## Section 1: Document Overview

This document is a wrap-around Plan Document and Summary Plan Description. When accompanied by the appropriate Certificates of Coverage, this document, along with those Certificates, becomes the Summary Plan Description. When accompanied by the appropriate Insurance Contracts, this document, along with those Contracts, becomes the Plan Document.

## Section 2: Plan Information

On September 2, 1974, the Employee Retirement Income Security Act of 1974 (often referred to as ERISA) was enacted, establishing Federal controls over most employee welfare benefit plans. The plans identified on the following pages are subject to regulation by ERISA.

All plans outlined have the following ERISA specifications in common:

**Plan Name:** The Signature Building Maintenance, Inc. Employee Benefit Plan

**Plan Number:** 501

**Employer/Plan Sponsor Name, Address and Phone Number:** Signature Building Maintenance
1330 White Oaks Road
Campbell, CA 95008

**Affiliated Employers/ Subsidiaries:** None

**Employer ID #:** 77-0501823

**Effective Date:** June 01

**Plan Year:** June 1, 2015 through May 31, 2016

**Plan Administrator:** Summit Health Insurance Services

1800 217 9963
Memberservices@simplysummit.com

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

**Agent for Service of Legal Process:** McPharlin Sprinkles & Thomas LLP
Attn: Jeanine DeBacker
160 West Santa Clara , St
San Jose, CA 95113

**Plan Changes or Termination:** The Plan Administrator may terminate, suspend, withdraw, amend or modify any element of this Plan in whole or in part at any time, subject to the applicable provisions of the group benefit policies or corporate policies as outlined in the contracts, corporate minutes and/or bylaws.

**HIPAA Covered Entity Status:** Hands-Off PHI for HIPAA Privacy
Hands-Off PHI for HIPAA Security

The following pages outline those plan specifications that vary between the different programs established as part of the Employee Benefits Plan.

*If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Section 18 for more details.*

**Language Assistance:**
SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-838-8482.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-838-8482.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-838-8482.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-838-8482 (NOT needed unless employee population exists in AZ or NM.)

### Section 3: Benefit Plan Information

| | | |
|---|---|---|
| **Plan Name:** | The Signature Building Maintenance, Inc. Employee Benefit Plan | |
| **Plan Number:** | 501 | 501 |
| **Policy Number:** | 42730 | 15792 |
| **Type of Plan Benefit:** | Medical and Prescription Drugs | Dental |
| **Type of Plan Administration:** | Contract administration with benefits provided in accordance with the group policy. | Contract administration with benefits provided in accordance with the group policy. |
| **Contract Administrator:** *Responsible for plan administration and processing of claims.* | Cal –Choice<br>581 South Parker, Suite 200<br>Orange, CA 92868 | Premier Access<br>8890 Cal Center Drive<br>Sacramento, CA<br><br>Premier Access Claim Dept<br>P.O. Box 659010<br>Sacramento, CA 95865-9010 |
| **Contract Funding Agent:** *Responsible for payment of claims and for financial risk of claims.* | Same as above | Same as above |
| **Claims Appeal Address:** | Same as above | Same as above. |
| **Funding Arrangement:** | Fully Insured | Fully Insured |
| **Plan Premiums/ Contributions:** | This benefit is paid by Employer contributions, including, in some cases, those made at employee direction through a salary reduction agreement. | This benefit is paid by Employer contributions, including, in some cases, those made at employee direction through a salary reduction agreement. |
| **Medicare Part D:** | Creditable | Creditable |
| **Grandfathered Plan:** | No | Not applicable |

| | | |
|---|---|---|
| **Employee Eligibility:** | Regular status employees working 30 or more hours per week are eligible on the first day of the month following or coinciding with two (2) months of full-time employment. | Regular status employees working 30 or more hours per week are eligible on the first day of the month following or coinciding with two (2) months of full-time employment. |
| **Dependent Eligibility:** | Include children (married or unmarried) until the age of 26 | Eligible dependents include your spouse and your child(ren) under the age of 26.. |
| | | |
| **Special Notes:** | This plan is available to ALL employees | This plan is available to ALL employees |

*The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and the Contract Administrator. If the terms of this plan detail document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.*

## Section 4: Purpose

The Employer/Plan Sponsor and its named subsidiaries and affiliates sponsor various Benefit Plans as outlined in Section 4 for the exclusive benefit of the Participants. This Plan has been written and is intended to conform to the written plan document and other requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Any assets of the Benefit Plans shall be held for the exclusive purposes of providing benefits to the Benefit Plan participants and their beneficiaries and for defraying reasonable costs of administration.

## Section 5: Accompanying Documents

A. Summary Plan Description (SPD). The term “Certificates of Coverage” refers to the plan documentation provided by the Contract Administrator, which describes the plan benefits in detail. Certificates of Coverage are sometimes alternately referred to as Certificates, Evidence of Coverage, Plan Booklets, summary Plan Detail Documents, etc. by the Plan Administrator that issues them. If you do not have a copy of your Certificate of Coverage you may obtain one from the Plan Administrator.

B. Plan Document. The term “Insurance Contract” refers to the plan documentation provided by the Contract Administrator, which outlines the important elements of the agreements/contracts between the Employer/Plan Sponsor and the Contract Administrator. Insurance Contracts are sometimes alternately referred to as Insurance Policies, Contracts/Policies, Service Agreements or Plan Detail Documents, etc. by the Contract Administrator that issues them.

C. Wrap-around Document. This document is a wrap-around Plan Document and a wrap-around Summary Plan Description. When accompanied by the appropriate Certificates of Coverage, this document, along with those Certificates, becomes the Summary Plan Description. When accompanied by the appropriate Insurance Contracts, this document, along with those Contracts, becomes the Plan Document. The detailed plan information required by ERISA is shown in your Certificates of Coverage or Insurance Contracts for each benefit. If you do not have a copy of your Certificate of Coverage you may obtain one from the Plan Administrator.

