and diagnostic treatment at 100% without a deductible if you use an in-network provider. The Plan reimburses 80% of the Plan's Allowable Amount, after a lifetime deductible of \$50.00 per individual is met, for out-of-network providers.

The Dental Plan

The Plan helps you pay the Plan's Allowable Amount for other dental expenses, as determined by the Plan Administrator.

A. Dental Plan Deductible

Before preventive, diagnostic and general dental benefits are paid, you must first pay a deductible. The deductible amount for each individual is:

Preventive, diagnostic and general services in network: No deductible
Preventive, diagnostic and general services out of network: \$50.00 per lifetime

There is no deductible for major or orthodontic services.

Also, there is no carryover deductible feature.

B. Diagnostic and Preventive Services

The Plan pays for Diagnostic and Preventive Services according to the Schedule of Benefits earlier in this section.

Covered diagnostic and preventive services include:

- (1) routine oral examinations, but not more than 2 in a calendar year
- (2) dental prophylaxis, including cleaning, scaling and polishing of teeth, but not more than 2 in a calendar year
- (3) topical application of fluoride, for children under age 18, limited to 2 applications per person in a calendar year
- (4) palliative emergency treatment (for pain)
- (5) routine X-rays taken as part of an oral examination, limited to:
 - full mouth X-rays, including panograph, one every 36-consecutive month period
 - bitewing X-rays, as required, but not more than twice during a calendar year.

- (6) sealants for permanent molars only, for dependent children until their 15th birthday, one in any 24 month period
- (7) space maintainers, when used to replace premature loss of extracted teeth, for dependent children until their 15th birthday

C. General Services

The Plan pays for eligible charges for general services according to the Schedule of Benefits earlier in this section including:

- (1) simple tooth extractions
- (2) restorative type fillings (silver, silicate, plastic, porcelain, and composite)
- (3) pulpotomy
- (4) pulp capping
- (5) root canal therapy
- (6) repair or recementing of crowns, inlays, bridgework, or dentures, and relining of dentures
- (7) oral surgery, except when covered by the Medical Plan
- (8) general anesthesia when medically necessary and administered in connection with oral surgery or other covered dental services
- (9) endodontic treatment, including root canal therapy if tooth is “opened” while covered by the Plan
- (10) treatment of periodontal and other diseases of the gums and tissues of the mouth
- (11) injection of antibiotic drugs

D. Major Services

The Plan pays 50% of eligible charge for major services according to the Schedule of Benefits earlier in this section including:

- (1) inlays, onlays, gold fillings, or crown restorations
- (2) initial installation of partial or full removable dentures, including adjustments for the six month period following installation
- (3) replacement of an existing partial or full removable denture or fixed bridgework by a new denture or bridgework, the addition of teeth to existing

fixed bridgework or partial removable denture--as stated in the Prosthesis Replacement Rule described below.

The Prosthesis Replacement Rule states the replacement of or additions to existing crowns, dentures or bridgework will be covered only if satisfactory evidence is furnished to the Plan Administrator that one of the following applies:

- (1) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing crown, denture or bridgework was installed, and while the individual is covered by the Plan;
- (2) the existing crown, denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement; or
- (3) the existing crown, bridgework, or denture is an immediate, temporary denture and replacement by a permanent denture is required within 6 months from the date of initial installation of the immediate temporary denture

E. Orthodontic Treatment

Orthodontic treatment is the detection, prevention, and correction of abnormalities in the positioning of the teeth in their relationship to the jaws.

The Plan covers 50% of eligible charges for dependent children until their 19th birthday. If treatment begins prior to age 19, the plan covers 50% of eligible charges for dependent children who are full time students until their 25th birthday.

The Plan covers 25% of the orthodontist's eligible charge when treatment begins. The balance of the charge is considered in equal monthly amounts over the period of time treatment is expected to continue.

The total amount payable for all orthodontic treatment is \$2,500.00 per lifetime per individual.

F. Dental Plan Maximum

There is a \$1,750.00 maximum dental benefit for each individual per calendar year. There is a separate lifetime maximum of \$2,500 for orthodontic treatment.

G. Dental Plan Exclusions

The Plan **does not** cover the following dental services:

- (1) services which do not meet the standards of dental practice accepted by the American Dental Association
- (2) services performed for cosmetic reasons, including personalization of dentures

- (3) services paid in full or in part under any other plan of benefits provided by the employer, school or government or for services you are not required to pay
- (4) the replacement of a lost, missing or stolen device or appliance, or an appliance to be used as a spare
- (5) charges for any services or appliance to alter vertical dimension, periodontal splinting, or implantology
- (6) charges not provided by a dentist, except cleaning or scaling of teeth, topical application of fluoride performed by a licensed dental hygienist under the supervision of a dentist
- (7) educational, research or training programs, such as training in plaque control, dietary counseling, or oral hygiene
- (8) any procedure started before the individual was covered under this Plan
- (9) analgesia (numbing type of medicine rubbed on gums)
- (10) veneers on crowns or pontics other than the ten upper and lower anterior teeth
- (11) periodontal services, except in areas where natural teeth are present
- (12) training in, or supplies used for dietary counseling, oral hygiene or plaque control, or sealants
- (13) general anesthesia, unless medically necessary and administered in connection with oral surgery
- (14) charges made by a dentist for missed appointments
- (15) charges for completion of claim forms or filing of claims
- (16) claims filed more than one year after the expenses were incurred
- (17) experimental treatment
- (18) charges made for any services not covered by the Dental Plan, according to the Plan provisions

H. Pre-Treatment Review

When you expect dental treatment to cost \$300.00 or more, you should follow the special pretreatment review procedure. By using this procedure, you and your dentist will know exactly what services are covered before any actual expenses are incurred.

Most dentists are familiar with pretreatment review. Here's how it works:

- (1) Before beginning a course of treatment for which charges are expected to be \$300.00 or more, ask your dentist to complete a pretreatment review form describing the treatment plan and indicating the itemized services and charges.
- (2) Ask your dentist to submit the completed form to Allegeant the claims processor.
- (3) Based upon the treatment plan, the claim processor's dental specialists will determine what expenses are covered by the Plan and notify you and your dentist. In determining the covered expenses, the Alternative Treatment Provision will be used, as described below.
- (4) Ask your dentist to submit a revised treatment plan to Allegeant if there is a major change in the original treatment plan.

Emergency treatments, oral examinations including cleaning, and dental X-rays are considered part of a treatment plan; however, these services may be rendered before the pretreatment review is made.

I. Alternate Treatment Provision

There is often more than one solution to a dental problem. The most expensive answer is not always the best. In dentistry, new technology and procedures give dentists many treatment choices--and the costs can vary greatly.

The Dental Plan has an alternative treatment provision which governs the amount of benefits paid for dental treatment. It assures that sound dental practices and cost-efficient alternatives are being utilized without compromising the quality of care.

For example, if a tooth can be restored with a material such as amalgam and you and your dentist select another type of restoration (gold, for example), the Plan will limit payment to the Plan's Allowable Amount for the procedures using the amalgam or other similar material. You and your dentist may decide to use gold fillings, but the Plan will only cover the cost of amalgam and you will be responsible for the difference.

Another example might be if you would select a specialized, precision appliance rather than a standard denture. The Plan limits payment to the Plan's Allowable Amount of a standard cast chrome or acrylic denture. Again, you will have to pay the difference.

It's important to obtain a pretreatment estimate before you have work done. This way you won't find out after dental work has been completed that the Plan pays less than you expect or that it excludes payment entirely.

MILLER & LONG DC, INC.
Vision Plan Description

	<u>IN-NETWORK</u>	<u>OUT-OF-NETWORK</u>
	Reimbursement	Reimbursement
EXAMINATION <i>(once every 12-months)</i>	<i>Paid In Full (including tonometry)</i>	<i>\$28.00 toward retail pricing</i>
LENSES <i>(standard - pair)</i> SINGLE BIFOCAL TRIFOCAL LENTICULAR	<i>PAID IN FULL</i>	Single \$15.00 Bifocal \$21.00 Trifocal \$30.00 LENTICULAR \$60.00
FRAME	<i>Up to \$30.00 wholesale (buys a \$90-120 retail frame)</i>	<i>\$30.00 towards retail pricing</i>
LENS OPTIONS – not covered under plan UV PROGRESSIVE TINTS PHOTOCHROMATIC	<i>Employee pays wholesale pricing plus 25% up to 50% discount on all options</i>	<i>Not Covered</i>
Contacts <i>(in lieu of glasses)</i>	Paid in Full	<i>\$30.00 towards retail pricing</i>
COSMETIC	Retail –25%	
LASIK DISCOUNTS	National Lasik Program 25 – 30% Discount	N/A
MAIL ORDER CONTACTS	<i>YES</i> <i>SIGNIFICANT SAVINGS THRU</i> CFI Mail Order Harrisburg, PA	N/A
SAFETY GLASSES	<i>\$50 ALLOWANCE (member only)</i>	<i>\$50.00 ALLOWANCE</i>

PLEASE NOTE THAT THIS SCHEDULE IS MERELY A SUMMARY OF SOME FEATURES OF OUR PLAN. IF THERE IS A DISPUTE BETWEEN THIS SCHEDULE AND THE SUMMARY PLAN DESCRIPTION, THE SUMMARY PLAN DESCRIPTION WILL PREVAIL. ALSO, PLEASE NOTE THAT THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO ANY SERVICES WHICH ARE NOT MEDICALLY NECESSARY, AS DETERMINED BY THE PLAN ADMINISTRATOR. IN ADDITION, THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO SERVICE COST WHICH ARE NOT THE PLAN'S ALLOWABLE AMOUNT, AS DETERMINED BY THE PLAN ADMINISTRATOR.

- Additional savings will occur if a network provider is used. Network providers charge a discounted price for services, so the 20% employee co-pay is reduced as well.
- If you require any additional information, please contact Miller & Long at 301-951-8690.

OTHER IMPORTANT INFORMATION

ABOUT YOUR MEDICAL, PRESCRIPTION, VISION AND DENTAL PLANS

A. Coordination of Benefits

The Plan has been designed to help pay for the cost associated with a sickness and injury. Since it is not intended to pay benefits greater than your actual health care expenses, the amount of benefits payable under this Plan will be reduced by taking into account any coverage which you or your dependent have under “other plans”.

For purposes of applying the following rules, an allowable expense is any medically necessary, charge previously described as covered in this Summary Plan Description. Plan means care benefits provided by:

- (1) group insurance coverage,
- (2) any group contractual prepayment or indemnity arrangement, group practice, or individual practice coverage,
- (3) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans,
- (4) any group plan provided by an educational institution, or
- (5) self-funded employer health plan

When a claim is made, the primary plan pays benefits first, without regard to any other plan. The secondary plan (or plans) adjusts their benefits so that the total benefits from the two plans do not exceed the allowable expense. No plan pays more than it would without the coordination of benefits provision.

A plan without a coordination provision is always considered the primary plan. If all plans have such a provision, then the plan of the patient's employer is the primary plan.

If a child is covered under both parent's plans, the plan of the parent with the earliest birthdate in the calendar year is primary; but if the parents are separated or divorced, their plans pay in this order:

- (1) if a court decree has established financial responsibility for the child's health care expenses, the plan of the parent with this responsibility;
- (2) the plan of the parent with custody of the child;
- (3) the plan of the stepparent married to the parent with custody of the child;
- (4) the plan of the parent not having custody of the child

If none of the above applies, the plan covering the patient the longest is the primary plan.

If both this Plan and another plan contain a coordination of benefits clause providing that each plan is secondary, this Plan will pay benefits only for allowable expenses and only in an amount in excess of that which the other plan would have paid if it were the primary plan. For example, if this Plan provides coverage of up to \$50 per day for hospitalization for in-patient surgery and the other plan would pay \$40 for the same coverage if it were primary, and both this Plan and the other plan provide that they are secondary, this Plan will pay no more than \$10 per day for the covered hospitalization.

B. Utilization Review – Pre-Certification Requirement

The Plan requires that hospital admissions be precertified to determine all days are medically necessary.

Call 877-608-2200 at least 72 hours prior to a planned admission or no later than 48 hours after an emergency admission.

CLAIMS FILING PROCEDURES

When you enroll for coverage, you will receive a Group Health Plan, Dental and combined Prescription/Vision identification cards. Please follow the proper procedures when filing a claim:

Network providers will file claims on your behalf.

For out-of-network providers, the procedures are as follows.

Hospitalization: Present your identification card to the admitting personnel at the hospital. This card provides all the necessary information for your admission. The card also instructs the hospital to send their bill directly to Allegeant, along with their standard assignment form for payment. If you should receive the bill directly from the hospital, please mail it to Allegeant.

All other expenses: Obtain a Health Claim, Dental Claim, or Vision Claim form from your employer. Instructions on how to submit a claim are found on the form. Also, special pre-addressed envelopes are available to simplify the claims procedure.

You must complete the form in full, indicating your Social Security number, name, address, the dependent's name, etc. You must also indicate whether or not you wish to authorize payment directly to the physician or dentist.

Your physician or dentist should complete their part of the claim form. When sending an itemized bill, the following information must be included:

- (1) patient's name
- (2) nature of illness or injury
- (3) type of service or supply
- (4) date(s) of treatment
- (5) itemized charge(s) for treatment

Please submit claims promptly. All claims must be submitted within 1 year after expenses are incurred.

Claims submitted after one (1) year will not be considered for payment.

Please note that you must submit special prescription drug claims (for prescriptions purchased at the full price, without your Health Plan card) directly to Express Scripts using the Express Scripts special prescription drug claim forms.

Medical and Dental should be mailed to:

Allegeant
PO Box 981801
El Paso, TX 79998-1801

Vision claims should be mailed to:

NVA
PO Box 1981
East Hanover, NJ 07936-1981



SUMMARY PLAN DESCRIPTION



MILLER & LONG DC, INC. HEALTH AND WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Effective January 1, 2019

ABOUT THIS SUMMARY

The following is a summary of some of the principal features of the Miller & Long DC, Inc. Health and Welfare Benefit Plan (the Plan). We urge you to read this summary carefully.

This summary is the “Summary Plan Description” for the Plan and is meant to summarize the Plan in easy-to-understand language. However, in the event of any ambiguity or any inconsistency between this Summary Plan Description and any formal Plan documents, the Plan documents will control.

Copies of the formal Plan documents for the Plan are on file at Miller & Long DC, Inc. (the Employer) and are available to you for inspection at a time and place mutually agreeable to you and to the Employer.

If anything in this Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator.

MILLER & LONG DC, INC. HEALTH AND WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Effective January 1, 2019

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GENERAL INFORMATION ABOUT THE PLAN

Name of Plan

Miller & Long DC, Inc. Health and Welfare Benefit Plan

Name and Business Address of Employer

Miller & Long DC, Inc.
4001 Brandywine Street, NW, Suite 400
Washington, DC 20016

Employer's Taxpayer Identification Number

27-5492647

Plan Number

501

Type of Administration

The Plan is administered by the Plan Administrator. Please note that participant benefit accounts under the Plan are merely bookkeeping entries, no assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. Some benefits may be provided through insurance contracts. To the extent that any benefits are not provided through insurance contracts, they are paid from the Employer's general assets.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's discretionary authority includes but is not limited to, discretionary authority to interpret plan provisions and to make all determinations of facts, including factual determinations relating to eligibility for benefits, and to make all determinations that require application of facts to the terms of the Plan. The Plan Administrator's determinations shall be given deference and are final and binding on all interested parties. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Health Coverage Funding Information

Cigna, P.O. Box 182223, Chattanooga, TN 37422-7223 is the claims processor of your medical and dental benefits under the Plan. Cigna Vision, P.O. Box 385018, Birmingham, AL 35238-5018 is the claims processor of your vision benefits under the Plan. The Plan's medical, dental and vision benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by Cigna or any other insurance carrier.