## Section 6: Termination/Modification/Amendment of the Plan

A. Permanency. While the Employer/Plan Sponsor fully expects this Plan to continue indefinitely, permanency of the Plan is subject to the Employer/Plan Sponsor’s right to amend or terminate the plan as provided below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant to vested or non-terminable benefits.

B. Right to Modify or Amend. The Employer/Plan Sponsor reserves the right to amend or modify the Plan or any element or provision of the Plan at any time. No consent of any Participant is required to amend or modify the Plan. Any amendment or modification shall be effective as of the date determined by the Employer/Plan Sponsor. All amendments shall be made in writing and shall be approved by the Employer/Plan Sponsor according to its normal procedures for transacting business. Such amendments may apply retroactively or

prospectively as provided in the amendment. Any amendment made shall be deemed to be approved and adopted by any Affiliated Employer who has adopted the Plan.

C. Right to Terminate. The Employer/Plan Sponsor has the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. No consent of any participant is required to amend or modify the Plan. Any discontinuance or termination shall be effective as of the date determined by the Employer/Plan Sponsor. The decision to terminate the Plan shall be made in writing and shall be approved by the Employer, according to its normal procedures for transacting business. Affiliated Employers who have adopted the Plan may withdraw from participation in the Plan, but may not terminate the Plan.

D. Contract Administration. The Employer/Plan Sponsor may enter into contracts with a Contract Administrator to provide coverage. The Employer/Plan Sponsor has the right to amend, terminate, or modify any relationship with a Contract Administrator at any time. A Contract Administrator may terminate coverage if the Employer/Plan Sponsor fails to pay the required premium in a timely manner as prescribed by the contract. A Contract Administrator may also terminate the Insurance Contract on any premium due date if the number of persons insured is less than the minimum number required, or if the Employer/Plan Sponsor fails to meet any other criteria under the Insurance Contract.

E. Effect on Participants. A Participant's coverage is amended or modified upon the amendment or modification of the Plan. An individual Participant's coverage terminates at the earliest of the following conditions:
   1. When you leave your employment;
   2. When you are no longer eligible;
   3. When you cease to contribute, (if the Plan is contributory);
   4. When the Plan terminates.

   If a Participant ceases active work, individual Certificates of Coverage will determine what arrangements, if any, may be made to continue your coverage beyond the date active work is ceased.

## Section 7: Participation, Eligibility, and Benefit Termination Specifications

A. Participation. The term "Participant" with respect to this Plan means any employee or beneficiary who meets the eligibility requirements of one of the Benefit Plans offered and participates in the Plan in accordance with the terms and conditions established for that specific Benefit Plan and has not for any reason become ineligible to participate. An employee, dependent, or beneficiary shall be a Participant in this plan if he or she actively elects coverage under one or more of the Benefit Plans or if that employee becomes covered by one or more of the Benefit Plans by virtue of automatic administrative processing. Specific participation requirements for each Benefit Plan are outlined in the Certificates of Coverage or Insurance Contracts for each Benefit Plan.

B. Eligibility Requirements. This SPD and Plan Document is issued in conjunction with corresponding Certificates of Coverage or Insurance Contracts for each of the Benefit Plans identified in Section 4 and with federal and state guidelines. Information regarding eligibility requirements can be found in the Certificate of Coverage or the Insurance Contracts describing each separate Benefit Plan. Eligible dependents include dependents who qualify under the Insurance Contracts currently in force under the Employee Benefit Plan of the Employer/Plan Sponsor. A plan participant or beneficiary may obtain a copy of the plan's Qualified Medical Child Support Order (QMCSO) procedures from the Plan Administrator. Plan participants must complete an enrollment application (provided by the Plan Administrator) in a timely fashion in order to receive certain benefits under this plan.

C. Benefit Termination. This SPD and Plan Document is issued in conjunction with corresponding Certificates of Coverage or Insurance Contracts for each of the plans identified on the previous pages. Information regarding loss of benefits and when benefits terminate can be found in the Certificates of Coverage or the Insurance Contracts describing each separate Benefit Plan.

## Section 8: Description of Types of Funding Arrangements

A. Fully Insured Plan. In a fully insured plan, benefits are provided under a group insurance contract entered into between the Employer/Plan Sponsor and the insurance company identified as the Contract Funding Agent. Claims for benefits are sent to the insurance company or Contract Administrator. The insurance company, not the Employer/Plan Sponsor, is responsible for paying claims and for the financial risk of paying claims under the plan. (However, the insurance company and Employer share the responsibilities for administering the plan.) Insurance premiums for plan participants as well as employee contributions (pre-tax and after-tax, as applicable) are paid by the Employer/Plan Sponsor out of the general assets of the Employer/Plan Sponsor.

B. Self-Insured Plan. In a self-insured plan or a partially self-insured plan, the Employer/Plan Sponsor hires the Contract Administrator to process claims under the plan. The Contract Administrator does not serve as an insurer, but merely as a claims processor and administrator. Claims for benefits are sent to the Contract Administrator. The Contract Administrator processes the claims, then requests and receives funds from the Employer/Plan Sponsor to pay the claims and make payment on the claims to health care providers. The Employer/Plan Sponsor is ultimately responsible for providing plan benefits, not the Contract Administrator. (However, the insurance company and Employer/Plan Sponsor share responsibilities for administering the plan.) Plan benefits are paid by the Employer/Plan Sponsor out of the general assets of the Employer/Plan Sponsor. There is no special fund or trust or insurance from which benefits are paid. Employee contributions (pre-tax and after-tax, as applicable) are also paid by the Employer/Plan Sponsor out of the general assets of the Employer/Plan Sponsor.

C. Pre-paid Plan. In a pre-paid plan, benefits are provided under a contract entered into between the Employer/Plan Sponsor and the Contract Administrator. Premiums are due in advance of services being received. Providers are typically paid on a capitated basis for basic services and on a fee-for-service basis for other services. The Contract Administrator negotiates payment arrangements with providers. Insurance premiums for plan participants as well as employee contributions (pre-tax and after-tax, as applicable) are paid by the Employer/Plan Sponsor out of the general assets of the Employer/Plan Sponsor.

## Section 9: Important Disclosures

A. Newborns and Mothers Health Protection Act of 1996. Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

B. Women's Health and Cancer Rights Act of 1998. The Federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If you are eligible for mastectomy benefits under your health coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

1. Reconstruction of the breast on which mastectomy has been performed;
2. Surgery and reconstruction on the other breast to produce a symmetrical appearance;
3. Prostheses;
4. Treatment of physical complications of all states of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under your plan. Coverage is subject to applicable deductibles, copayments and coinsurance payments.

C. Mental Health Parity Act. When required by law, it is the intent of this Plan that health care benefit plans comply with the Federal Mental Health Parity Act (MHPA). In general, the law requires parity of mental health benefits, meaning that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. In addition, the law provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity). The law does not apply to benefits for substance abuse or chemical dependency. Small employers are exempt from this law; any group health plan of any employer who employed an average of between 2 and 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year is exempt.

D. Mental Health Parity and Addiction Equity Act. When required by law, this law requires that if a group health plan provides medical/surgical benefits and mental health benefits, the financial requirements (deductibles and co-payments) and any treatment limitations that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. Likewise, if the plan includes substance use disorder benefits, the financial requirements and treatment limitations for substance use disorders must also be equivalent to coverage for other conditions. Small employers are exempt from this law; any group health plan of any employer who employed an average of between 2 and 50 employees during the preceding calendar year is exempt.

E. Qualified Medical Child Support Orders (QMCSO) Provision. A dependent Child may become eligible for coverage by way of a QMCSO. If approved, coverage will become effective as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process. The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

A Plan participant must submit a Medical Child Support Order to the Plan Administrator to determine whether it is qualified, and thus a QMSCO. A copy of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders may be requested from Plan Administrator, at no charge.

**Section 9: Important Disclosures (Continued)**

F. Patient Protection and Affordable Care Act. Following is an outline of plan provisions implemented in accordance with PPACA. These provisions become effective for group health plans upon renewal after September 23, 2010. Where noted, some provisions may not apply to grandfathered plans. Please refer to Section 4 to determine the grandfathering status of your health plan.

1. Pre-Existing Conditions: This provision applies to all group health plans, regardless of grandfathering status. Health plans may not deny or exclude benefits for pre-existing conditions of children under age 19. Coverage for pre-existing conditions will become universal for all insured individuals upon the health plan's renewal in 2014.
2. Choice of Primary Care Provider: This provision does not apply to grandfathered plans. For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries (such as an HMO plan), you have the right to designate any primary care provider who participates in that plan's network and who is available to accept you or your family members. Until you affirmatively make this designation, the health plan designates a primary care provider for you. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers or participating health care professionals who specialize in obstetrics or gynecology, contact the health plan (contact information is provided in Section 3).
3. External Claims Review: This provision does not apply to grandfathered plans. Plans and issuers are required to establish both internal and external review procedures in accordance with state or federal guidelines, as appropriate. Please refer to your health plan certificate of coverage for complete claim appeal and review procedures.
4. Rescission of Coverage: This provision applies to all group health plans, regardless of grandfathering status. Coverage may only be rescinded or cancelled if there is fraud or intentional misrepresentation of fact, as prohibited by plan terms of coverage. Plan must provide 30 days advance notice before coverage can be rescinded. Rescission of coverage will be treated as a claim denial, and may be appealed in accordance with the claim appeal procedures of the plan.
5. Medical Loss Ratio Rebates: This provision applies to all group health plans, regardless of grandfathering status. The plan must meet minimum loss ratio standards established by the PPACA. Plans that do not meet the minimum requirement must rebate excess premium to the employer. Your employer is required to apply that rebate equitably for the benefit of all currently enrolled employees. Funds may be used to offset future premium increases or to enhance future plan benefits. Cash rebates will not be issued.

G. Children's Health Insurance Program (CHIP) Reauthorization Act of 2009. As required by law, this plan complies with the applicable provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA provisions apply to group health plans only, not all benefit plans offered under this plan.

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

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for**

**premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. You should contact your state for further information on eligibility.**