Affordable Care Act

This Summary includes various provisions that are required to comply with the requirements of the federal health care reform law, (the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010) and with regulations and other guidance issued under that law. Whenever this Summary refers to the “Affordable Care Act” it is referring to the PPACA, as amended, and any applicable regulations. The health care reform requirements of the Affordable Care Act generally apply only to the Plan’s medical coverage. When this Summary refers to coverage that is subject to the Affordable Care Act, it means the Plan’s medical coverage, including any prescription drug or vision benefits that are offered as part of a bundled package with the medical coverage.

Plan Year

The Plan Year for the Plan is the period beginning each September 1 and ending on the next August 31, but for purposes of the Plan’s medical, dental and flexible spending account benefits, references to “Plan Year” mean the calendar year, January 1 through December 31.

Name, Business Address and Telephone Number of Plan Administrator

Miller & Long DC, Inc.
c/o Human Resources Department
4001 Brandywine Street, NW, Suite 400
Washington, DC 20016
(202) 524-4600

Service of Legal Process

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

Type of Plan

This Plan is a form of employee welfare benefit plan called a “cafeteria plan” because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the Employer to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan. For certain benefits, because your salary is reduced before federal taxes (and, in most states, state taxes) are imposed, you pay less in taxes if you participate in the Plan. (Some benefits may require that you make after-tax contributions.)

Eligibility

If you are a full-time regular employee of the Employer (i.e., if you are regularly scheduled to work at least thirty hours per week, as determined by the Employer), you and your eligible dependents are eligible to participate in the Plan beginning on the day on which you complete ninety days of continuous employment with the Employer (your “Participation Date”). For purposes of this continuous employment requirement as it applies to the Plan’s health benefits, if you are absent from work because of a health condition, your absence will not interrupt your completion of the continuous employment requirement. That is, any period of continuous service that you complete before your health-related absence will apply toward the

continuous employment requirement and will be added to any period of continuous service that you complete after you return to work following your health-related absence.

Leased employees, persons classified by the Employer as temporary employees of the Employer (as determined by the Employer), and employees covered by a collective bargaining agreement and their dependents (unless Plan participation is provided for in the collective bargaining agreement) are not permitted to participate in the Plan. A person who is not characterized by the Employer as an employee of the Employer, but who is later characterized by a regulatory agency or court as being an employee, will not be eligible for the period during which he or she is not characterized as an employee by the Employer.

If you are laid-off by the Employer and are rehired within six months, your Participation Date will be your date of rehire. Otherwise, your Participation Date will be the day on which you complete ninety days of continuous employment with the Employer after you are rehired. However, if you are rehired during the same Plan Year and within 30 days after your previous period of eligible employment ended, you generally will not be permitted to make a new election of benefits for that Plan Year, but your previous election of benefits will be reinstated.

Please note that your eligibility for any particular benefit is determined under Plan terms applicable to that benefit. The Benefit Booklets delivered with this Summary include information about any additional or different eligibility requirements that may apply to specific benefits.

Dependent Eligibility

(NOTE: This Dependent Eligibility section does not apply to flexible spending account benefits. For details on whether a family member's expenses can be covered under a flexible spending account, see the separate explanations of those benefits in the "Summary of Available Benefits" section.)

For purposes of all benefits available under the Plan to dependents, your *spouse* is considered an eligible dependent (*spouse* and other *italicized* terms used in this section are defined below).

The Plan's dependent eligibility requirements for children of eligible employees have changed to comply with the requirements of the Affordable Care Act. Your *child* is eligible for coverage offered to dependents under the Plan based on the following rules:

1. Coverage for Children under Age 26. Your eligible dependents include your *child* who is under age 26, regardless of the child's marital status, tax dependent status or student status and regardless of whether the child lives with you.
2. Coverage for Older Children with Disabilities. For purposes of all coverage offered to dependents under the Plan, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable calendar year is an eligible dependent if he or she is physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 26.

The following definitions apply for purposes of this Dependent Eligibility section:

Child means a natural child, a legally adopted child who is under age 18 at the time of the adoption, a child placed with you for adoption who is under age 18 at the time of the placement, a foster child (if the child is an “eligible foster child”, as defined in the Internal Revenue Code) or a stepchild. *Child* also includes any other person whose welfare is your legal responsibility under a legal guardianship, written divorce settlement, written separation agreement or a court order.

Spouse means a person who is treated as your spouse because of a marriage that is recognized as a marriage for purposes of federal income tax law, which currently includes any marriage that is recognized as a valid marriage in the State, District, territory or foreign jurisdiction in which the marriage occurred.

Dependent for Federal Income Tax Purposes

Whether someone is your *dependent for federal income tax purposes* is determined under IRS rules. For details on the requirements for someone to be your federal income tax dependent, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* under the Plan. However, for purposes of this Plan’s health benefits, note that even if your family member would not qualify as your dependent for federal income tax purposes under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for purposes of the Plan’s dependent eligibility requirements.

Also, in determining if your child is your *dependent for federal income tax purposes*, a special rule applies in cases of divorce or legal separation or if you and your child’s other parent live apart for all of the last six months of the calendar year if either you or the child’s other parent has custody of the child and is actually entitled to claim the child as a dependent for tax purposes. In those cases, as long as at least half of the child’s support for the applicable calendar year is being provided by you and the other parent (and your current spouses, if any) together, the child can be considered your *dependent for federal income tax purposes* for purposes of the Plan’s health benefits.

A person otherwise qualifying as your eligible dependent will not be covered for any coverage providing benefits to dependents unless you have elected to pay and have paid the required additional contributions, if any, for dependent coverage. Also, unless otherwise required by law, note that your spouse or child will not qualify as an eligible dependent while on active duty in the armed forces of any country.

You are responsible for determining if someone qualifies as your spouse or dependent for purposes of the Plan’s dependent eligibility rules, subject to the Employer’s final approval. The Employer may require you to provide proof that an individual satisfies all of the Plan’s eligibility requirements. Also, if at any time during a Plan Year your eligible spouse or dependent becomes ineligible for coverage, you are responsible for notifying the Employer of that change in eligibility.

If you and your eligible spouse or dependent are both employees of the Employer and

each of you meets the Plan's eligibility requirements to participate in the Plan as employees, you may elect employee-only medical, dental or vision coverage or one of you may elect family (or employee and spouse or dependent) coverage. However, no employee can be covered under the Plan's medical, dental and vision coverage as another employee's spouse or dependent at the same time that he or she is also covered under the Plan as an employee/participant.

For any insured coverage offered under the Plan, the terms of the insurance contract, instead of this "Dependent Eligibility" section, will determine whether any person is your dependent for purposes of that benefit (if there is any difference between the language in this Dependent Eligibility section and the terms of the contract). The Benefits Booklets provided to you with this Summary will include any additional or different dependent eligibility requirements that apply for any insured coverage.

All Qualified Medical Child Support Orders that require the Plan to provide Plan coverage for so-called "Alternate Recipients" will be honored by the Plan in accordance with applicable law. (These orders are a type of order by a court or by an administrative agency providing coverage for children of Plan participants.) As required by applicable law, the Plan uses procedures to determine whether a medical child support order is a "Qualified Medical Child Support Order" that must be honored by the Plan. Upon request to the Plan Administrator, you may receive, without any charge, a summary of these procedures.

Participation

(a) Initial Election Period. If you are not already a participant in the Plan, to become a participant on your Participation Date, you must be an active employee of the Employer on your Participation Date and you must properly complete and submit an initial Election Form to the Plan Administrator (or complete a designated electronic enrollment process, if available) before your Participation Date and during the period designated by the Plan Administrator as your initial "enrollment period". For purposes of medical benefits only, you will be treated as an active employee on your Participation Date even if you are absent from work if your absence occurs because of a health condition (as determined by the Employer).

Your benefit elections made during your initial enrollment period will be effective from your Participation Date until the last day of the Plan Year in which you change your initial benefit election (see subsection (b) below) or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (e) below) or qualify to change your elections for certain other reasons (see subsection (d) below).

If you fail to properly complete and submit an Election Form to the Plan Administrator during your initial election period, you will not automatically participate in the Plan.

(b) Election Periods after Initial Election Period. After you complete the initial Election Form, your initial benefit election will remain in effect indefinitely or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (e) below) or qualify to change your elections for certain other reasons (as described in subsection (d) below) or until you make a new benefit election by requesting, completing and submitting a new Election Form to the Plan Administrator for a future Plan Year during the period preceding the Plan Year that is designated by the Plan Administrator as the Plan's annual "election period". Your new benefit election will be effective from the first day of

the Plan Year following the election period in which you make your new benefit election until you change your election during a later election period, or you experience a Status Change, exercise a Special Enrollment right or otherwise qualify to make an election change that is permitted under the Plan.. However, this automatic carry-over of previous elections does not apply to your elections regarding participation in the Plan's health care flexible spending account or dependent care flexible spending account. If you fail to complete and submit a new Election Form for these benefits, you will not automatically receive coverage.

The Employer, in its discretion, may determine that it will not offer an annual "election period" for a future plan year. If the Employer determines that there will be no annual "election period" or open enrollment for the upcoming year, the elections you made on your most recent Election Form will carry over for the next year. You will still be able to make changes to your election if you or your dependents experience a Status Change, exercise a Special Enrollment Period right or qualify to make a change for certain other reasons, as described below.

Also, although your benefit elections normally will carryover from one Plan Year to the next as described above, the Employer may announce before the start of a Plan Year that new elections will be required for all eligible employees to participate in benefits for that upcoming Plan Year. In such cases, a special required election period will be announced for all eligible employees to make new elections, which will take effect at the beginning of the next Plan Year. An employee who fails to make an election of available benefits for the following Plan Year during that special required election period will cease to participate in the Plan at the end of the Plan Year in which the special required election period occurs.

(c) Changes of Election to Reflect Status Change. If you are currently participating in the Plan, you may, with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, change your elections by filing a Status Change Form within 30 days after a Status Change event. If you are not currently a participant in the Plan but you have satisfied all the requirements to be eligible to participate (except that you do not have a current benefit election in place), with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, you may become a participant by filing an Election Form and a Status Change Form within 30 days after a Status Change event occurs.

Under applicable law, to be permitted to make a change in your benefit elections because of a Status Change event, the Status Change event must result in you or your spouse or dependent gaining or losing eligibility for that coverage or similar coverage under the Plan, a plan sponsored by another employer by whom you are employed or a plan sponsored by the employer of your spouse or other dependent. (For dependent care flexible spending account benefits, you are also permitted to make an election change if a Status Change increases or decreases your eligible dependent care expenses and the election change corresponds to the change in expenses.)

Any change that you wish to make to your benefit elections must be consistent with the Status Change event that occurred. The Employer will determine whether, under applicable law, a requested change (or a new election) is consistent with the Status Change you experience. For example, if you become eligible for health coverage offered by your spouse's

employer because you get married or because your spouse changes employers, you may cancel your health coverage under this Plan only if you certify to the Employer that you have actually enrolled or intend to enroll in the other Plan. Under applicable law, it would not be consistent with the Status Change if you merely dropped coverage under this Plan without enrolling in the other plan.

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the elections are approved by the Plan Administrator, and will be effective, for health care flexible spending account or dependent care flexible spending account coverage, for the balance of the Plan Year in which the new election is made or, for all other coverage, until you change your elections according to the Section entitled "Election Periods After Initial Election Period" or you experience another Status Change.

You will experience a Status Change if:

- (1) your legal marital status changes including changes because of marriage, the death of your spouse, divorce or legal annulment;
- (2) there is an event which causes you to gain or lose a dependent;
- (3) you, your spouse or your dependent terminates or begins employment;
- (4) you experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or the beginning or ending of an unpaid leave of absence);
- (5) you, your spouse or your dependent becomes eligible or loses eligibility for coverage under a plan offered by that person's employer because of a change in employment status (for example, if your dependent switches from hourly to salaried employment and the dependent's employer's medical plan covers only salaried employees);
- (6) an event happens that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or similar circumstance;
- (7) for purposes of dependent care flexible spending account benefits, there is an event that changes the number of your dependents who are under the age of 13 or mentally or physically incapacitated; or
- (8) for any election made on an after-tax basis, you experience any event which, in the Administrator's sole discretion, qualifies as a Status Change.

(d) Other Election Changes. Except as otherwise provided below, if you are entitled to an election change described below, you must request the change within 30 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

(i) Orders Requiring Coverage. If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical coverage for your child, you, or, if required by the order, the Plan Administrator, may change your health coverage elections (to the extent permitted by the Plan Administrator, in its discretion) to provide such coverage and you, or if required by the Order, the Plan Administrator,

may change the amount of your salary reduction contributions to cover the cost of such coverage. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order and you provide evidence to the Employer that such coverage is actually being provided, subject to the Employer's approval, you will be permitted to change your election to stop providing medical coverage for your child.

(ii) Medicare or Medicaid Enrollment. If you or your spouse or dependent becomes enrolled in Medicare or Medicaid, subject to the Employer's approval, you may change your election to cancel or reduce medical coverage for that individual. If you or your spouse or dependent loses eligibility for Medicare or Medicaid, again subject to the Employer's approval, you may change your election to commence or increase medical coverage for that individual.

(iii) Paying for COBRA Coverage. If you or your spouse or dependent becomes eligible for continued health coverage under the Employer's health plan as provided under COBRA or any similar state law, you may change your election to pay for that COBRA coverage with salary reduction contributions.

(iv) FMLA Leave. If you take leave under the Family and Medical Leave Act of 1993 (FMLA), you may make certain election changes that are permitted by the Employer in accordance with the FMLA.

(e) Special Enrollment Periods for Employees and Dependents. If you decline enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption (90 days in the case of the addition of a spouse or child that does not result in an increase in your contribution).

If you or your eligible dependent are covered under Medicaid or a State Children's Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and any affected dependent in this Plan's medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. Also, if you or your eligible dependent become eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days after the date a government agency determines that you are eligible for that financial assistance.

To request special enrollment or obtain more information, contact the Plan Administrator at the address provided in this Summary.

Termination of Participation

Except as otherwise provided below, coverage for a participant generally terminates on the earliest of the following dates:

- (a) The day on which the participant terminates employment.
- (b) Except for certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant.
- (c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.
- (d) Except to the extent required by law, the day on which the participant reports for active duty as a member of the armed forces of any country.
- (e) The day on which all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

Coverage for an eligible dependent of a participant generally terminates on the earliest of the following dates:

- (a) The day on which the participant terminates employment.
- (b) Except for certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant.
- (c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.
- (d) Except to the extent required by law, the day on which the eligible dependent reports for active duty as a member of the armed forces of any country.
- (e) The day on which all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.
- (f) The day on which the eligible dependent ceases to be an eligible dependent.

Coverage under the Plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.

For coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may occur in only two situations. First, as indicated above, if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with respect to the Plan, or makes an intentional misrepresentation of a material fact. In that case, the Plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

Coverage under the Plan may be extended after the date that the participant would otherwise cease to be a participant because of any of the preceding provisions if, on that date, the participant is totally disabled from a sickness or injury and is under a doctor's care. However, this coverage extension applies only to the disability and any related sickness or injury (as determined by the Employer). Any such extended coverage is subject to all of the terms of this Plan. In such cases, the extended coverage will end on the earliest of (i) the date the participant is no longer totally disabled, (ii) the date the participant becomes eligible for other health coverage under another group health plan or Medicare or (iii) 90 days from the date the participant would otherwise cease to be a participant based on the Termination of Participation events listed above.

In addition, if your employment is terminated due to a layoff, you will continue to be a participant in the Plan for an additional 30 days after the date your participation would otherwise terminate.

If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the Plan. See the "Continuation and Conversion Rights" and "COBRA Notice" sections of this Summary for more details.

Also, if you take a leave of absence from employment with the Employer because of military service and your coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in the COBRA notice section of this Summary and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the last day of the 24-month period beginning on the date your military leave of absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer. Please contact the Employer if you have questions about coverage during periods of military service.

Summary of Available Benefits

The following benefits are available under the Plan. Any salary reduction contributions you will be required to make to obtain any elected benefit will be determined by the Employer, and will be communicated to you from time to time. Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect you or require a

change to your elections or benefits, you will be notified.