**Section 9: Important Disclosures (Continued)**

| **ALABAMA –** Medicaid | **NEW HAMPSHIRE** – Medicaid |
|---|---|
| Website: http://www.medicaid.alabama.gov<br>Phone: 1-855-692-5447 | Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf<br>Phone: 1-603-271-5218 |
| **ALASKA –** Medicaid | **NEW JERSEY** – Medicaid and CHIP |
| Website: http://health.hss.state.ak.us/dpa/programs/medicaid/<br>Phone: (Outside of Anchorage): 1-888-318-8890<br>Phone: (Anchorage): 1-907-269-6529 | Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 1-609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **ARIZONA** – CHIP | **NEW YORK** – Medicaid |
| Website: http://www.azahcccs.gov/applicants<br>Phone (Outside Maricopa County): 1-877-764-5437<br>Phone (Maricopa County): 1-602-417-5437 | Website: http://www.nyhealth.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **COLORADO** – Medicaid | **NORTH CAROLINA** – Medicaid |
| Website: http://www.colorado.gov/<br>Phone (in state): 1-800-866-3513<br>Phone (out of state): 1-800-221-3943 | Website: http://www.ncdhhs.gov/dma<br>Phone: 1-919-855-4100 |
| **GEORGIA** – Medicaid | **NORTH DAKOTA** – Medicaid |
| Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)<br>Phone: 1-800-869-1150 | Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-800-755-2604 |
| **IDAHO** – Medicaid | **OKLAHOMA** – Medicaid and CHIP |
| Website:<br>http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/default.aspx<br>Phone: 1-800-926-2588 | Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 |
| **INDIANA** – Medicaid | **OREGON** – Medicaid |
| Website: http://www.in.gov/fssa/<br>Phone: 1-800-889-9949 | Website: http://www.oregonhealthykids.gov<br>http://www.hijossaludablesoregon.gov<br>Phone: 1-800-699-9075 |
| **IOWA** – Medicaid | **PENNSYLVANIA** – Medicaid |
| Website: www.dhs.state.ia.us/hipp/<br>Phone: 1-888-346-9562 | Website: http://www.dpw.state.pa.us/hipp<br>Phone: 1-800-692-7462 |
| **KANSAS** – Medicaid | **RHODE ISLAND** – Medicaid |
| Website: https://www.kdheks.gov/hcf/<br>Phone: 1-800-792-4884 | Website: http://www.ohhs.ri.gov<br>Phone: 1-401-462-5300 |
| **KENTUCKY** – Medicaid | **SOUTH CAROLINA** – Medicaid |
| Website: http://chfs.ky.gov/dms/default.htm<br>Phone: 1-800-635-2570 | Website: http://www.scdhhs.gov<br>Phone: 1-888-549-0820 |
| **LOUISIANA** – Medicaid | **SOUTH DAKOTA** – Medicaid |
| Website: http://www.lahipp/dhh.louisiana.gov<br>Phone: 1-888-695-2447 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **MAINE –** Medicaid | **TEXAS** – Medicaid |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-977-6740 TTY: 1-800-977-6741 | Website: https://www.gethipptexas.com/<br>Phone: 1-800-440-0493 |
| **MASSACHUSETTS –** Medicaid and CHIP | **UTAH** – Medicaid and CHIP |
| Medicaid & CHIP Website: http://www.mass.gov/MassHealth<br>Medicaid & CHIP Phone: 1-800-462-1120 | Website: http://health.utah.gov/upp<br>Phone: 1-866-435-7414 |
| **MINNESOTA** – Medicaid | **VERMONT**– Medicaid |
| Website: http://www.dhs.state.mn.us/<br>Click on Health Care, then Medical Assistance<br>Phone): 1-800-657-3629 | Website: http://www.greenmountaincare.org/<br>Telephone: 1-800-250-8427 |
| **MISSOURI** – Medicaid | **VIRGINIA** – Medicaid and CHIP |

| | |
|---|---|
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 1-573-751-2005 | Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website: http://www.famis.org/<br>CHIP Phone: 1-866-873-2647 |
| **MONTANA** – Medicaid | **WASHINGTON** – Medicaid |
| Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml<br>Telephone: 1-800-694-3084 | Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx<br>Phone: 1-800-562-3022, ext. 15473 |
| **NEBRASKA** – Medicaid | **WEST VIRGINIA** – Medicaid |
| Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-800-383-4278 | Website: http://www.dhhr.wv.gov/bms/<br>Phone: 1-877-598-5820, HMS Third Party Liability |
| **NEVADA** – Medicaid | **WISCONSIN** – Medicaid |
| Website: http://dwss.nv.gov/<br>Phone: 1-800-992-0900 | Website: http://www.badgercareplus.org/pubs/p-10095.htm<br>Phone: 1-800-362-3002 |
| | **WYOMING** – Medicaid |
| | Website: http://www.health.wyo.gov/healthcarefin/equalitycare<br>Telephone: 1-307-777-7531 |

To see if any more states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

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

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

## Section 10: Conversion Privileges

Life insurance and disability benefits, if applicable, are not subject to the COBRA continuation provisions. However, in certain circumstances an existing life or disability insurance conversion privilege may be exercised within 31 days following the date of termination. If you wish to exercise this conversion, please refer to your Certificate of Coverage for specific requirements.

## Section 11: HIPAA

As required by law, this plan complies with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA provisions apply to group health plans only, not all benefit plans offered under this plan.

A. Special Enrollment Rights. HIPAA also requires a group health plan to provide special mid-year enrollment opportunities to certain employees and/or their dependents in two circumstances: 1) loss of other coverage, or 2) acquisition of a new dependent. A participant enrolled under these special enrollment rules is not a late enrollee and thus would not be subject to the late enrollment penalties prescribed by HIPAA.

If you are covered under another group health plan and involuntarily lose that coverage (due to expiration of COBRA or loss of eligibility under the other group plan), you or your dependents may enter the plan under the special mid-year enrollment rights. You must request enrollment in writing within 30 days after the loss of other coverage or the Employer/Plan Sponsor's cessation of contributions for such other coverage. Coverage will begin on the first day of the month after the plan receives the enrollment form.

If you as an employee acquire a new dependent -- by marriage, birth, adoption, or placement for adoption -- you have a right to enroll yourself and the new dependent in the group health plan. You must request enrollment in writing within 30 days of the marriage, birth, adoption, or placement for adoption. Coverage applied for as a result of one of these HIPAA special enrollment events will become effective as outlined in your plan certificate. Please refer to your Certificate for specifics.

B. Continuity of Coverage. HIPAA requires that your group health plan reduce or eliminate the exclusionary period of coverage for pre-existing conditions under your group health plans (not long term disability plans), if you have creditable coverage from another plan. Typically, you should be provided with a certificate of creditable

coverage, free of charge, from your group health plan or health insurance issuer in the following events: when you lose coverage under the plan; when you become entitled to elect COBRA continuation coverage; or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion of 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## Section 12: Continuation Coverage (COBRA)

When required by law, our benefit program complies with the Federal COBRA legislation (Public Law 99-272, Title X) which requires continuation rights for health expense coverage explained in this notice. If the Employer/Plan Sponsor is subject to the law and you have health expense coverage under their benefit plan, and if that coverage would end for a reason listed below, you may be able to continue the coverage under the Employer/Plan Sponsor's benefit plan for a specified period of time. Employers/Plan Sponsors are subject to COBRA if they employed 20 or more persons for more than 50% of the business days during the prior calendar year. Employed persons are defined as any persons who appeared on the payroll for full or part time work.