Medical/Prescription Drug and Vision Coverage. If you are eligible to participate in the Plan, you may purchase medical/prescription drug and vision coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time. Medical coverage under the Plan will comply with the reconstructive surgery requirements of the Women's Health and Cancer Rights Act of 1998.

Dental Coverage. If you are eligible to participate in the Plan, you may purchase dental coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Life Insurance/AD&D Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense life insurance/accidental death and dismemberment (AD&D) coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Long Term Disability Coverage. If you are a salaried employee and you are eligible to participate in the Plan, you will receive at the Employer's sole expense long term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

If you are eligible for long-term disability coverage, you have the option of receiving coverage as an employer-paid tax-free benefit or treating it as an after-tax benefit. If you elect to receive the coverage as a tax-free benefit, that means that you do not have to pay federal income and payroll tax (and you may not have to pay state taxes) on the amount that the employer pays for the coverage. However, if you become eligible for disability benefits during the coverage period, you generally will be subject to tax on those benefit payments. Under the other option, if you elect to receive the coverage as an after-tax benefit, you will be treated as receiving the value of the coverage as a taxable benefit, so you will be subject to income and payroll tax on the amount the Employer pays for the coverage. However, if you become eligible for disability benefits during that coverage period, any benefit payments you receive would generally not be subject to tax. You should consult with a financial advisor if you have questions about how you should pay for long-term disability coverage.

Short Term Disability Coverage. If you are an hourly employee and you are eligible to participate in the Plan, you will receive at the Employer's sole expense short term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Employee Assistance Program Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense employee assistance program coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Health Care Flexible Spending Account. Flexible spending account elections are

administered based on a calendar year Plan Year. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed \$2,700 (for the 2019 calendar year). The Plan's maximum contribution amount is required by federal law. The maximum amount is adjusted by the IRS each year based on inflation. The Plan's maximum contribution amount will also be automatically adjusted each year based on the new maximum announced by the IRS.

The Employer also may make contributions to a Health FSA for each employee who enrolls in medical coverage under the Plan during the Plan's annual open enrollment period and who elects to contribute to the Health FSA. For the 2019 Plan Year, the Employer will automatically make Employer contributions to a Health FSA for such participants equal to \$100 for any Employee who is enrolling in individual medical coverage for the Plan Year or \$300 for any Employee who enrolls in family coverage under the Plan. For later years, the Employer reserves the right to contribute different amounts or no amount at all, as communicated to eligible Employees during each annual open enrollment period. Employer contributions to your Health FSA are credited even if you do not elect to make your own contributions to the Health FSA. If you do elect to make your own contributions, the Employer contribution simply increases the amount available under the Health FSA and does not reduce the amount you may contribute. Employer contributions are subject to all of the rules that apply to employee salary reduction contributions under the Health FSA, as described in this section and in other documents available to employees. Employer contributions are provided only for eligible Employees who enroll in medical coverage during the applicable open enrollment period and are not made for any Employee who enrolls in the Health FSA after the start of the calendar year.

If you do not use up your entire Health FSA balance with expenses incurred by the end of the Plan Year, there is also a "grace period" that lasts two and one-half months after the end of the Plan Year (that is, until March 15th of the next calendar year). Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Health FSA on the last day of the Plan Year. You will still be treated as participating in the Health FSA for this purpose if you elected COBRA continuation coverage under the Health FSA and that COBRA coverage is in effect on the last day of the Plan Year. If your participation in the Health FSA ends before the end of the Plan Year, there is no grace period.

Generally, eligible medical expenses are expenses that you or your dependent (determined as described below) have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of medical expenses (including legally obtained prescription drugs or insulin), and that have not been taken as a deduction in any year. As required by law, the Health FSA does not reimburse expenses for over-the-counter medicine (other than insulin), unless the medicine has been prescribed by a physician or another qualified health care provider.

Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

For purposes of Health FSA reimbursements, "dependent" includes:

(1) your spouse;

(2) your biological, adopted or step-child or your eligible foster child if the child will be younger than 27 on the last day of the calendar year in which the expense is incurred, (even if the child is not your dependent for tax purposes); and

(3) any person who is expected to be your *dependent for federal income tax purposes* (as defined below) for the calendar year in which the expense is incurred.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Health FSA benefits. However, for purposes of the Health FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for Health FSA benefits. The Plan Administrator always has the right to require documentation that an individual qualifies as your spouse or dependent for health FSA purposes and to deny benefits if you fail to provide adequate documentation when required. If you have any question about whether someone qualifies as your dependent for purposes of the Health FSA, you should consult a tax advisor.

To be reimbursed from your Health FSA, you must submit to the Plan Administrator a request for reimbursement on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than the next April 15th following the end of the calendar year (or grace period) in which the expenses were incurred. However, if you cease to be a participant in the Health FSA (because your employment terminates or for any other reason) before the end of the Plan Year, you must submit all requests for reimbursement to the Plan Administrator no later than 60 days after you cease to be a participant in the Health FSA.

Please note that amounts held in your Health FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Health Savings Account Eligibility

You should be aware that, if you or your spouse or any eligible dependent wishes to be eligible to make Health Savings Account (HSA) contributions, your participation in the Health FSA (including automatic participation based solely on Employer contributions) could make you or your spouse or dependent ineligible to make HSA contributions. To avoid that issue, you have two options:

(1) You can elect on your Election Form to exclude your spouse from eligibility for Health FSA reimbursements, which would simply mean that you could not use the Health FSA to reimburse any expenses incurred by your spouse; or

(2) You can elect on your Election Form for the Health FSA to be treated as a “limited-scope” Health FSA. If you choose that option, that choice will apply to you and any other eligible dependents under your Health FSA. The amount contributed to your limited-scope Health FSA (including any Employer contributions) generally would be available to pay only eligible dental or vision care expenses. You could not use the Health FSA to pay or be reimbursed for any other types of expenses.

Qualified Reservist Distributions

If you are called or ordered to active duty in a United States reserve component for a period of 180 days or longer or for an indefinite period (or for a shorter period that is later expanded to 180 days or longer), and the amount you have received in reimbursements from your Health FSA for the Plan Year is less than the amount you have contributed, you may request a Qualified Reservist Distribution of your unused balance (the difference between what you have contributed and the amount of reimbursements you have received). The distribution generally would be treated as taxable compensation to you. You must request the distribution before the end of the grace period for the Plan Year during which you are called or ordered to active duty. If you request a distribution, you may continue to submit claims for expenses incurred before you made your request, but you may not submit claims for expenses incurred after that date. Your request must include a copy of the document that orders or calls you to active duty (if not already provided to the Employer). If you qualify for a Qualified Reservist Distribution, the distribution will be made within a reasonable period (no later than 60 days) after you request it. Once you receive a distribution equal to your entire unused balance, you will no longer be a participant in the Health FSA for that Plan Year and will not be able to submit or be reimbursed for any additional claims for eligible medical expenses. To request a Qualified Reservist Distribution or for more information, you should contact the Plan Administrator at the address provided in this Summary.

Dependent Care Flexible Spending Account. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed \$5,000 per calendar year or, for married participants filing separately, \$2,500 per calendar year, credited to your dependent care flexible spending account (Dependent Care FSA). You can receive amounts from this Account, in cash, as reimbursement for Employment Related Expenses incurred during the Plan Year and while you are a participant in the Dependent Care FSA. However, if you do not use up your entire Account balance with expenses incurred by the end of the Plan Year, there is also a “grace period” that lasts two and one-half months after the end of the Plan Year (that is, until March 15 of the next Plan Year). Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Dependent Care FSA on the last day of the Plan Year. If your participation in the Dependent Care FSA ends before the end of the Plan Year, there is no grace period.

The amount of any reimbursement for Employment Related Expenses may not exceed the amount credited to your Account at the time of your reimbursement request. Generally, under federal law, Employment Related Expenses are expenses for household services and expenses related to the care of a “Qualifying Individual”, which you incur to enable you to work.

“Qualifying Individual” is defined under federal law and currently means someone who is:

- (1) your child (including a stepchild), brother, sister, stepbrother or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13, who has the same principal residence as you for at least half of the calendar year and who does not provide at least half of his or her own support for the current calendar year,
- (2) your spouse who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year or
- (3) your *dependent for federal income tax purposes* (as defined below) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Dependent Care FSA benefits. However, for purposes of the Dependent Care FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for Dependent Care FSA benefits.

The Plan Administrator always has the right to require documentation that an individual qualifies as a Qualifying Individual under the above rules and to deny benefits if you fail to provide adequate documentation when required or if the Administrator determines that expenses for any person are not eligible for reimbursement. If you have any question about whether someone qualifies as your dependent for purposes of the Dependent Care FSA, you should consult a tax advisor. Also, note that the determination of whether someone is a Qualifying Individual must be made each time expenses are incurred. For example, if your child is age 12 at the start of the calendar year, otherwise eligible expenses for that child can be reimbursed under the Dependent Care FSA only for services provided before the child's 13th birthday (unless the child is mentally or physically incapable of taking care of himself or herself).

The amount of reimbursements that you may receive from your Dependent Care FSA on a tax-free basis in a calendar year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. Thus, for example, if you have \$5,000 in your Dependent Care FSA and you and your spouse have Earned Income of \$20,000 and \$4,000, respectively, you can receive \$4,000 worth of reimbursement from the Account on a tax-free basis, and you will be taxed on \$1,000 worth of the reimbursement you receive. If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have Earned Income for each month that he or she is a full-time student or incapacitated. The amount of deemed earnings will be \$250 a month, if you provide care for one Qualifying Individual, or \$500 a month, if you provide care for more than one Qualifying Individual.

Employment Related Expenses that are incurred for services outside your household may be reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under thirteen years of age (category (1) in the above definition of Qualifying Individual), or (ii) another Qualifying Individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center (as defined below), the Center must comply with applicable laws and regulations of a state or local government. A “Dependent Care Center” is any facility that provides care for more than six individuals who do not reside at the center and receives a fee, payment or grant for providing services for any of the individuals.

No reimbursements will be made for Employment Related Expenses for services rendered by any person for whom you or your spouse is entitled to a deduction on your federal income tax return for the applicable calendar year or who is your child (including a stepchild or a foster child) who will be under the age of 19 at the end of the year.

To be reimbursed from your Dependent Care FSA, you must submit a reimbursement request to the Plan Administrator on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than the next April 15th following the end of the calendar year (or grace period) in which the expenses were incurred. However, if you cease to be a participant in the Dependent Care FSA (because your employment terminates or for any other reason) before the end of the Plan Year, you must submit all requests for reimbursement to the Plan Administrator no later than 60 days after you cease to be a participant in the Dependent Care FSA.

Please note that amounts held in your Dependent Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts which you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the tax credit available. Attached as an Exhibit is a notice which further explains the dependent care tax credits and the income exclusions. The notice also provides a worksheet to help you determine which tax reduction method is more beneficial for you.

Dependent Care FSA benefits are not subject to the federal law known as ERISA, so the “Your Rights under ERISA” section of this Summary does not apply to these benefits.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your health care continuation or conversion rights, please contact the Plan Administrator. Also, please review the next section regarding continuation coverage under the federal law known as “COBRA”.

Continuation Coverage Under COBRA (COBRA Notice)

This “COBRA Notice” section of your Summary Plan Description applies to employees and covered spouses and dependents who have health coverage under the Plan. For purposes of this notice, “Plan” refers only to the medical, prescription drug, dental and health care flexible spending account benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

You are receiving this notice because you are covered under a group health plan offered under the Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice 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.** Both you and your spouse (if you are married and your spouse is covered by the Plan) should take the time to carefully read this notice.

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 at the address provided in this notice.

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 period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health coverage under the Plan 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 COBRA continuation coverage.

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

- 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 happens:

- 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 happens:

- 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 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 the employee and 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 later of (1) the date the qualifying event occurs or (2) the date coverage would end because of the qualifying event. This notice must be provided, along with any required documentation to:

Miller & Long DC, Inc.
c/o Human Resources Department
4001 Brandywine Street, NW, Suite 400
Washington, DC 20016

Your notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- Your name, address, phone number and health plan ID number.
- The name, address, phone number and health plan ID number for any dependent or spouse whose eligibility is affected by the qualifying event.
- A description of the qualifying event and the date on which it occurred.
- The following statement: "By signing this letter, I certify that the qualifying event described in this letter occurred on the date described in this letter."
- Your signature.

You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided in this notice.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, you may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. (NOTE: The rest of this paragraph applies to health plans other than a health care flexible spending account plan. For the rules that apply for a health care flexible spending account, see the “*Special Rules for Health Care Flexible Spending Accounts*” section below.) 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 employment terminates, COBRA continuation coverage for his 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, as described in the next two sections of this Notice.

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 a disability determination, you should follow the same procedures described above under “*You Must Give Notice of Some Qualifying Events*”. Your notice must include documentation of the Social Security Administration’s decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying

event occurred or (2) the date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event.

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 (following the same procedures described above under “*You Must Give Notice of Some Qualifying Events*”). 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.

Special Rules for Health Care Flexible Spending Accounts

For a health care flexible spending account (Health FSA), COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs (plus any grace period that applies after the end of that Plan Year (as described in this Summary Plan Description), but only if the qualified beneficiary keeps COBRA coverage in effect through the last day of the Plan Year). COBRA continuation coverage for the Health FSA cannot be extended beyond that time for any reason.

EXAMPLE: Assume that an employee elected to contribute a total of \$1,200 to her Health FSA account for a Plan Year and then her employment terminates six months after the start of that Plan Year. By that time, she has contributed \$600 to her FSA account through payroll deductions. Assume that she has already received \$800 in reimbursements from her account for eligible expenses she paid before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is \$400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of \$600 (plus about \$12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about \$612) is more than the maximum that she would be eligible to receive in reimbursements (\$400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of \$588 or less before her employment terminated, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay (\$612).

Any filing deadlines or other rules (including any grace period rules) for filing a request for reimbursement under the Health FSA, as described earlier in this Summary Plan Description, will continue to apply if you elect continuation coverage under the Health FSA.

Additional Continuation Coverage Election Period for “TAA-Eligible Individuals”

In addition to the other COBRA rules described in this section of your Summary Plan Description, there are some special rules that apply if you are classified as a “TAA-eligible individual” by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.)

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than 6 months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this Notice, your coverage period will be measured from the date of your TAA-related loss of coverage.

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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (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 EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

If you have questions or need more information about COBRA continuation coverage under the Plan, please contact the Plan Administrator at the address or phone number provided in this Summary.

Emergency Medical Care

If you believe you need emergency medical care, you should not forego that care because you believe it will not be covered by the Plan.

Patients to Evaluate Care

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any practitioner. Each patient should evaluate the quality of care and act accordingly. No Plan provision expressed in this Summary or the Plan documents should be interpreted to restrict the access to or delivery of medically necessary services. A patient's decision to forego such care should not be based on his or her interpretation of this Summary Plan Description or the Plan documents.

Health Information Privacy

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. If you are an employee and you are covered under any of the Plan's health benefit options, you should have received a copy of the Plan's Privacy Notice with this Summary (if you did not previously receive one). In addition, a copy of the Plan's current Privacy Notice is always available upon request. Please contact the Plan Administrator at the address indicated later in this Summary if you would like to request a copy of the Notice or if you have questions about the Plan's privacy policies.

Medical Benefits Following Childbirth

The Plan and any health insurance company insuring health benefits under the Plan, 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 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 and/or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, the Plan and any health insurance company may not, under federal law require that a provider obtain authorization from the Plan or health insurance company, if any, for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

Claims Procedures

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and for certain medical benefits, the applicable requirements of regulations issued under the Affordable Care Act and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures generally will apply instead of the claims procedures described in this Summary. This Claims Procedure section includes descriptions of the minimum requirements for claims procedures that apply to insured benefits, but full details of claims procedure rules for insured benefits are described in the insurer's Benefit Booklet that describes the specific insured benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims, including claims for dependent care flexible spending account or short term disability benefits, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator (or an insurer) provide notice to a claimant about any right under ERISA will not apply to such a claim.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act and for purposes of any disability benefits that are subject to ERISA, "adverse determination" also includes any rescission of coverage. A rescission of coverage generally is a retroactive termination of coverage because of fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a "rescission" and is therefore an adverse determination that is subject to these claims procedures will be determined by the Reviewer based on applicable law.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. Claims should be submitted promptly after an expense is incurred. Unless a different deadline expressly applies in this Summary or under a Benefits Booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred. (For deadlines for submitting flexible spending account reimbursement requests, see the "Summary of Available Benefits" section of this Summary.)

The Reviewer will review the claim itself or appoint an individual or an entity to review

the claim, using the following procedures.

For purposes of these procedures, "health benefit" or "health claim" refer to benefits or claims involving medical, dental, vision or health care flexible spending account coverage. Also, a benefit or claim is considered a "disability benefit" or "disability claim" for purposes of these procedures if the benefit or claim, including claims for accidental death and dismemberment benefits, is subject to ERISA and requires that the Plan or an Insurer make a determination of whether a claimant has experienced a disability.

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. The Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

(A) For any pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(B) For any post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services or other benefits already provided (or any other health benefit claim that is not a pre-service claim).

(c) Disability Benefit Claims. For any disability benefits claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the

extension and the date by which the Reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

- (i) A description of the specific reasons for the denial;
- (ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;
- (iii) A description of any additional information that the Claimant must provide to perfect the claim (including an explanation of why the information is needed);
- (iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;
- (v) A statement of the Claimant's right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial and a description of any time limit that would apply under the Plan for bringing such an action.

In addition, for a denial of health benefits, the following will be provided to the Claimant:

- (vi) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and
- (vii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).
- (viii) For an adverse determination concerning an urgent care health claim involving, the notice will also include information about the expedited process that applies to such claims and the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

For any claim for disability benefits, the notice will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and also will include the following:

- (ix) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(x) If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(xi) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

(xii) 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.

Reviews of Initial Adverse Determinations

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

(a) Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after you receive notice of the initial denial of the claim. The decision on review will be made within a reasonable time but no later than 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records 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.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) For purposes of any medical coverage and for claims for disability benefits, the Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:

(A) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by or on behalf of the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the

Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(B) For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within a reasonable time but not later than 45 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

- (i) a description of its decision;
- (ii) a description of the specific reasons for the decision;
- (iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;
- (iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claim for benefits;
- (v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA section 502(a) and a description of any time limit that applies under the Plan for bringing such an action (including, for disability benefit claims, the date that any applicable time limit for bringing such an action would expire);
- (vi) if applicable, a statement describing any voluntary appeal procedures offered by the Plan and about the Claimant's rights to obtain information about such procedures
- (vii) in addition to items (i)-(vi) above, for any notice of adverse determination regarding health benefits (or disability benefits if the claim was filed on or before April 1, 2018), the following will be provided:

(A) if an internal rule, guideline, protocol or other similar criterion was

relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(B) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request; and

(viii) in addition to items (i)-(vi) above, for claims for disability benefits, the notice of Adverse Determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices and will include:

(A) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(B) If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

Additional Requirements for Medical and Disability Claims

For any adverse determination involving medical coverage, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in

denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Also, for all claims involving coverage that is subject to the Affordable Care Act and for disability benefit claims, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the determination will be “frozen” from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits other than health benefits, the period for making the determination on appeal will be “frozen” from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant's Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan's Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under [ERISA] [applicable state law] on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim involving medical coverage, you will be deemed to have exhausted the

Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the Plan's claim procedures (and applicable regulations unless the Plan's failure to adhere to those requirements is a minor violation (as defined below). If you are deemed to have exhausted the Plan's internal claims and appeals process based on the preceding sentence, in addition to the right to pursue any available remedy under ERISA, you will have the right to pursue any remedy under any available external review process provided under federal or state law.

Also, for claims for disability benefits, you will be deemed to have exhausted the Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the requirements of applicable regulations unless the Plan's failure to adhere to those requirements is a "minor violation" (as defined below).

For purposes of this Section, the Plan's failure to satisfy applicable claim procedure regulations is a "minor violation" if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this minor violation exception applies, you may request a written explanation of the violation from the Plan, and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

For claims involving medical coverage, if an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon your receipt of the notice.

For claims involving disability benefits, if a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, the claim will be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. In such cases, within a reasonable time after the Plan's receipt of the decision, the Plan will provide you with notice of the resubmission.

External Review

(a) External Review Process. For purposes of any coverage that is subject to the Affordable Care Act, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with the interim procedures for federal external review in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance. The Plan will begin complying with any new requirements for external review guidance on or before the date that those requirements become applicable to the Plan.

(b) Availability of External Review. External review is not available for all adverse determinations. For example, external review is not available for an adverse determination based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan. External review is available only for:

(i) any final internal adverse determination (or an initial internal adverse determination on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal adverse determination that involves a rescission of coverage; or

(iii) Any other final adverse determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

(c) Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives notice of an adverse determination for which external review is available.

(d) Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the time the health care item or service was provided;

(ii) The adverse determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe the reasons external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the Claimant receives the notice.

(e) Referral to Independent Review Organization. External reviews are conducted by independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan will contract with at least three different IROs. The Plan will take action against bias and to ensure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Under a contract between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving any information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(A) The Claimant's medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating provider;

(D) The terms of the Plan, unless the terms are inconsistent with applicable law;

(E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(G) The opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.

(vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.

(vii) The IRO's notice will include:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;

(F) A statement that judicial review may be available to the Claimant; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA.

(viii) The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by the Claimant, Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(e) Effect of External Review Decision. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse determination, the Plan will provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

(a) Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an adverse determination that otherwise qualifies for external review (as described above) and that is:

(i) An adverse determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under the Plan's normal procedures for urgent care claims would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final adverse determination, if the Claimant has a medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(b) Procedures for Expedited External Review.

(i) In General. The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review. The Plan will immediately send the Claimant a notice of its eligibility determination that meets the preliminary review notice requirements described above.

(iii) Referral to IRO. Upon a determination that a request is eligible for external review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide review as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

Insured Benefits and State Law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Termination or Amendment of Plan

The Employer expects to maintain the Plan indefinitely as a program of employee benefits. However, the Employer has the right, in its sole discretion, to terminate or amend any provision of the Plan at any time. Therefore, no Plan participant (including any future retiree or retiree who has already retired) has a right to the continued enjoyment of any particular benefit under the Plan after a Plan termination or amendment affecting those benefits.

No Right to Continued Employment

No provision of the Plan or this Summary shall be interpreted as giving any employee any rights of continued employment with the Employer or in any way prohibiting changes in the terms of employment of any employee covered by the Plan.

Non-Assignment of Benefits; Payments to Providers

Except as otherwise expressly provided in this Summary or in an applicable Benefits Booklet, no participant or beneficiary may transfer, assign or pledge any Plan benefits, and no benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. Also, no benefit under the Plan will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

The Administrator may, in its discretion, elect to make a direct payment to a provider of services for which benefits are available under a Component Plan and such direct payment to the provider by the Plan shall not be considered an assignment or alienation under the Plan or any Component Plan, and neither the direction by a Plan participant, or any eligible or covered dependent to make such payment nor the payment itself shall be construed as an assignment of benefits or as a recognition by the Administrator of the validity of any attempted alienation or assignment of benefits under the Plan nor will any such payment confer on the payee any rights

besides the right to receive the payment in the amount of that specific payment.

No Covered Person may, at any time, either while covered under the Plan or following termination of coverage, assign his or her right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

The Plan will honor any Qualified Medical Child Support Order (QMCSO) that provides for Plan coverage for an Alternate Recipient, in the manner described in ERISA §609(a) and in the Plan's QMCSO Procedures.

Coordination of Benefits

The coordination of benefits provisions described in the Benefits Booklets delivered to you with this Summary, as interpreted by the Plan Administrator (or insurer, if applicable) in its discretion, control all coordination of benefits situations involving the Plan and other payers.

Subrogation/Right of Reimbursement

As a condition of receiving medical, dental, vision, disability or any other benefits under the Plan, all covered persons, including all covered dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person, organization or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to the "make whole" doctrine, the "common-fund" doctrine or other similar common-law subrogation rules or legal theories.

Also, each participant and each covered person, as a condition for and consequence of receiving medical, disability or any other benefits under the Plan with respect to any amount that is subject to this subrogation provision, agrees as follows:

(1) The participant and each covered person (or their attorneys or other authorized representatives) will promptly inform the Plan of any settlement agreement and to provide reasonable advance notice of any plans for the disbursement of any settlement funds to the Participant or covered person (or to any other person on behalf of the covered person);

(2) The participant and each other covered person (or their attorneys or other authorized representatives) will hold any settlement funds received with respect to a claim that is subject to the Plan's subrogation rights in trust for the benefit of the Plan until all obligations to the Plan under this subrogation provision are satisfied (or to disburse such funds to the Plan to satisfy any obligations to the Plan under this subrogation provision);

(3) The participant and each other covered person (or their attorneys or other authorized representatives) will maintain and treat any settlement funds received by or on their behalf, as Plan assets, to the full extent of any benefits paid by the Plan with the Participant or other covered person being a trustee of Plan assets with respect to such amounts until the covered person's obligations under this subrogation provision are satisfied; and

(4) The participant and each other covered person (or their attorneys or other authorized representatives) agree that the Plan has an equitable lien on any settlement funds payable to or on behalf of the Participant to the full extent of any benefits paid by the Plan amounts until the covered person's obligations under this subrogation provision are satisfied in full.

Insurance Contracts

The Employer may contract with one or more insurance companies for insured benefits to be provided under the Plan. The Employer has the right to replace any such insurance companies from time to time for any reason. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any insurance contract used to provide benefits are the property of the Employer, except to the extent, if any, that the Plan Administrator determines that a portion of the amount payable is required to be treated as an asset of the Plan. Any portion of such a payment that is required under applicable law to be treated as a Plan asset may be used to provide or pay for benefits for eligible employees or to pay reasonable Plan expenses or may be used or paid in any other manner that is consistent with applicable law regarding the use of Plan assets.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA):

- You can examine, free of charge, at the Plan Administrator's office and at other locations, all of the Plan documents, including insurance contracts, if any, collective bargaining agreements and copies of all documents filed by the Plan (such as detailed annual reports) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You can obtain copies of all Plan documents governing the operation of the Plan, by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

- In some cases, the law may require the Plan Administrator to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. As described above, if your claim for a Plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision, without charge and have the Plan review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials 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 until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied after review and reconsideration by the Plan or is ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof considering the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse Plan funds, if any, 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.

You may have the right to continued health 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. You should review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage.

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

EXHIBIT: Dependent Care Tax Credit vs. Dependent Care FSA

If you have qualifying dependent care expenses, you may be able to choose one or both of two ways to reduce your taxes. You may be able to obtain a tax credit (which is a direct reduction in the amount of taxes you otherwise would owe) or you may be able to reduce your taxable income by contributing to a dependent care flexible spending account (FSA). This worksheet will help you decide which is better for you.

DEPENDENT CARE TAX CREDIT

If you qualify for the tax credit, you are allowed to deduct from the taxes you owe a percentage of the lesser of (1) your actual qualifying dependent care expenses or (2) \$3,000 if you have one dependent or \$6,000 if you have two or more dependents. The percentage is based on your adjusted gross income for the year. The following chart will help you determine your percentage.

If your adjusted gross income is		The percentage of the cost of dependent care you can deduct from your taxes is:
over	to	
\$0	\$15,000	35%
\$15,000	\$17,000	34%
\$17,000	\$19,000	33%
\$19,000	\$21,000	32%
\$21,000	\$23,000	31%
\$23,000	\$25,000	30%
\$25,000	\$27,000	29%
\$27,000	\$29,000	28%
\$29,000	\$31,000	27%
\$31,000	\$33,000	26%
\$33,000	\$35,000	25%
\$35,000	\$37,000	24%
\$37,000	\$39,000	23%
\$39,000	\$41,000	22%
\$41,000	\$43,000	21%
\$43,000	unlimited	20%

Example: An employee's adjusted gross income for the year is \$34,000 and the employee spends \$2,600 each year for day care for one dependent. When you compare \$2,600 with the \$3,000 allowed for one dependent, the lesser of the two amounts is \$2,600. To find the employee's allowable percentage, you use the above chart. Since the employee's adjusted gross income is \$34,000, the employee's percentage will be 25%. Therefore, the amount the employee will be able to deduct from his or her taxes will be $\$2,600 \times 25\%$ or \$650.

INCOME EXCLUSION (DEPENDENT CARE FSA CONTRIBUTIONS)

Instead of the Dependent Care Tax Credit, each year you may elect to have a designated amount taken out of your paycheck before taxes and put into your Dependent Care FSA. This amount must be used during the year to pay for qualifying dependent care expenses. You will not have to pay taxes on the amount you put into the FSA that will be used to pay your qualifying dependent care expenses. If, however, either you or your spouse has Earned Income (as defined in the Plan) of less than \$5,000, your income exclusion will be limited to the Earned Income of you or your spouse, whichever is less. Note that your maximum dependent care FSA contribution for any calendar year is \$5,000 (\$2,500, if you are married but file a separate federal income tax return), regardless of the number of qualifying dependents.

Example: The following is an example of an employee's comparison of the Dependent Care Tax Credit and the Dependent Care FSA. Assume the employee is married and the employee and spouse together expect to have \$70,000 in adjusted gross income (AGI), and they expect to have \$2,800 in qualifying dependent care expenses for the year for one qualifying child. They plan to file a joint federal income tax return. After taking the standard deduction (\$24,400), their federal taxable income would be \$45,600. Assume they live in a state that uses the same definition of taxable income as the IRS and a 5% tax rate. (Note that state income tax rates vary from zero to about 13% and states may use different definitions of taxable income. The federal tax rates and standard deduction amounts in this example are for the 2019 tax year.)

	Using the Tax Credit	Using the FSA
Federal Taxable Income (without Dependent Care FSA)	\$45,600	\$45,600
Subtract: Dependent Care FSA contribution	(0)	(2,800)
Federal Taxable Income	\$45,600	\$42,800
Taxes		
Federal (10% of first \$19,400 of taxable income + 12% of amounts from \$19,400 up to \$78,950)	\$5,084	\$4,748
Social Security and Medicare (7.65% of AGI (minus Dependent Care FSA contributions))	5,355	5,141
State (5.0% of taxable income)	2,300	2,160
Total	\$12,739	\$12,049
Subtract: Tax Credit (20% of \$2,800)	(560)	(0.00)
Total Taxes	\$12,179	\$12,049

In this example, the employee would pay \$130 less in taxes by using the Dependent Care FSA. Of course, this is just one example. Other employees might pay lower taxes using the tax credit, so you should perform the calculations using your own estimated income, qualifying expenses and filing status. Also, note that participation in the FSA may affect other tax credits or deductions that you may qualify for, such as the Earned Income Tax Credit or the Child Tax Credit. You should consult with a tax advisor to determine which approach is best for you.

CALCULATE YOUR TAX CREDIT

Use the following chart to determine if you should use the Dependent Care Tax Credit or the Dependent Care FSA.

	Using the Tax Credit	Using the Income Exclusion (FSA)
Federal Taxable Income (before Dependent Care FSA)	\$ _____	\$ _____
Subtract: Dependent Care FSA contribution		(\$ _____)
Taxable Income	\$ _____	\$ _____
Taxes		
Federal* (_____ %)	\$ _____	\$ _____
State* (_____ %)	_____	_____
Social Security (generally 7.65% of total wages – remember to subtract FSA contributions for the second column)	_____	_____
Total	\$ _____	\$ _____
Subtract: Tax Credit (% from chart on previous page based on your adjusted gross income X your expected qualifying dependent care expenses)	(\$ _____)	
Total Taxes	\$ _____	\$ _____

*Federal and state tax rates vary depending upon your taxable income and filing status. Estimate your tax liability or check with your tax consultant. Also, note that Pennsylvania and New Jersey, unlike other states, do not exclude Dependent Care FSA contributions from state income tax.