It is important that you, your covered spouse, and any covered child(ren) over the age of 18 read this COBRA section carefully as it outlines both your rights and your responsibilities under the COBRA law.

A. What is a Qualifying Event. A Qualifying Event is an event that causes you or your dependents to lose health benefits. The law defines Qualifying Events as a termination of employment (voluntary or involuntary except for gross misconduct), reduction in work hours, death of employee, divorce or legal separation, or a child no longer satisfying eligibility requirements of a plan (for example, when a child no longer qualifies as a dependent because of age).

B. When Continued Coverage Applies. Following is an outline of when continuation coverage applies based on the type of Qualifying Event.

    1. If you are an *employee or the dependent of an employee* you may elect up to 18 months of continued health expense coverage for yourself if you lose coverage due to voluntary or involuntary termination of employment (except for gross misconduct) or reduction in work hours to less than the minimum needed to remain covered by the plan; or if an employee (or spouse or dependent child of an employee) is enrolled on the group health plan the day before the first day of a leave defined under the Family Medical Leave Act (FMLA), or becomes enrolled during the FMLA leave, and the employee does not return to employment at the end of the FMLA leave.

    2. If you are an *employee's spouse or dependent child*, you may also elect up to 36 months of continued health expense coverage for yourself if you lose coverage due to the employee's death, or divorce or legal separation, or no longer qualifying as a dependent child under the contract *(dependent children only).*

    3. If you are a *covered retiree* and your Employer/Plan Sponsor commences a bankruptcy proceeding, you and your dependents are entitled to a lifetime of continuation coverage. Upon the retiree's death, dependents are entitled to up to 36 months of coverage from the date of death.

    4. If your plan covers *domestic partners* or *children of domestic partners*, those individuals are generally not eligible for COBRA continuation coverage unless they qualify as IRS dependents under IRC 152(a)(9). Your Employer/Plan Sponsor may have negotiated COBRA rights for your covered domestic partners; please check with your Employer/Plan Sponsor for full details.

C. What Coverage is Continued. COBRA continuation rights apply only to health coverage as defined by the law (typically medical, dental, vision, employee assistance programs, health reimbursement accounts, and health care spending accounts). Any other type of coverage provided by the employee benefit plan is not included in these continuation rights. Your continued health coverage will be the *same* as the health coverage provided by the plan for similarly situated employees or dependents who have not had a Qualifying Event. Any future plan or rate changes affecting the group plan will affect your continued coverage as well. Continuation is available only for coverages that you or your dependents were enrolled in at the time of the Qualifying Event. However, you may enroll new dependents acquired while you are covered under COBRA in the same manner as similarly situated employees. A child born to or placed for adoption with an employee covered under COBRA is considered a Qualified Beneficiary, provided the child is enrolled under COBRA, and may have additional COBRA extension rights. The covered employee or family member must notify the plan administrator within 30 days of the birth or adoption, in order to enroll the child on COBRA.

D. How Long Can Coverage Continue. There are three different potential durations of COBRA coverage, depending on the type of Qualifying Event.

1. *18 Month Duration* - Coverage continuation based on a Qualifying Event of termination of your employment or a reduction in your work hours is available for up to 18 months.
2. *36 Month Duration* - Coverage continued by virtue of a Qualifying Event of death of the employee, divorce or legal separation of the employee, or loss of dependent child eligibility is available for up to 36 months.
3. *Extensions Beyond 18 Months* - There are several additional circumstances when you can potentially continue COBRA beyond 18 months.

   (a) If you become entitled to Medicare and, within 18 months, experience a termination of employment or reduction in work hours resulting in a loss of coverage, your covered dependents may elect to continue coverage for the period ending 36 months after the date you became entitled to Medicare.

   (b) If any Qualified Beneficiary (employee, spouse, or child) is determined to have been disabled according to the Social Security Administration before the date of the original Qualifying Event (termination of employment or reduction of work hours) or within the first 60 days of COBRA coverage, all Qualified Beneficiaries may extend COBRA coverage for up to 29 months total, from the date of the Qualifying Event. Non-disabled family members on COBRA coverage may also be eligible for this extension. To receive such an extension, you must notify the plan administrator of your disability determination before the end of the initial 18-month COBRA period and within 60 days of the Social Security determination date. If Social Security makes a determination of disability prior to the date of the Qualifying Event, then you must notify the plan administrator within 60 days of the date of the Qualifying Event.

   (c) The Cal-COBRA extension provides up to 36 months of medical coverage from the date Federal COBRA coverage began. You may be eligible for this extension provided you are entitled to less than 36 months of continuation coverage under Federal COBRA. The premium charged under this Cal-COBRA extension may be up to 110% of the total cost. You must contact your insurance carrier directly to inquire about the availability of this option. Note this extension applies to medical coverage only and self-funded plans are not subject to this extension.

E. When Does Coverage End. Within the limits described above, continuation coverage will terminate on the earliest of the following dates. COBRA coverage can be terminated before the maximum coverage period expires. In no event can coverage continue beyond 36 months from the original Qualifying Event date:

1. When no health coverage is provided by the Employer/Plan Sponsor for any employees; or
2. When premium payment for your continued coverage is not made in the prescribed time limit; or
3. When, after electing COBRA, you become a covered employee and/or dependent under another group health plan; or
4. When, after electing COBRA, you first become entitled to Medicare; or
5. When you or your dependents have extended coverage for up to 29 months due to a disability and there has been a final determination by the Social Security Administration that you are or your dependent is no longer disabled. (You are required to notify the Plan Administrator within 60 days of the Social Security determination.)

In no event will COBRA continuation coverage last beyond 36 months from the original Qualifying Event date that enabled election of continuation coverage.