USE OF BOTH DEPENDENT CARE TAX CREDIT AND INCOME EXCLUSION

You may use both the Dependent Care Tax Credit and the Dependent Care FSA (although not for the same qualifying dependent care expenses.) However, any amounts that you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the \$3,000 or \$6,000 Dependent Care Tax Credit figure, whichever is applicable.

Example: An employee's adjusted gross income for the year is \$35,000 and the employee spends \$2,600 during the year for qualifying day care for one dependent. The employee elects to place \$1,200 into a Dependent Care FSA to pay for a portion of the dependent care expenses. When you compare the employee's remaining dependent care expenses of \$1,400 with \$1,800 (\$3,000 - \$1,200), the lesser of the two amounts is \$1,400. Given the employee's adjusted gross income of \$35,000, the employee's percentage from the chart is 25%. Therefore, the amount the employee may deduct from the employee's taxes will be \$1,400 x 25% or \$350.

ALWAYS DISCUSS THESE ISSUES WITH YOUR TAX ADVISOR.



SUMMARY PLAN DESCRIPTION



MILLER & LONG DC, INC. HEALTH AND WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Effective January 1, 2022

ABOUT THIS SUMMARY

The following is a summary of some of the principal features of the Miller & Long DC, Inc. Health and Welfare Benefit Plan (the Plan). We urge you to read this summary carefully.

This summary is the “Summary Plan Description” for the Plan and is meant to summarize the Plan in easy-to-understand language. However, in the event of any ambiguity or any inconsistency between this Summary Plan Description and any formal Plan documents, the Plan documents will control.

Copies of the formal Plan documents for the Plan are on file at Miller & Long DC, Inc. (the Employer) and are available to you for inspection at a time and place mutually agreeable to you and to the Employer.

If anything in this Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator.

NOTE: In a few places in this Summary, you will see special temporary rules that apply during the COVID-19 “Outbreak Period”. Those rules extend the time period for you to take certain actions. Under rules provided by the Internal Revenue Service and the U.S. Department of Labor, the “Outbreak Period” is a time period that began on March 1, 2020 or if later, the date that the applicable time period would have started under the normal plan rules. The Outbreak Period for any event cannot last longer than one year, but, for all events, it will end 60 days after the end of the federally declared National Emergency, as determined by the IRS and the Department of Labor (or on another date announced by the IRS and the Department of Labor announce a different ending date). Any extension of time based on these Outbreak Period rules applies only to a time period that otherwise would have included at least one day of the Outbreak Period.

For example: Assume an employee is eligible for a special enrollment period (as described in the “Participation” section of this Summary) because the employee got married on June 15, 2021. That employee normally would have had 30 days (until July 15, 2021) to request enrollment in medical coverage for the employee’s new spouse. However, because that special enrollment period began during the Outbreak Period, the normal 30-day special enrollment period would not start until the end of the Outbreak Period, so the employee would have until 30 days after the end of the Outbreak Period to request enrollment for the new spouse. The Outbreak Period for this employee’s special enrollment opportunity will end no later than June 15, 2022, which would mean the employee would have until July 15, 2021 to request enrollment for the spouse. However, if the IRS and the Department of Labor announce an earlier end to the Outbreak Period, the employee’s deadline would be earlier (30 days from the end of the Outbreak Period). Note that the employee can request enrollment at any time before that extended deadline, but the spouse’s enrollment in that case would not take effect until after the employee requests enrollment, so it may still be in the employee’s interest to request enrollment as soon as possible, if the employee wants coverage for the spouse to begin earlier.

MILLER & LONG DC, INC. HEALTH AND WELFARE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION
Effective January 1, 2022

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GENERAL INFORMATION ABOUT THE PLAN

Name of Plan

Miller & Long DC, Inc. Health and Welfare Benefit Plan

Name and Business Address of Employer

Miller & Long DC, Inc.
4001 Brandywine Street, NW, Suite 400
Washington, DC 20016

Employer's Taxpayer Identification Number

27-5492647

Plan Number

501

Type of Administration

The Plan is administered by the Plan Administrator. Please note that participant benefit accounts under the Plan are merely bookkeeping entries, no assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. Some benefits may be provided through insurance contracts. To the extent that any benefits are not provided through insurance contracts, they are paid from the Employer's general assets.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's discretionary authority includes but is not limited to, discretionary authority to interpret plan provisions and to make all determinations of facts, including factual determinations relating to eligibility for benefits, and to make all determinations that require application of facts to the terms of the Plan. The Plan Administrator's determinations shall be given deference and are final and binding on all interested parties. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Health Coverage Funding Information

Cigna, P.O. Box 182223, Chattanooga, TN 37422-7223 is the claims processor of your medical and dental benefits under the Plan. Cigna Vision, P.O. Box 385018, Birmingham, AL 35238-5018 is the claims processor of your vision benefits under the Plan. The Plan's medical, dental and vision benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by Cigna or any other insurance carrier.

Affordable Care Act

This Summary includes various provisions that are required to comply with the requirements of the federal health care reform law, (the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010) and with regulations and other guidance issued under that law. Whenever this Summary refers to the “Affordable Care Act” it is referring to the PPACA, as amended, and any applicable regulations. The health care reform requirements of the Affordable Care Act generally apply only to the Plan’s medical coverage. When this Summary refers to coverage that is subject to the Affordable Care Act, it means the Plan’s medical coverage, including any prescription drug or vision benefits that are offered as part of a bundled package with the medical coverage.

Plan Year

The Plan Year for the Plan is the period beginning each September 1 and ending on the next August 31, but for purposes of the Plan’s medical, dental and flexible spending account benefits, references to “Plan Year” mean the calendar year, January 1 through December 31.

Name, Business Address and Telephone Number of Plan Administrator

Miller & Long DC, Inc.
c/o Human Resources Department
4001 Brandywine Street, NW, Suite 400
Washington, DC 20016
(202) 524-4600

Service of Legal Process

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

Type of Plan

This Plan is a form of employee welfare benefit plan called a “cafeteria plan” because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the Employer to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan. For certain benefits, because your salary is reduced before federal taxes (and, in most states, state taxes) are imposed, you pay less in taxes if you participate in the Plan. (Some benefits may require that you make after-tax contributions.)

Eligibility

If you are a full-time regular employee of the Employer (i.e., if you are regularly scheduled to work at least thirty hours per week, as determined by the Employer), you and your eligible dependents are eligible to participate in the Plan beginning on the day on which you complete ninety days of continuous employment with the Employer (your “Participation Date”). For purposes of this continuous employment requirement as it applies to the Plan’s health benefits, if you are absent from work because of a health condition, your absence will not interrupt your completion of the continuous employment requirement. That is, any period of continuous service that you complete before your health-related absence will apply toward the continuous employment requirement and will be added to any period of continuous service that

you complete after you return to work following your health-related absence.

Leased employees, persons classified by the Employer as temporary employees of the Employer (as determined by the Employer), and employees covered by a collective bargaining agreement and their dependents (unless Plan participation is provided for in the collective bargaining agreement) are not permitted to participate in the Plan. A person who is not characterized by the Employer as an employee of the Employer, but who is later characterized by a regulatory agency or court as being an employee, will not be eligible for the period during which he or she is not characterized as an employee by the Employer.

If you are laid-off by the Employer and are rehired within six months, your Participation Date will be your date of rehire. Otherwise, your Participation Date will be the day on which you complete ninety days of continuous employment with the Employer after you are rehired. However, if you are rehired during the same Plan Year and within 30 days after your previous period of eligible employment ended, you generally will not be permitted to make a new election of benefits for that Plan Year, but your previous election of benefits will be reinstated.

Please note that your eligibility for any particular benefit is determined under Plan terms applicable to that benefit. The Benefit Booklets delivered with this Summary include information about any additional or different eligibility requirements that may apply to specific benefits.

Dependent Eligibility

(NOTE: This Dependent Eligibility section does not apply to flexible spending account benefits. For details on whether a family member's expenses can be covered under a flexible spending account, see the separate explanations of those benefits in the "Summary of Available Benefits" section.)

For purposes of all benefits available under the Plan to dependents, your *spouse* is considered an eligible dependent (*spouse* and other *italicized* terms used in this section are defined below).

The Plan's dependent eligibility requirements for children of eligible employees have changed to comply with the requirements of the Affordable Care Act. Your *child* is eligible for coverage offered to dependents under the Plan based on the following rules:

1. Coverage for Children under Age 26. Your eligible dependents include your *child* who is under age 26, regardless of the child's marital status, tax dependent status or student status and regardless of whether the child lives with you.
2. Coverage for Older Children with Disabilities. For purposes of all coverage offered to dependents under the Plan, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable calendar year is an eligible dependent if he or she is physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 26.

The following definitions apply for purposes of this Dependent Eligibility section:

Child means a natural child, a legally adopted child who is under age 18 at the time of the adoption, a child placed with you for adoption who is under age 18 at the time of the

placement, a foster child (if the child is an “eligible foster child”, as defined in the Internal Revenue Code) or a stepchild. *Child* also includes any other person whose welfare is your legal responsibility under a legal guardianship, written divorce settlement, written separation agreement or a court order.

Spouse means a person who is treated as your spouse because of a marriage that is recognized as a marriage for purposes of federal income tax law, which currently includes any marriage that is recognized as a valid marriage in the State, District, territory or foreign jurisdiction in which the marriage occurred.

Dependent for Federal Income Tax Purposes

Whether someone is your *dependent for federal income tax purposes* is determined under IRS rules. For details on the requirements for someone to be your federal income tax dependent, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* under the Plan. However, for purposes of this Plan’s health benefits, note that even if your family member would not qualify as your dependent for federal income tax purposes under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for purposes of the Plan’s dependent eligibility requirements.

Also, in determining if your child is your *dependent for federal income tax purposes*, a special rule applies in cases of divorce or legal separation or if you and your child’s other parent live apart for all of the last six months of the calendar year if either you or the child’s other parent has custody of the child and is actually entitled to claim the child as a dependent for tax purposes. In those cases, as long as at least half of the child’s support for the applicable calendar year is being provided by you and the other parent (and your current spouses, if any) together, the child can be considered your *dependent for federal income tax purposes* for purposes of the Plan’s health benefits.

A person otherwise qualifying as your eligible dependent will not be covered for any coverage providing benefits to dependents unless you have elected to pay and have paid the required additional contributions, if any, for dependent coverage. Also, unless otherwise required by law, note that your spouse or child will not qualify as an eligible dependent while on active duty in the armed forces of any country.

You are responsible for determining if someone qualifies as your spouse or dependent for purposes of the Plan’s dependent eligibility rules, subject to the Employer’s final approval. The Employer may require you to provide proof that an individual satisfies all of the Plan’s eligibility requirements. Also, if at any time during a Plan Year your eligible spouse or dependent becomes ineligible for coverage, you are responsible for notifying the Employer of that change in eligibility.

If you and your eligible spouse or dependent are both employees of the Employer and each of you meets the Plan’s eligibility requirements to participate in the Plan as employees, you may elect employee-only medical, dental or vision coverage or one of you may elect family (or employee and spouse or dependent) coverage. However, no employee can be covered under the

Plan's medical, dental and vision coverage as another employee's spouse or dependent at the same time that he or she is also covered under the Plan as an employee/participant.

Also, for purposes of the Plan's medical and dental coverage, if a child would otherwise qualify as an eligible dependent of more than one eligible employee, the child may be enrolled as the dependent of only one employee at the same time. For example, if you and your spouse are both eligible employees of the Employer and you separately elect medical coverage under the Plan, only one parent may enroll your child in his or her medical coverage. In such cases, it is up to you and the child's other parent to determine which parent will enroll the child in each type of coverage. If both parents attempt to enroll a child for the same period, one request for enrollment will be denied in accordance with procedures established by the Plan Administrator.

For any insured coverage offered under the Plan, the terms of the insurance contract, instead of this "Dependent Eligibility" section, will determine whether any person is your dependent for purposes of that benefit (if there is any difference between the language in this Dependent Eligibility section and the terms of the contract). The Benefits Booklets provided to you with this Summary will include any additional or different dependent eligibility requirements that apply for any insured coverage.

All Qualified Medical Child Support Orders that require the Plan to provide Plan coverage for so-called "Alternate Recipients" will be honored by the Plan in accordance with applicable law. (These orders are a type of order by a court or by an administrative agency providing coverage for children of Plan participants.) As required by applicable law, the Plan uses procedures to determine whether a medical child support order is a "Qualified Medical Child Support Order" that must be honored by the Plan. Upon request to the Plan Administrator, you may receive, without any charge, a summary of these procedures.

Participation

(a) Initial Election Period. If you are not already a participant in the Plan, to become a participant on your Participation Date, you must be an active employee of the Employer on your Participation Date and you must properly complete and submit an initial Election Form to the Plan Administrator (or complete a designated electronic enrollment process, if available) before your Participation Date and during the period designated by the Plan Administrator as your initial "enrollment period". For purposes of medical benefits only, you will be treated as an active employee on your Participation Date even if you are absent from work if your absence occurs because of a health condition (as determined by the Employer).

Your benefit elections made during your initial enrollment period will be effective from your Participation Date until the last day of the Plan Year in which you change your initial benefit election (see subsection (b) below) or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (e) below) or qualify to change your elections for certain other reasons (see subsection (d) below).

If you fail to properly complete and submit an Election Form to the Plan Administrator during your initial election period, you will not automatically participate in the Plan.

(b) Election Periods after Initial Election Period. After you complete the initial Election Form, your initial benefit election will remain in effect indefinitely or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period

right (see subsection (e) below) or qualify to change your elections for certain other reasons (as described in subsection (d) below) or until you make a new benefit election by requesting, completing and submitting a new Election Form to the Plan Administrator for a future Plan Year during the period preceding the Plan Year that is designated by the Plan Administrator as the Plan's annual "election period". Your new benefit election will be effective from the first day of the Plan Year following the election period in which you make your new benefit election until you change your election during a later election period, or you experience a Status Change, exercise a Special Enrollment right or otherwise qualify to make an election change that is permitted under the Plan.. However, this automatic carry-over of previous elections does not apply to your elections regarding participation in the Plan's health care flexible spending account or dependent care flexible spending account. If you fail to complete and submit a new Election Form for these benefits, you will not automatically receive coverage.

The Employer, in its discretion, may determine that it will not offer an annual "election period" for a future plan year. If the Employer determines that there will be no annual "election period" or open enrollment for the upcoming year, the elections you made on your most recent Election Form will carry over for the next year. You will still be able to make changes to your election if you or your dependents experience a Status Change, exercise a Special Enrollment Period right or qualify to make a change for certain other reasons, as described below.

Also, although your benefit elections normally will carryover from one Plan Year to the next as described above, the Employer may announce before the start of a Plan Year that new elections will be required for all eligible employees to participate in benefits for that upcoming Plan Year. In such cases, a special required election period will be announced for all eligible employees to make new elections, which will take effect at the beginning of the next Plan Year. An employee who fails to make an election of available benefits for the following Plan Year during that special required election period will cease to participate in the Plan at the end of the Plan Year in which the special required election period occurs.

(c) Changes of Election to Reflect Status Change. If you are currently participating in the Plan, you may, with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, change your elections by filing a Status Change Form within 30 days after a Status Change event. If you are not currently a participant in the Plan but you have satisfied all the requirements to be eligible to participate (except that you do not have a current benefit election in place), with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, you may become a participant by filing an Election Form and a Status Change Form within 30 days after a Status Change event occurs.

Under applicable law, to be permitted to make a change in your benefit elections because of a Status Change event, the Status Change event must result in you or your spouse or dependent gaining or losing eligibility for that coverage or similar coverage under the Plan, a plan sponsored by another employer by whom you are employed or a plan sponsored by the employer of your spouse or other dependent. (For dependent care flexible spending account benefits, you are also permitted to make an election change if a Status Change increases or decreases your eligible dependent care expenses and the election change corresponds to the change in expenses.)

Any change that you wish to make to your benefit elections must be consistent with the Status Change event that occurred. The Employer will determine whether, under applicable law, a requested change (or a new election) is consistent with the Status Change you experience. For example, if you become eligible for health coverage offered by your spouse's employer because you get married or because your spouse changes employers, you may cancel your health coverage under this Plan only if you certify to the Employer that you have actually enrolled or intend to enroll in the other Plan. Under applicable law, it would not be consistent with the Status Change if you merely dropped coverage under this Plan without enrolling in the other plan.

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the elections are approved by the Plan Administrator, and will be effective, for health care flexible spending account or dependent care flexible spending account coverage, for the balance of the Plan Year in which the new election is made or, for all other coverage, until you change your elections according to the Section entitled "Election Periods After Initial Election Period" or you experience another Status Change.

You will experience a Status Change if:

- (1) your legal marital status changes including changes because of marriage, the death of your spouse, divorce or legal annulment;
- (2) there is an event which causes you to gain or lose a dependent;
- (3) you, your spouse or your dependent terminates or begins employment;
- (4) you experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or the beginning or ending of an unpaid leave of absence);
- (5) you, your spouse or your dependent becomes eligible or loses eligibility for coverage under a plan offered by that person's employer because of a change in employment status (for example, if your dependent switches from hourly to salaried employment and the dependent's employer's medical plan covers only salaried employees);
- (6) an event happens that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or similar circumstance;
- (7) for purposes of dependent care flexible spending account benefits, there is an event that changes the number of your dependents who are under the age of 13 or mentally or physically incapacitated; or
- (8) for any election made on an after-tax basis, you experience any event which, in the Administrator's sole discretion, qualifies as a Status Change.

(d) Other Election Changes. Except as otherwise provided below, if you are entitled to an election change described below, you must request the change within 30 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

(i) Orders Requiring Coverage. If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical

coverage for your child, you, or, if required by the order, the Plan Administrator, may change your health coverage elections (to the extent permitted by the Plan Administrator, in its discretion) to provide such coverage and you, or if required by the Order, the Plan Administrator, may change the amount of your salary reduction contributions to cover the cost of such coverage. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order and you provide evidence to the Employer that such coverage is actually being provided, subject to the Employer's approval, you will be permitted to change your election to stop providing medical coverage for your child.

(ii) Medicare or Medicaid Enrollment. If you or your spouse or dependent becomes enrolled in Medicare or Medicaid, subject to the Employer's approval, you may change your election to cancel or reduce medical coverage for that individual. If you or your spouse or dependent loses eligibility for Medicare or Medicaid, again subject to the Employer's approval, you may change your election to commence or increase medical coverage for that individual.

(iii) Paying for COBRA Coverage. If you or your spouse or dependent becomes eligible for continued health coverage under the Employer's health plan as provided under COBRA or any similar state law, you may change your election to pay for that COBRA coverage with salary reduction contributions.

(iv) FMLA Leave. If you take leave under the Family and Medical Leave Act of 1993 (FMLA), you may make certain election changes that are permitted by the Employer in accordance with the FMLA.

(e) Special Enrollment Periods for Employees and Dependents. If you decline enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Note that days during the "Outbreak Period", as defined on the "About This Summary" page at the beginning of this document, are not counted in determining if you have requested enrollment within that 30-day period (so the 30-day period is extended to also include the full Outbreak Period).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption (90 days in the case of the addition of a spouse or child that does not result in an increase in your contribution). Note that days during the "Outbreak Period" are not counted in determining if you have requested enrollment within the 30-day period (so the 30-day period is extended to also include the full Outbreak Period).

If you or your eligible dependent are covered under Medicaid or a State Children's Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and any affected dependent in this Plan's medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. Also, if you or your eligible dependent become eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days after the date a government

agency determines that you are eligible for that financial assistance. Note that days during the “Outbreak Period” are not counted in determining if you have requested enrollment within that 60-day period (so the 60-day period is extended to also include the full Outbreak Period).

If you are eligible to make a special enrollment election described in this section, you may elect coverage under any medical coverage options for which you are eligible under the Plan. If you are eligible for more than one medical coverage option and you are currently enrolled in one coverage option, you may change to a different medical coverage option that is available to you. Benefits elected during a special enrollment period become effective no later than the first day of the first month that starts after you properly elect coverage. However, for a special enrollment election based on a birth, adoption or placement for adoption, your coverage would be effective starting on the date of the birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator at the address provided in this Summary.

Termination of Participation

Except as otherwise provided below, coverage for a participant generally terminates on the earliest of the following dates:

- (a) The day on which the participant terminates employment.
- (b) Except for certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant.
- (c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.
- (d) Except to the extent required by law, the day on which the participant reports for active duty as a member of the armed forces of any country.
- (e) The day on which all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

Coverage for an eligible dependent of a participant generally terminates on the earliest of the following dates:

- (a) The day on which the participant terminates employment.
- (b) Except for certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant.
- (c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.
- (d) Except to the extent required by law, the day on which the eligible dependent reports for active duty as a member of the armed forces of any country.
- (e) The day on which all benefits, or the applicable benefits, are terminated by

amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

- (f) The day on which the eligible dependent ceases to be an eligible dependent.

Coverage under the Plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.

For coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may occur in only two situations. First, as indicated above, if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with respect to the Plan, or makes an intentional misrepresentation of a material fact. In that case, the Plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

Coverage under the Plan may be extended after the date that the participant would otherwise cease to be a participant because of any of the preceding provisions if, on that date, the participant is totally disabled from a sickness or injury and is under a doctor's care. However, this coverage extension applies only to the disability and any related sickness or injury (as determined by the Employer). Any such extended coverage is subject to all of the terms of this Plan. In such cases, the extended coverage will end on the earliest of (i) the date the participant is no longer totally disabled, (ii) the date the participant becomes eligible for other health coverage under another group health plan or Medicare or (iii) 90 days from the date the participant would otherwise cease to be a participant based on the Termination of Participation events listed above.

In addition, if your employment is terminated due to a layoff, you will continue to be a participant in the Plan for an additional 30 days after the date your participation would otherwise terminate.

If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the Plan. See the "Continuation and Conversion Rights" and "COBRA Notice" sections of this Summary for more details.

Also, if you take a leave of absence from employment with the Employer because of military service and your coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the

continuation coverage described in the COBRA notice section of this Summary and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the last day of the 24-month period beginning on the date your military leave of absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer. Please contact the Employer if you have questions about coverage during periods of military service.

Summary of Available Benefits

The following benefits are available under the Plan. Any salary reduction contributions you will be required to make to obtain any elected benefit will be determined by the Employer, and will be communicated to you from time to time. Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect you or require a change to your elections or benefits, you will be notified.

Medical/Prescription Drug and Vision Coverage. If you are eligible to participate in the Plan, you may purchase medical/prescription drug and vision coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time. Medical coverage under the Plan will comply with the reconstructive surgery requirements of the Women's Health and Cancer Rights Act of 1998.

Dental Coverage. If you are eligible to participate in the Plan, you may purchase dental coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Life Insurance/AD&D Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense life insurance/accidental death and dismemberment (AD&D) coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Long Term Disability Coverage. If you are a salaried employee and you are eligible to participate in the Plan, you will receive at the Employer's sole expense long term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

If you are eligible for long-term disability coverage, you have the option of receiving coverage as an employer-paid tax-free benefit or treating it as an after-tax benefit. If you elect to receive the coverage as a tax-free benefit, that means that you do not have to pay federal income and payroll tax (and you may not have to pay state taxes) on the amount that the employer pays for the coverage. However, if you become eligible for disability benefits during the coverage period, you generally will be subject to tax on those benefit payments. Under the other option, if you elect to receive the coverage as an after-tax benefit, you will be treated as receiving the value of the coverage as a taxable benefit, so you will be subject to income and payroll tax on the amount the Employer pays for the coverage. However, if you become eligible for disability benefits during that coverage period, any benefit payments you receive would generally not be subject to tax. You should consult with a financial advisor if you have questions

about how you should pay for long-term disability coverage.

Short Term Disability Coverage. If you are an hourly employee and you are eligible to participate in the Plan, you will receive at the Employer's sole expense short term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Employee Assistance Program Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense employee assistance program coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Health Care Flexible Spending Account. Flexible spending account elections are administered based on a calendar year Plan Year. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed \$2,850 (for the 2022 calendar year). The Plan's maximum contribution amount is required by federal law. The maximum amount is adjusted by the IRS each year based on inflation. The Plan's maximum contribution amount will also be automatically adjusted each year based on the new maximum announced by the IRS.

The Employer also may make contributions to a Health FSA for each employee who enrolls in medical coverage under the Plan during the Plan's annual open enrollment period and who elects to contribute to the Health FSA. For the 2022 Plan Year, the Employer will automatically make Employer contributions to a Health FSA for such participants equal to \$100 for any Employee who is enrolling in individual medical coverage for the Plan Year or \$300 for any Employee who enrolls in family coverage under the Plan. For later years, the Employer reserves the right to contribute different amounts or no amount at all, as communicated to eligible Employees during each annual open enrollment period. Employer contributions to your Health FSA are credited even if you do not elect to make your own contributions to the Health FSA. If you do elect to make your own contributions, the Employer contribution simply increases the amount available under the Health FSA and does not reduce the amount you may contribute. Employer contributions are subject to all of the rules that apply to employee salary reduction contributions under the Health FSA, as described in this section and in other documents available to employees. Employer contributions are provided only for eligible Employees who enroll in medical coverage during the applicable open enrollment period and are not made for any Employee who enrolls in the Health FSA after the start of the calendar year.

If you do not use up your entire Health FSA balance with expenses incurred by the end of the Plan Year, there is also a "grace period" that lasts two and one-half months after the end of the Plan Year (that is, until March 15th of the next calendar year). Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Health FSA on the last day of the Plan Year. You will still be treated as participating in the Health FSA for this purpose if you elected COBRA continuation coverage under the Health FSA and that COBRA coverage is in effect on the last day of the Plan Year. If your participation in the Health FSA ends before the end of the Plan Year, there is no grace period.

Generally, eligible medical expenses are expenses that you or your eligible dependent (determined as described below) have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of medical expenses (including legally obtained prescription drugs, over-the-counter medicine and

menstrual care products), and that have not been taken as a deduction in any year.

Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

For purposes of Health FSA reimbursements, “dependent” includes:

- (1) your spouse;
- (2) your biological, adopted or step-child or your eligible foster child if the child will be younger than 27 on the last day of the calendar year in which the expense is incurred, (even if the child is not your dependent for tax purposes); and
- (3) any person who is expected to be your *dependent for federal income tax purposes* (as defined below) for the calendar year in which the expense is incurred.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Health FSA benefits. However, for purposes of the Health FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for Health FSA benefits. The Plan Administrator always has the right to require documentation that an individual qualifies as your spouse or dependent for health FSA purposes and to deny benefits if you fail to provide adequate documentation when required. If you have any question about whether someone qualifies as your dependent for purposes of the Health FSA, you should consult a tax advisor.

To be reimbursed from your Health FSA, you must submit to the Plan Administrator a request for reimbursement on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than the next April 15th following the end of the calendar year (or grace period) in which the expenses were incurred. However, if you cease to be a participant in the Health FSA (because your employment terminates or for any other reason) before the end of the Plan Year, you must submit all requests for reimbursement to the Plan Administrator no later than 60 days after you cease to be a participant in the Health FSA.

Note that the time limit for submitting claims described in the preceding paragraph is extended if that time limit would otherwise end during the Outbreak Period (as defined on the “About This Summary” page at the beginning of this document). Days during the Outbreak Period do not count for purposes of any such time limit.

Please note that amounts held in your Health FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Health Savings Account Eligibility

You should be aware that, if you or your spouse or any eligible dependent wishes to be eligible to make Health Savings Account (HSA) contributions, your participation in the Health FSA (including automatic participation based solely on Employer contributions) could make you or your spouse or dependent ineligible to make HSA contributions. To avoid that issue, you have two options:

(1) You can elect on your Election Form to exclude your spouse from eligibility for Health FSA reimbursements, which would simply mean that you could not use the Health FSA to reimburse any expenses incurred by your spouse; or

(2) You can elect on your Election Form for the Health FSA to be treated as a “limited-scope” Health FSA. If you choose that option, that choice will apply to you and any other eligible dependents under your Health FSA. The amount contributed to your limited-scope Health FSA (including any Employer contributions) generally would be available to pay only eligible dental or vision care expenses. You could not use the Health FSA to pay or be reimbursed for any other types of expenses.

Qualified Reservist Distributions

If you are called or ordered to active duty in a United States reserve component for a period of 180 days or longer or for an indefinite period (or for a shorter period that is later expanded to 180 days or longer), and the amount you have received in reimbursements from your Health FSA for the Plan Year is less than the amount you have contributed, you may request a Qualified Reservist Distribution of your unused balance (the difference between what you have contributed and the amount of reimbursements you have received). The distribution generally would be treated as taxable compensation to you. You must request the distribution before the end of the grace period for the Plan Year during which you are called or ordered to active duty. If you request a distribution, you may continue to submit claims for expenses incurred before you made your request, but you may not submit claims for expenses incurred after that date. Your request must include a copy of the document that orders or calls you to active duty (if not already provided to the Employer). If you qualify for a Qualified Reservist Distribution, the distribution will be made within a reasonable period (no later than 60 days) after you request it. Once you receive a distribution equal to your entire unused balance, you will no longer be a participant in the Health FSA for that Plan Year and will not be able to submit or be reimbursed for any additional claims for eligible medical expenses. To request a Qualified Reservist Distribution or for more information, you should contact the Plan Administrator at the address provided in this Summary.

Dependent Care Flexible Spending Account. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed \$5,000 per calendar year or, for married participants filing separately, \$2,500 per calendar year, credited to your dependent care flexible spending account (Dependent Care FSA). You can receive amounts from this Account, in cash, as reimbursement for Employment Related Expenses incurred during the Plan Year and while you are a participant in the Dependent Care FSA. However, if you do not use up your entire Account balance with expenses incurred by the end of the Plan Year, there is also a “grace period” that lasts two and one-half months after the

end of the Plan Year (that is, until March 15 of the next Plan Year). Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Dependent Care FSA on the last day of the Plan Year. If your participation in the Dependent Care FSA ends before the end of the Plan Year, there is no grace period.

The amount of any reimbursement for Employment Related Expenses may not exceed the amount credited to your Account at the time of your reimbursement request. Generally, under federal law, Employment Related Expenses are expenses for household services and expenses related to the care of a “Qualifying Individual”, which you incur to enable you to work.

“Qualifying Individual” is defined under federal law and currently means someone who is:

- (1) your child (including a stepchild), brother, sister, stepbrother or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13, who has the same principal residence as you for at least half of the calendar year and who does not provide at least half of his or her own support for the current calendar year,
- (2) your spouse who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year or
- (3) your *dependent for federal income tax purposes* (as defined below) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Dependent Care FSA benefits. However, for purposes of the Dependent Care FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for Dependent Care FSA benefits.

The Plan Administrator always has the right to require documentation that an individual qualifies as a Qualifying Individual under the above rules and to deny benefits if you fail to provide adequate documentation when required or if the Administrator determines that expenses for any person are not eligible for reimbursement. If you have any question about whether someone qualifies as your dependent for purposes of the Dependent Care FSA, you should consult a tax advisor. Also, note that the determination of whether someone is a Qualifying Individual must be made each time expenses are incurred. For example, if your child is age 12 at the start of the calendar year, otherwise eligible expenses for that child can be reimbursed under the Dependent Care FSA only for services provided before the child’s 13th birthday (unless the child is mentally or physically incapable of taking care of himself or herself).

The amount of reimbursements that you may receive from your Dependent Care FSA on a tax-free basis in a calendar year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. Thus, for example, if you have \$5,000 in your Dependent Care FSA and you and your spouse have Earned Income of \$20,000 and \$4,000, respectively, you can receive \$4,000 worth of reimbursement from the Account on a tax-free basis, and you will be taxed on \$1,000 worth of the reimbursement you receive. If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have Earned Income for each month that he or she is a full-time student or incapacitated. The amount of deemed earnings will be \$250 a month, if you provide care for one Qualifying Individual, or \$500 a month, if you provide care for more than one Qualifying Individual.