In the event a partial premium payment is made that results in a significant shortfall in the total premium due, coverage will be terminated retroactively with no opportunity for reinstatement, unless sufficient premium is postmarked no later than the end of the payment due grace period. A premium shortfall is insignificant if it is not more than the lesser of $50 or 10% of the full premium due.

F. Interaction with Other Group Health Plan or Medicare. Qualified Beneficiaries may be enrolled in both COBRA and another group health plan or Medicare at the same time, provided the other group health plan or Medicare coverage was elected prior to, or on the same date as the COBRA election. Having coverage provided by more than one entity will affect which entity is the primary or secondary payer of medical claims. Medicare Secondary Payer (MSP) rules will apply if you are enrolled in, eligible to enroll, or if you waived enrolling in any part of

Medicare. In other words, COBRA coverage will generally be the secondary payer of claims. Please check with your health plan to determine which plan is the primary and secondary payer during your COBRA period.

G. Continuation Beyond COBRA. In some instances, you may be eligible to continue health coverage beyond COBRA by conversion to an individual plan. A conversion privilege can be exercised, subject to all the rules that would apply to conversion privileges. However, coverages and costs will not be the same as your COBRA coverage.

H. Health Insurance Marketplace. Individual private health insurance can be purchased through an online Marketplace in lieu of electing COBRA or after COBRA coverage ends. You have a "special enrollment" period 60 days from the date you lose your employer's group health coverage to enroll in the Marketplace. After 60 days our special enrollment period will end and you may not be able to enroll until a Marketplace "open enrollment" which typically starts in the fall for coverage starting as early as January 1st. However, if you elect COBRA and your coverage ends involuntarily, such as exhausting the maximum coverage period or if the employer no longer offers group health plan coverage, you may be able to enroll in the Marketplace through the special enrollment period. Coverage through the Marketplace may cost less than COBRA. Subsidies may be available if your household income is between 138% and 400% of the federal poverty level.

**Section 12: Continuation Coverage (COBRA)**

I. What Does It Cost. You are required to pay the entire cost of your continued health coverage. Where the plan benefits are provided by insurance, your cost would be the amount of the insurance premium (including any part formerly paid by the Employer/Plan Sponsor) plus an administrative expense fee of 2% of the premium. (In the case of extended COBRA eligibility due to disability as specified above, the administrative fee increases to 50% of the premium after the 18th month through the 29th month.) You have 45 days from your election date to pay premiums that were incurred prior to your election. Thereafter, you have a grace period of 30 days for regularly scheduled premium payments. Where the plan pays its benefits directly (without insurance), your cost will not exceed the plan's actuarial estimate of its expense for the benefits of similarly situated employees, plus the administrative expense fee.

J. What You Have To Do. In the event of a divorce, legal separation or dependent child who no longer qualifies as an eligible dependent, you must formally advise the Employer/Plan Sponsor. Our plan guidelines dictate that this notification *must* be received in writing on a COBRA Notification of Qualifying Event form as specified by the Plan Administrator. This form must be postmarked to the Employer/Plan Sponsor within 60 days of the date of the Qualifying Event or loss of coverage, whichever is later.

In the event of a termination of employment, reduction of work hours, or death, you need not take any action to request election materials. You should automatically receive COBRA election materials at your home via the U.S. Postal Service. The COBRA election materials will outline coverage costs and options available to you and your covered dependents. If you wish to elect coverage, you *must* follow the guidelines and timelines detailed in the COBRA election materials.

If you decide to elect continued coverage, you must notify the Plan Administrator within 60 days from the later of: (a) the date your coverage would terminate due to the Qualifying Event; or (b) the date on which the Qualified Beneficiary is provided the notice and election materials. You then have 45 days to pay all the retroactive and current premium. Your coverage will be retroactively reinstated once the premium(s) and all required re-enrollment forms are received.

**Section 13: Uniformed Services Employment and Reemployment Act (USERRA)**

Congress enacted the USERRA legislation to protect the rights and benefits of employees who leave their civilian jobs to perform service in the military. In general, USERRA establishes employment and reemployment rights and benefits protections for returning military personnel and prohibits discrimination by employers against veterans, members of the military services and applicants for military service. USERRA applies to all employers, regardless of size, including foreign employers doing business in the United States, and covers full-time, part-time, seasonal and temporary employees. As required by law, our benefit program complies with the Federal USERRA legislation, which requires continuation rights for health expense coverage.

Continuation coverage during a military leave under USERRA is available if you have health expense coverage under the benefit plan. If that coverage would otherwise end because of a military tour of duty, you and/or your dependents

may be able to continue the coverage under the Employer/Plan Sponsor's benefit plan for up to 24 months while you continue to be in military service. USERRA coverage is similar to COBRA continuation coverage in that the employee must make an election for coverage and may be required to pay up to 102% of the full premium for the coverage elected during the leave. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to the benefit plan coverage when you are reemployed, generally without any waiting period or exclusions (for example, pre-existing condition exclusions), except for service-connected illnesses or injuries. For military service of less than 31 days, health care coverage is provided as if the service member had remained continuously employed.

## Section 14: Family Medical Leave Act (FMLA)

A. Compliance. When required by law, our benefit program will comply with the Family and Medical Leave Act (FMLA) requiring continuation rights for health expense coverage assuming the Employer/Plan Sponsor meets certain criteria during the preceding calendar year. If the Employer/Plan Sponsor is subject to the law and you are covered under health benefit plans, you may be able to continue the coverage under our benefit plan for a certain period of time.

B. Benefits. To the extent required under the FMLA, and the regulations thereunder, an employee on leave of absence under the FMLA may choose to continue coverage under the Plan by making the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with the FMLA. In addition, to the extent required under and in accordance with the FMLA and the regulations thereunder, any Employer/Plan Sponsor contributions made under the terms of the Plan shall continue to be made on behalf of an employee on an FMLA leave.