Employment Related Expenses that are incurred for services outside your household may be reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under thirteen years of age (category (1) in the above definition of Qualifying Individual), or (ii) another Qualifying Individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center (as defined below), the Center must comply with applicable laws and regulations of a state or local government. A "Dependent Care Center" is any facility that provides care for more than six individuals who do not reside at the center and receives a fee, payment or grant for providing services for any of the individuals.

No reimbursements will be made for Employment Related Expenses for services rendered by any person for whom you or your spouse is entitled to a deduction on your federal income tax return for the applicable calendar year or who is your child (including a stepchild or a foster child) who will be under the age of 19 at the end of the year.

To be reimbursed from your Dependent Care FSA, you must submit a reimbursement request to the Plan Administrator on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than the next April 15th following the end of the calendar year (or grace period) in which the expenses were incurred. However, if you cease to be a participant in the Dependent Care FSA (because your employment terminates or for any other reason) before the end of the Plan Year, you must submit all requests for reimbursement to the Plan Administrator no later than 60 days after you cease to be a participant in the Dependent Care FSA.

Please note that amounts held in your Dependent Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts which you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the tax credit available. Attached as an Exhibit is a notice which further explains the dependent care tax credits and the income exclusions. The notice also provides a worksheet to help you determine which tax reduction method is more beneficial for you.

Dependent Care FSA benefits are not subject to the federal law known as ERISA,

so the “Your Rights under ERISA” section of this Summary does not apply to these benefits.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your health care continuation or conversion rights, please contact the Plan Administrator. Also, please review the next section regarding continuation coverage under the federal law known as “COBRA”.

Continuation Coverage Under COBRA (COBRA Notice)

This “COBRA Notice” section of your Summary Plan Description applies to employees and covered spouses and dependents who have health coverage under the Plan. For purposes of this notice, “Plan” refers only to the medical, prescription drug, dental, vision and health care flexible spending account benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

You’re getting this notice because you are covered under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. (Both you and, if you are married and your spouse is covered by the plan, your spouse should take the time to carefully read this notice.)

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 and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or 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 period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it 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

COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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; 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 of the following qualifying events:

- 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 parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

For purposes of the Plan and this COBRA notice, a "dependent child" is anyone who is covered under the plan as a dependent and as your child. "Child" for this purpose has the same meaning as provided in the "Dependent Eligibility" section of this Summary Plan Description.

When is COBRA continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment; or
- Death of the employee.

You must give notice of some qualifying events

For all other qualifying events (divorce or legal separation of the employee and 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 later of (1) the date the qualifying event occurs or (2) the date that coverage would otherwise end because of the qualifying event. You must provide this notice, along with any required documentation to:

Miller & Long DC, Inc.
c/o Human Resources Department
4001 Brandywine Street, NW, Suite 400
Washington, DC 20016

Note that the 60-day period described above is extended for any qualifying event, if that 60-day period otherwise would have included any day of the Outbreak Period (as defined on the “About This Summary” page at the beginning of this booklet). Days during the Outbreak Period do not count towards the 60-day time limit.

Your notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- Your name, address, phone number and health plan ID number.
- The name, address, phone number and health plan ID number for any dependent or spouse whose eligibility is affected by the qualifying event.
- A description of the qualifying event and the date on which it occurred.
- The following statement: “By signing this letter, I certify that the qualifying event described in this letter occurred on the date described in this letter.”
- Your signature.

You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided in this notice.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, you may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage. (NOTE: The rest of this paragraph applies to health plans other than the health care flexible spending account plan. For the rules that apply to the health care flexible spending account, see the “Special Rules for Health Care Flexible Spending Accounts” section below.) COBRA coverage generally lasts for 18 months if the qualifying event is employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA 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 get 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 COBRA continuation coverage. To notify the Plan Administrator of a

disability determination, you should follow the same procedures described above under “You Must Give Notice of Some Qualifying Events”. Your notice must include documentation of the Social Security Administration’s decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event. However, regardless of the deadline described in the previous sentence, your notice must be provided no later than the date your COBRA coverage would terminate without a disability extension.

Note that the 60-day period for you to provide notice of a disability determination is extended if that 60-day period otherwise would have included any day of the Outbreak Period (as defined on the “About This Summary” page at the beginning of this booklet). Days during the Outbreak Period do not count towards that 60-day time limit.

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event (following the same procedures described above under “You Must Give Notice of Some Qualifying Events”). This extension may be available to the spouse and any dependent children getting COBRA 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 this extension is available only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Special rules for health care flexible spending accounts

For a health care flexible spending account (Health FSA), COBRA continuation coverage is available **only if** the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs (plus any grace period that applies after the end of that Plan Year (as described in the Plan’s SPD), but only if the qualified beneficiary keeps COBRA coverage in effect through the last day of the Plan Year). COBRA coverage under the Health FSA cannot be extended beyond that time for any reason.

EXAMPLE: Assume that an employee elected to contribute a total of \$1,200 to her Health FSA account for a Plan Year and then her employment terminates six months after the beginning of the Plan Year. By that time, she has contributed \$600 to her FSA account through payroll deductions. Assume that she has already received \$800 in reimbursements from her account for expenses incurred before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is \$400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of \$600 (plus about \$12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about \$612) is more than the maximum that she would be eligible to

receive in reimbursements (\$400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of \$588 or less before her termination date, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay (\$612).

Any deadlines or other rules for filing a request for reimbursement under the Health FSA will continue to apply if you elect continuation coverage under the Health FSA. See your Summary Plan Description for more details.

Additional continuation coverage election period for “TAA-eligible individuals”

In addition to the other COBRA rules described in this section of your Summary Plan Description, there are some special rules that apply if you are classified as a “TAA-eligible individual” by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.)

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than six months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this Notice, your coverage period will be measured from the date of your TAA-related loss of coverage.

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, Medicare, Medicaid, [Children’s Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

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

If you don’t enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (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 EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

If you have questions or need more information about COBRA continuation coverage under the Plan or to report any address changes, please contact the Plan Administrator at the address or phone number provided in this Summary.

Emergency Medical Care

If you believe you need emergency medical care, you should not forego that care because you believe it will not be covered by the Plan. Also, in accordance with the No Surprises Act, if you are covered under the plan's medical coverage, the Plan must cover services, supplies, and treatment for the stabilization, evaluation, and/or initial treatment of an emergency medical condition when provided on an outpatient basis at a hospital emergency room or department or at a freestanding independent emergency department ("Emergency Services") without prior authorization and with in-network cost-sharing. In addition, the No Surprises Act prohibits balance billing by nonpreferred providers. As a result, your responsibility for Emergency Services will be limited to your deductible and coinsurance amounts.

Patients to Evaluate Care

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any practitioner. Each patient should evaluate the quality of care and act

accordingly. No Plan provision expressed in this Summary or the Plan documents should be interpreted to restrict the access to or delivery of medically necessary services. A patient's decision to forego such care should not be based on his or her interpretation of this Summary Plan Description or the Plan documents.

Health Information Privacy

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. If you are an employee and you are covered under any of the Plan's health benefit options, you should have received a copy of the Plan's Privacy Notice with this Summary (if you did not previously receive one). In addition, a copy of the Plan's current Privacy Notice is always available upon request. Please contact the Plan Administrator at the address indicated later in this Summary if you would like to request a copy of the Notice or if you have questions about the Plan's privacy policies.

Medical Benefits Following Childbirth

The Plan and any health insurance company insuring health benefits under the Plan, 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 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 and/or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, the Plan and any health insurance company may not, under federal law require that a provider obtain authorization from the Plan or health insurance company, if any, for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

Claims Procedures

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and for certain medical benefits, the applicable requirements of regulations issued under the Affordable Care Act and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures generally will apply instead of the claims procedures described in this Summary. This Claims Procedure section includes descriptions of the minimum requirements for claims procedures that apply to insured benefits, but full details of claims procedure rules for insured benefits are described in the insurer's Benefit Booklet that describes the specific insured benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims, including claims for dependent care flexible spending account benefits, the claims procedures described in this

section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator (or an insurer) provide notice to a claimant about any right under ERISA will not apply to such a claim.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act and for purposes of any disability benefits that are subject to ERISA, "adverse determination" also includes any rescission of coverage. A rescission of coverage generally is a retroactive termination of coverage because of fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a "rescission" and is therefore an adverse determination that is subject to these claims procedures will be determined by the Reviewer based on applicable law.

Temporary "Outbreak Period" Extension of Time Periods for Filing Claims and Appeals

Note that any time limit described in this Claims Procedure Summary or in a Benefits Booklet for submitting an initial claim or requesting a review or appeal or external review of an adverse determination regarding a claim under a benefit that is subject to ERISA is extended if that time limit would otherwise include any day in the Outbreak Period (as defined on the "About This Summary" page at the beginning of this document). Days during the Outbreak Period do not count for purposes of any such time limit.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. Claims should be submitted promptly after an expense is incurred. Unless a different deadline expressly applies in this Summary or under a Benefits Booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred. (For deadlines for submitting flexible spending account reimbursement requests, see the "Summary of Available Benefits" section of this Summary.)

The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, using the following procedures.

For purposes of these procedures, "health benefit" or "health claim" refer to benefits or claims involving medical, dental, vision or health care flexible spending account coverage. Also, a benefit or claim is considered a "disability benefit" or "disability claim" for purposes of these procedures if the benefit or claim, including claims for accidental death and dismemberment benefits, requires that the Plan or an Insurer make a determination of whether a claimant has experienced a disability.

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. The Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments will be

decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

(A) For any pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(B) For any post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services or other benefits already provided (or any other health benefit claim that is not a pre-service claim).

(c) Disability Benefit Claims. For any disability benefits claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days

within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

- (i) A description of the specific reasons for the denial;
- (ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;
- (iii) A description of any additional information that the Claimant must provide to perfect the claim (including an explanation of why the information is needed);
- (iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;
- (v) A statement of the Claimant's right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial and a description of any time limit that would apply under the Plan for bringing such an action.

In addition, for a denial of health benefits, the following will be provided to the Claimant:

- (vi) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and
- (vii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).
- (viii) For an adverse determination concerning an urgent care health claim involving, the notice will also include information about the expedited process that applies to such claims and the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

For any claim for disability benefits, the notice will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and also will include the following:

(ix) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to

whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(x) If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(xi) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

(xii) 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.

Reviews of Initial Adverse Determinations

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

(a) Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after you receive notice of the initial denial of the claim. The decision on review will be made within a reasonable time but no later than 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records 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.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition to providing the right to review documents and submit comments as

described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) For purposes of any medical coverage and for claims for disability benefits, the Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:

(A) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by or on behalf of the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Reviewer will notify the

Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(B) For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within a reasonable time but not later than 45 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

- (i) a description of its decision;
- (ii) a description of the specific reasons for the decision;
- (iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;
- (iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claim for benefits;
- (v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA section 502(a) and a description of any time limit that applies under the Plan for bringing such an action (including, for disability benefit claims, the date that any applicable time limit for bringing such an action would expire);
- (vi) if applicable, a statement describing any voluntary appeal procedures offered by the Plan and about the Claimant's rights to obtain information about such procedures
- (vii) in addition to items (i)-(vi) above, for any notice of adverse determination regarding health benefits (or disability benefits if the claim was filed on or before April 1, 2018), the following will be provided:

(A) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(B) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request; and

(viii) in addition to items (i)-(vi) above, for claims for disability benefits, the notice of Adverse Determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices and will include:

(A) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(B) If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

Additional Requirements for Medical and Disability Claims

For any adverse determination involving medical coverage, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Also, for all claims involving coverage that is subject to the Affordable Care Act and for disability benefit claims, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the determination will be “frozen” from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits other than health benefits, the period for making the determination on appeal will be “frozen” from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant’s Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan’s Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under [ERISA] [applicable state law] on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim involving medical coverage, you will be deemed to have exhausted the Plan’s internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the Plan’s claim procedures (and applicable regulations unless the Plan’s failure to adhere to those requirements is a minor violate (as defined below). If are you are deemed to have exhausted the Plan’s internal claims and appeals process based on the preceding sentence, in addition to the right to pursue any available remedy under ERISA, you will have the right to pursue any remedy under any available external review process provided under federal or state law.

Also, for claims for disability benefits, you will be deemed to have exhausted the Plan’s internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the requirements of applicable requirements of applicable regulation unless the Plan’s failure to

adhere to those requirements is a "minor violation" (as defined below).

For purposes of this Section, the Plan's failure to satisfy applicable claim procedure regulations is a "minor violation" if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this minor violation exception applies, you may request a written explanation of the violation from the Plan, and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

For claims involving medical coverage, if an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon your receipt of the notice.

For claims involving disability benefits, if a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, the claim will be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. In such cases, within a reasonable time after the Plan's receives the decision, the Plan will provide you with notice of the resubmission.

External Review

(a) External Review Process. For purposes of any coverage that is subject to the Affordable Care Act, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with the interim procedures for federal external review in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance. The Plan will begin complying with any new requirements for external review guidance on or before the date that those requirements become applicable to the Plan.

(b) Availability of External Review. External review is not available for all adverse determinations. For example, external review is not available for an adverse determination based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan. External review is available only for:

(i) any final internal adverse determination (or an initial internal adverse determination on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal adverse determination that involves a rescission of coverage; or

(iii) items and services within the scope of the requirements under the federal law known as the No Surprises Act (i.e., emergency services provided by a nonpreferred provider, air ambulance services provided by a nonpreferred provider, ancillary services, and other non-emergency services), except that external review is not available when:

(A) adjudication of the claim results in a decision that does not affect the amount the Participant or covered Dependent owes;

(B) the dispute only involves payment amounts due from the Plan to the provider; or

(C) the provider has no recourse against the Participant or covered Dependent.

(iv) Any other final adverse determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

(c) Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives notice of an adverse determination for which external review is available.

(d) Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the time the health care item or service was provided;

(ii) The adverse determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe the reasons external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the

Claimant receives the notice. However, the time period for a Claimant to respond to a notice regarding an incomplete request is extended during the Outbreak Period (as defined on the “About This Summary” page at the beginning of this Summary). Days in the Outbreak period are not counted in determining if the information needed to perfect a request for external review is provided within the specified time period.

(e) Referral to Independent Review Organization. External reviews are conducted by independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan will contract with at least three different IROs. The Plan will take action against bias and to ensure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Under a contract between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request’s eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving any information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- (A) The Claimant's medical records;
 - (B) The attending health care professional's recommendation;
 - (C) Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating provider;
 - (D) The terms of the Plan, unless the terms are inconsistent with applicable law;
 - (E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
 - (F) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - (G) The opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.
- (vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.
- (vii) The IRO's notice will include:
- (A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (E) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;
 - (F) A statement that judicial review may be available to the Claimant;
- and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA.

(viii) The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by the Claimant, Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(e) Effect of External Review Decision. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse determination, the Plan will provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

(a) Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an adverse determination that otherwise qualifies for external review (as described above) and that is:

(i) An adverse determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under the Plan's normal procedures for urgent care claims would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final adverse determination, if the Claimant has a medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(b) Procedures for Expedited External Review.

(i) In General. The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review. The Plan will immediately send the Claimant a notice of its eligibility determination that meets the preliminary review notice requirements described above.

(iii) Referral to IRO. Upon a determination that a request is eligible for external review, the Plan will assign an IRO. The Plan will provide or transmit all necessary

documents and information considered in making the adverse determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide review as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

Insured Benefits and State Law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Termination or Amendment of Plan

The Employer expects to maintain the Plan indefinitely as a program of employee benefits. However, the Employer has the right, in its sole discretion, to terminate or amend any provision of the Plan at any time. Therefore, no Plan participant (including any future retiree or retiree who has already retired) has a right to the continued enjoyment of any particular benefit under the Plan after a Plan termination or amendment affecting those benefits.

No Right to Continued Employment

No provision of the Plan or this Summary shall be interpreted as giving any employee any rights of continued employment with the Employer or in any way prohibiting changes in the terms of employment of any employee covered by the Plan.

Non-Assignment of Benefits; Payments to Providers

Except as otherwise expressly provided in this Summary or in an applicable Benefits Booklet, no participant or beneficiary may transfer, assign or pledge any Plan benefits. and no benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. Also, no benefit under the Plan will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

The Administrator may, in its discretion, elect to make a direct payment to a provider of services for which benefits are available under a Component Plan and such direct payment to the provider by the Plan shall not be considered an assignment or alienation under the Plan or any Component Plan, and neither the direction by a Plan participant, or any eligible or covered dependent to make such payment nor the payment itself shall be construed as an assignment of

benefits or as a recognition by the Administrator of the validity of any attempted alienation or assignment of benefits under the Plan nor will any such payment confer on the payee any rights besides the right to receive the payment in the amount of that specific payment.

No Covered Person may, at any time, either while covered under the Plan or following termination of coverage, assign his or her right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

The Plan will honor any Qualified Medical Child Support Order (QMCSO) that provides for Plan coverage for an Alternate Recipient, in the manner described in ERISA §609(a) and in the Plan's QMCSO Procedures.

Coordination of Benefits

The coordination of benefits provisions described in the Benefits Booklets delivered to you with this Summary, as interpreted by the Plan Administrator (or insurer, if applicable) in its discretion, control all coordination of benefits situations involving the Plan and other payers.

Subrogation/Right of Reimbursement

As a condition of receiving medical, dental, vision, disability or any other benefits under the Plan, all covered persons, including all covered dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person, organization or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to the "make whole" doctrine, the "common-fund" doctrine or other similar common-law subrogation rules or legal theories.

Also, each participant and each covered person, as a condition for and consequence of receiving medical, disability or any other benefits under the Plan with respect to any amount that is subject to this subrogation provision, agrees as follows:

(1) The participant and each covered person (or their attorneys or other authorized representatives) will promptly inform the Plan of any settlement agreement and to provide reasonable advance notice of any plans for the disbursement of any settlement funds to the Participant or covered person (or to any other person on behalf of the covered person);

(2) The participant and each other covered person (or their attorneys or other authorized representatives) will hold any settlement funds received with respect to a claim that is subject to the Plan's subrogation rights in trust for the benefit of the Plan until all obligations to the Plan under this subrogation provision are satisfied (or to disburse such funds to the Plan to satisfy any obligations to the Plan under this subrogation provision);

(3) The participant and each other covered person (or their attorneys or other authorized representatives) will maintain and treat any settlement funds received by or on their behalf, as Plan assets, to the full extent of any benefits paid by the Plan with the Participant or other covered person being a trustee of Plan assets with respect to such amounts until the covered person's obligations under this subrogation provision are satisfied; and

(4) The participant and each other covered person (or their attorneys or other authorized representatives) agree that the Plan has an equitable lien on any settlement funds payable to or on behalf of the Participant to the full extent of any benefits paid by the Plan amounts until the covered person's obligations under this subrogation provision are satisfied in full.

Insurance Contracts

The Employer may contract with one or more insurance companies for insured benefits to be provided under the Plan. The Employer has the right to replace any such insurance companies from time to time for any reason. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any insurance contract used to provide benefits are the property of the Employer, except to the extent, if any, that the Plan Administrator determines that a portion of the amount payable is required to be treated as an asset of the Plan. Any portion of such a payment that is required under applicable law to be treated as a Plan asset may be used to provide or pay for benefits for eligible employees or to pay reasonable Plan expenses or may be used or paid in any other manner that is consistent with applicable law regarding the use of Plan assets.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA):

- You can examine, free of charge, at the Plan Administrator's office and at other locations, all of the Plan documents, including insurance contracts, if any, collective bargaining agreements and copies of all documents filed by the Plan (such as detailed annual reports) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You can obtain copies of all Plan documents governing the operation of the Plan, by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

- In some cases, the law may require the Plan Administrator to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. As described above, if your claim for a Plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision, without charge and have the Plan review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials 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 until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied after review and reconsideration by the Plan or is ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof considering the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse Plan funds, if any, 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.

You may have the right to continued health 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. You should review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage.

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

EXHIBIT: Dependent Care Tax Credit vs. Dependent Care FSA

If you have qualifying dependent care expenses, you may be able to choose one or both of two ways to reduce your taxes. You may be able to obtain a tax credit (which is a direct reduction in the amount of taxes you otherwise would owe) or you may be able to reduce your taxable income by contributing to a dependent care flexible spending account (Dependent Care FSA). This worksheet will help you decide which is better for you.

DEPENDENT CARE TAX CREDIT

If you qualify for the tax credit, you are allowed to deduct from the taxes you owe a percentage of the lesser of (1) your actual qualifying dependent care expenses or (2) \$3,000 if you have one dependent or \$6,000 if you have two or more dependents. The percentage is based on your adjusted gross income for the year (including your spouse's income if you file a joint return). The following chart will help you determine your percentage.

If your adjusted gross income is		The percentage of the cost of dependent care you can deduct from your taxes is:
over	to	
\$0	\$15,000	35%
\$15,000	\$17,000	34%
\$17,000	\$19,000	33%
\$19,000	\$21,000	32%
\$21,000	\$23,000	31%
\$23,000	\$25,000	30%
\$25,000	\$27,000	29%
\$27,000	\$29,000	28%
\$29,000	\$31,000	27%
\$31,000	\$33,000	26%
\$33,000	\$35,000	25%
\$35,000	\$37,000	24%
\$37,000	\$39,000	23%
\$39,000	\$41,000	22%
\$41,000	\$43,000	21%
\$43,000	unlimited	20%

Example: An employee's adjusted gross income for the year is \$34,000 and the employee spends \$2,600 each year for day care for one dependent. When you compare \$2,600 with the \$3,000 allowed for one dependent, the lesser of the two amounts is \$2,600. To find the employee's allowable percentage, you use the above chart. Since the employee's adjusted gross income is \$34,000, the employee's percentage will be 25%. Therefore, the amount the employee will be able to deduct from his or her taxes will be \$2,600 x 25% or \$650.

INCOME EXCLUSION (DEPENDENT CARE FSA CONTRIBUTIONS)

Instead of the Dependent Care Tax Credit, each year you may elect to have a designated amount taken out of your paycheck before taxes and put into your Dependent Care FSA. This amount must be used during the year to pay for qualifying dependent care expenses. You will not have to pay taxes on the amount you put into the FSA that will be used to pay your qualifying dependent care expenses. If, however, either you or your spouse has Earned Income (as defined in the Plan) of less than \$5,000, your income exclusion will be limited to the Earned Income of you or your spouse, whichever is less. Note that your maximum Dependent Care FSA contribution for any calendar year is \$5,000 (\$2,500, if you are married but file a separate federal income tax return), regardless of the number of qualifying dependents.

Example: The following is an example of an employee's comparison of the Dependent Care Tax Credit and the Dependent Care FSA. Assume the employee is married and the employee and spouse together expect to have \$75,000 in adjusted gross income (AGI), and they expect to have \$3,000 in qualifying dependent care expenses for the year for one qualifying child. They plan to file a joint federal income tax return. After taking the standard deduction (\$25,900), their federal taxable income would be \$49,100. Assume they live in a state that uses the same definition of taxable income as the IRS and a 5% tax rate. (Note that state income tax rates vary from zero to about 13% and states may use different definitions of taxable income. The federal tax rates and standard deduction amounts in this example are for the 2022 tax year.)

	Using the Tax Credit	Using the FSA
Federal Taxable Income (without Dependent Care FSA)	\$49,100	\$49,100
Subtract: Dependent Care FSA contribution	(0)	(3,000)
Federal Taxable Income	\$49,100	\$46,100
Taxes		
Federal (10% of first \$20,550 of taxable income + 12% of amounts from \$20,550 up to \$83,550)	\$5,481	\$5,121
Social Security and Medicare (7.65% of AGI (minus Dependent Care FSA contributions))	5,737	5,508
State (5.0% of taxable income)	2,455	2,305
Total	\$13,673	\$12,934
Subtract: Tax Credit (20% of \$3,000)	(600)	(0.00)
Total Taxes	\$13,073	\$12,934

In this example, the employee would pay \$139 less in taxes by using the Dependent Care FSA. Of course, this is just one example. Other employees might pay lower taxes using the tax credit, so you should perform the calculations using your own estimated income, qualifying expenses and filing status. Also, note that participation in the FSA may affect other tax credits or deductions that you may qualify for, such as the Earned Income Tax Credit or the Child Tax Credit. You should consult with a tax advisor to determine which approach is best for you.

CALCULATE YOUR TAX CREDIT

Use the following chart to determine if you should use the Dependent Care Tax Credit or the Dependent Care FSA.

	Using the Tax Credit	Using the Income Exclusion (FSA)
Federal Taxable Income (before Dependent Care FSA)	\$ _____	\$ _____
Subtract: Dependent Care FSA contribution		(\$ _____)
Taxable Income	\$ _____	\$ _____
Taxes		
Federal* (____%)	\$ _____	\$ _____
State* (____%)	_____	_____
Social Security (generally 7.65% of total wages & remember to subtract FSA contributions for the second column)	_____	_____
Total	\$ _____	\$ _____
Subtract: Tax Credit (% from chart on previous page based on your adjusted gross income X your expected qualifying dependent care expenses)	(\$ _____)	
Total Taxes	\$ _____	\$ _____

*Federal and state tax rates vary depending upon your taxable income and filing status. Estimate your tax liability or check with your tax consultant. Also, note that Pennsylvania and New Jersey, unlike other states, do not exclude Dependent Care FSA contributions from state income tax.

USE OF BOTH DEPENDENT CARE TAX CREDIT AND INCOME EXCLUSION

You may use both the Dependent Care Tax Credit and the Dependent Care FSA (although not for the same qualifying dependent care expenses.) However, any amounts that you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the \$3,000 or \$6,000 Dependent Care Tax Credit figure, whichever is applicable.

Example: An employee's adjusted gross income for the year is \$34,000 and the employee spends \$2,600 during the year for qualifying day care for one dependent. The employee elects to contribute \$1,200 into a Dependent Care FSA to pay for a portion of the dependent care expenses. When you compare the employee's remaining dependent care expenses of \$1,400 with \$1,800 (\$3,000 - \$1,200), the lesser of the two amounts is \$1,400. Given the employee's adjusted gross income of \$34,000, the employee's percentage from the chart is 25%. Therefore, the amount the employee may deduct from the employee's taxes will be \$1,400 x 25% or \$350.

ALWAYS DISCUSS THESE ISSUES WITH YOUR TAX ADVISOR.

**AMENDMENT NO. 4
TO THE
MILLER & LONG DC, INC. HEALTH AND WELFARE BENEFIT PLAN**

Miller & Long DC, Inc. (the "Company") wishes to amend the Miller & Long DC, Inc. Health and Welfare Benefit Plan (the "Plan") to formally document the Plan's interpretation of the term "dependent child" for purposes of the federal law known as COBRA and to provide for the Plan's compliance with certain requirements of the Consolidated Appropriations Act of 2021. Therefore, the Plan is amended, effective January 1, 2022, as provided in this Amendment:

1. Section 9.10(b) is amended to read in its entirety as follows:

(b) Availability of External Review. External review under this Section is available only for:

(i) any final internal Adverse Determination (or an initial internal Adverse Determination that qualifies for the expedited external review process under Section 9.11) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal Adverse Determination that involves a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time);

(iii) items and services within the scope of the requirements of the No Surprises Act in Title I of Division BB of the Consolidated Appropriations Act of 2021, as amended (i.e., emergency services provided by a nonpreferred provider, air ambulance services provided by a nonpreferred provider, ancillary services, and other non-emergency services), except that external review is not available when:

(A) adjudication of the claim results in a decision that does not affect the amount the Participant or covered Dependent owes;

(B) the dispute only involves payment amounts due from the medical and prescription drug Component Plan to the provider; or

(C) the provider has no recourse against the Participant or covered Dependent.

(iv) any other final Adverse Determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

2. Section 11.12 of the Plan is amended to read in its entirety as follows:

11.12 HEALTH CARE CONTINUATION COVERAGE RULES. Notwithstanding any provision of the Plan to the contrary, (i) the Employer shall provide

Participants and Dependents with all health care continuation coverage rights to which they are entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any other similar, applicable state law, and (ii) for purposes of the Plan's compliance with COBRA, including for purpose of determining if a Dependent is a COBRA qualified beneficiary or has experienced a COBRA qualifying event, the Plan shall interpret the term "dependent child", as used in Code §4980B as referring to any person who on the relevant date is covered under the Plan as a Participant's Dependent as a child of a Participant. For purposes of the preceding sentence, the word "child" has the same meaning as provided under Section 1.8(b) of this Plan, which currently includes a natural child, a legally adopted child (or a child placed for adoption) if the child is under eighteen years of age at the time of the adoption (or placement for adoption), a stepchild, an eligible foster child (as defined in Code §152(f)(1)(C)) or any other person whose welfare is the legal responsibility of the Participant pursuant to a written divorce settlement, written separation agreement, court order or order by an administrative process having the force and effect of state law.

3. The following new Section 11.23 is added to the Plan to read as follows:

11.23 CONSOLIDATED APPROPRIATIONS ACT. Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with the applicable requirements of the Consolidated Appropriations Act of 2021 (including but not limited to the No Surprises Act) beginning on the applicable effective date.

4. Any new Schedules of Benefits or Benefit Booklets adopted since the last Plan Amendment was adopted are hereby incorporated by reference.

IN WITNESS WHEREOF, the Company has caused this Amendment to be duly executed on its behalf, effective as specified herein.

MILLER & LONG DC, INC.

By: _____

Print Name: _____

Title: _____

Date: _____

**AMENDMENT NO. 5
TO THE
MILLER & LONG DC, INC. HEALTH AND WELFARE BENEFIT PLAN**

Miller & Long DC, Inc. (the "Employer") wishes to amend the Miller & Long DC, Inc. Health and Welfare Benefit Plan (the "Plan") to make certain desired or required changes. Therefore, the Plan is amended as provided below, effective March 1, 2023, except as otherwise provided in this Amendment:

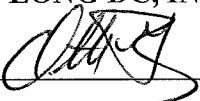
1. Section 6.1(c) is revised to read as follows:

(c) Long Term Disability Coverage. Each eligible participant who is a superintendent or an officer will receive Employer-provided long term disability coverage under one of the long term disability coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix.)

2. Any new Schedules of Benefits or Benefit Booklets for a Component Plan or any amendments to a Component Plan that have been adopted since the last Plan Amendment or Amendment and Restatement of the Plan was adopted are incorporated by this reference.

IN WITNESS WHEREOF, the Employer has caused this Amendment to be duly executed on its behalf, effective as specified herein.

MILLER & LONG DC, INC.

By:  _____

Print Name: Otto Girr, SPHR

Title: Senior Vice President Human Resources

Date: 9/12/2023

MILLER & LONG DC, INC. HEALTH AND WELFARE BENEFIT PLAN

SUMMARY OF MATERIAL MODIFICATIONS

TO: Participants in the Miller & Long DC, Inc. Health and Welfare Benefit Plan
FROM: Plan Administrator
DATE: September 12, 2023
RE: Summary of Material Modifications

This Summary of Material Modifications (“SMM”) amends certain provisions of your Summary Plan Description (“SPD”) for the Plan (the “Plan”). Please review this SMM carefully to familiarize yourself with the changes, and save it with your SPD. Except as otherwise provided in this SMM, the changes described in this SMM are effective March 1, 2023.

1. In the “Summary of Available Benefits” Section of your SPD, the first sentence of the first paragraph of “Long Term Disability” is revised to read as follows:

Long Term Disability Coverage. If you are a superintendent or an officer, and you are eligible to participate in the Plan, you will receive at the Employer’s sole expense long term disability coverage.

2. New Benefits Booklets. Any new Benefits Booklets which have been, or will be, distributed to you are part of your SPD.

If you have questions about these Plan changes, this SMM, or your SPD, please contact the Plan Administrator at the following address or at (202)524-4600:

Plan Administrator
4001 Brandywine Street NW, Suite 400
Washington, DC 20016