## Section 15: Claims Procedures

The determination of whether a claim falls under the procedures for health claims or under the procedures for disability and other non-health claims is based on the nature of the specific claim or benefit, not the characterization of the plan under which the claim is made or the benefit is offered.

A. Disability and Non-Health Claims. For a detailed description of the required procedures for filing claims and of the appeals procedures for any denied claims, please refer to the Certificates of Coverage for each of the separate Benefit Plans. If you cannot locate your plan Certificate, you may request a duplicate from the Plan Administrator identified on Page 1 of this Summary Plan Description.

B. Health Claims. Under PPACA, DOL and ERISA regulations, claimants are entitled to full and fair review of any claims made under the Plan. For a detailed description of the required procedures for filing claims and of the appeals procedures for any denied claims, please refer to the Certificates of Coverage for each of the separate Benefit Plans. Your Certificates of Coverage also describe the procedures for appealing an adverse benefit decision, for requesting internal review of an adverse benefit decision, and the procedures required to request an external review of any adverse benefit decision.

## Section 16: Use and Disclosure of Protected Health Information (Privacy Rule)

*This Section applies to Plan Sponsors that are considered Hands-On PHI Covered Entities under the HIPAA Privacy Rule (Section 45 CFR § 164.530). Determination of Covered Entity status (whether the Employer is Hands-Off PHI or Hands-On PHI for the Privacy Rule) is identified in Section 2 of this document.*

The Plan and any Contract Administrator, health insurance issuer or business associate servicing the Plan will disclose Protected Health Information to the Employer/Plan Sponsor only to permit the Employer/Plan Sponsor to carry out plan administrative functions for the Plan consistent with the requirements of 45 CFR § 164.504(f)(2) (collectively referred to as the "Privacy Rule"). Any disclosure to and use by the Employer/Plan Sponsor of Protected Health Information will be subject to and consistent with this Section 15.

A. Participant Disclosure. This Plan complies with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have questions about the privacy of your health information under the Plan, please contact the Plan Administrator or the Privacy Officer named in the Employer/Plan Sponsor's Privacy Policy.

B. Employer/Plan Sponsor's Obligations. Employer/Plan Sponsor certifies compliance with the following:

1. Not use or further disclose the information other than as permitted or required by this Section, the Plan, or such other plan documents or as Required by Law, which shall have the same meaning as the term “required by law” under the Privacy Rule (45 CFR §164.501).
2. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree, by signing a Business Associate Agreement, that the agent agrees to implement reasonable and appropriate privacy and security measures to protect any Protected Health Information received or created to a level that is equivalent to the protections required by HIPAA of the Covered Entity.
3. Not use or disclose the information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer/Plan Sponsor.
4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses and disclosures provided for in this Section or the Plan of which it becomes aware. Report to the Privacy Officer any security incident of which it becomes aware.
5. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (including electronic Protected Health Information) created, received, maintained, or transmitted.
6. Make available Protected Health Information (including electronic Protected Health Information) to Plan Participants upon their request of Protected Health Information or electronic Protected Health Information disclosures in accordance with the Privacy Rule (45 CFR §164.524).
7. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with the Privacy Rule (45 CFR §165.526).
8. Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule (45 CFR §164.528) and document such disclosures of Protected Health Information.
9. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information or electronic Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA.

**Section 16: Use, Disclosure, and Security of Protected Health Information (Continued)**

10. If feasible, return or destroy all Protected Health Information received from the Plan that Employer/Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
11. Ensure that adequate separation between the Plan and Employer/Plan Sponsor, is established pursuant to the Privacy Rule (45 CFR §164.504). Certain of employees, equivalently titled employees or classes of employees, or other workforce members under the control of the Employer/Plan Sponsor may be given access to Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan. The specific classes of employees or workforce members who may have access to Protected Health Information are identified in the Employer/Plan Sponsor’s separate Privacy Policy. The Plan Administrator or the Privacy Official named in the Employer/Plan Sponsor’s Privacy Policy can provide information on the specific employees or classes of employees who have access to Protected Health Information. The list provided in the Privacy Policy shall include every class of employees or other workforce members under the control of the Employer/Plan Sponsor who may receive Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The classes of employees or other workforce members identified in the Employer/Plan Sponsor’s Privacy Policy will have access to Protected Health Information only to perform the plan administration functions that the Employer/Plan Sponsor provides for the Plan.
12. The classes of employees or other workforce members identified in the Employer/Plan Sponsor’s Privacy Policy will be subject to disciplinary action and sanctions, including termination of employment or affiliation with Employer/Plan Sponsor, for any use or disclosure of Protected Health Information in breach or violation of or noncompliance with the provisions of this Section. Employer/Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant or beneficiary, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance

13. Provide participants in the Plan with such notice of privacy practices as required pursuant to the Privacy Rule (45 CFR §164.520).

C. Survival. The provisions of this Section shall survive the expiration or termination of the Plan or this Section for any reason.

D. Compliance with State and Federal Law. Employer/Plan Sponsor shall comply, and shall ensure that the Plan complies, with HIPAA and other applicable state and federal confidentiality, privacy, and security laws.

E. Interpretation. Any ambiguity in the Plan or this Section or in determining controlling provisions shall be resolved in favor of an interpretation that permits the parties to comply with HIPAA and other federal and state laws and that provides the greatest privacy protections for Protected Health Information. In the event of an inconsistency between the provisions of this Section and mandatory provisions of HIPAA, the HIPAA provisions shall control.

**Section 17: Security of Protected Health Information (Security Rule)**

*This Section applies to Plan Sponsors that are considered Hands-On PHI Covered Entities for the HIPAA Security Rule. Determination of Covered Entity status (whether the Employer is Hands-Off PHI or Hands-On PHI for Security Rule purposes) is identified in Section 2 of this document.*

A. Participant Disclosure. This Plan complies with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have questions about the privacy of your health information under the Plan, please contact the Plan Administrator or the Privacy Officer named in the Employer/Plan Sponsor's Privacy Policy.

B. Employer/Plan Sponsor's Obligations. Employer/Plan Sponsor certifies compliance with the following:

1. Develop, implement, and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Protected Health Information that it creates, receives, maintains, or transmits in an electronic format (with the exception of enrollment or disenrollment information and any Summary Health Information) on the Plan's behalf, and it will ensure that any of its agents or subcontractors to whom it may provide such electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect such information.

**Section 17: Security of Protected Health Information (Security Rule) (Continued)**

2. Report to the Plan any use or disclosure of the information that is inconsistent with the uses and disclosures provided for in this Section or the Plan of which it becomes aware. Report to the Security Official any security incident of which it becomes aware.

3. Follow the required notification procedures required by the Security Rule in the event of a breach of unsecured Protected Health Information which compromises the security of such information.

C. Survival. The provisions of this Section shall survive the expiration or termination of the Plan or this Section for any reason.

D. Interpretation. Any ambiguity in the Plan or this Section or in determining controlling provisions shall be resolved in favor of an interpretation that permits the parties to comply with HIPAA and other federal and state laws and that provides the greatest privacy protections for Protected Health Information. In the event of an inconsistency between the provisions of this Section and mandatory provisions of HIPAA, the HIPAA provisions shall control.

## Section 18: Prescription Coverage and Medicare Part D
## *(The font in this section is intentionally larger to comply with legal guidelines.)*

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a prescription drug program for people with Medicare. The Act established Medicare Part D, which is a federal program to subsidize the cost of prescription drugs for Medicare beneficiaries. In order to receive the benefit, eligible individuals must enroll in a standalone Prescription Drug Plan or the Medicare Advantage Plan. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans

might also offer more coverage for a higher monthly premium. Individuals covered by both Medicare and a group health plan should carefully evaluate their prescription drug needs to determine when and whether to purchase additional coverage under a Medicare Prescription Drug Plan.

That decision will depend heavily upon whether or not your group health plan offers prescription drug benefits that are "creditable" under Medicare. To be considered "creditable", the prescription drug benefit of your health plan must be expected to pay, on average for all plan participants, at least as much as the standard Medicare prescription drug coverage would pay.

The rules and potential penalties vary for creditable and non-creditable coverage. Please refer to the Plan Information in Section 3 (Benefit Information) of this Summary Plan Description to see whether your plan is Creditable or Non-Creditable under Medicare.

A. For Plans with Creditable Prescription Drug Coverage. Because your existing coverage is on average at least as good as the standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage, so long as you apply for Medicare prescription drug coverage within 63 days of terminating your creditable group sponsored plan. Each year, you will have the opportunity to enroll in a Medicare prescription drug plan between October 15th and December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a Medicare drug plan. If you drop your employer sponsored coverage and enroll in a Medicare prescription drug plan, you may not be able to get the employer sponsored coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

## Section 18: Prescription Coverage and Medicare Part D (Continued)

***(The font in this section is intentionally larger to comply with legal guidelines.)***

Information about your employer's group health plans and prescription drug benefits is available in your health plan certificate. In addition to prescription drugs, your current health plan coverage pays for other health expenses, and you may lose your current health and prescription drug benefits if you choose to drop your employer sponsored coverage in favor or enrolling in Medicare and a Medicare prescription drug plan.

B. For Plans with **Non-**Creditable Prescription Drug Coverage. Because your existing coverage is, on average for all plan participants, **not** expected to pay out as much as the standard Medicare prescription drug coverage would pay, you need to make some important decisions regarding your prescription drug coverage. Most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from the employer plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

Starting January 1, 2006, prescription drug coverage became available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

If you did not purchase Medicare prescription drug coverage or equivalent coverage before May 15, 2006, you may have to pay a higher premium if you join later. You will pay that higher premium as long as you have Medicare prescription drug coverage.

C. For all Medicare Eligible Individuals

1. Periodic Notice: Medicare eligible individuals are entitled to notice regarding their rights under Medicare before each annual enrollment period. You will also receive notification if the prescription benefit under your group health plan ends or changes so that is no longer creditable or becomes creditable. You may request a certificate of Medicare prescription drug plan creditability from the plan sponsor at any time.
2. Premium Surcharge for Late Enrollment: If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your Medicare base beneficiary premium will go up at least 1% per month for every month that you did not have that coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. In addition, you may have to wait until the following October to join.
3. Annual Enrollment Period for Medicare Prescription Drug Plans: Generally, you can only join a Medicare prescription drug plan between October 15 and December 7 of any year. This may mean the number of months you have to wait for coverage will be longer, which could make your premium higher.
4. Group Health Plan Considerations: Your current employer-sponsored coverage pays for other health expenses in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. When you make your decision, you should also compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
5. For Additional Information Regarding Available Medicare Prescription Drug Plans: Detailed information is available in the "Medicare and You" handbook. Medicare eligible individuals will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:
    - Visit www.medicare.gov
    - Call your State Health Insurance Assistance Program (see your copy of Medicare & You handbook for their telephone number)
    - Call 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048.
6. Extra Financial Help Available: For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information

about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

**Section 19: Health Savings Accounts**

This section only applies to the extent that a health savings account option is offered through the Plan and outlined in Section 3: Benefit Plan Information of this document.

A. Definition. A Health Savings Account (HSA) is a personal trust or custodial account established with a custodian or trustee to be used for reimbursement of eligible medical expenses incurred by the account Beneficiary and his or her tax dependents, as set forth in Code Section 223. The HSA is administered by the HSA Custodian or Trustee or its designee subject to the terms and conditions set forth in the Custodial or Trust Agreement between the Account Beneficiary and the Custodian or Trustee. The HSA is not an employee benefit plan sponsored or maintained by the Employer. The Employer's role with respect to the HSA is limited to making contributions through this Plan to the HSA established by you with the Custodian/Trustee (through Employer contributions and/or pre-tax salary reductions elected by you. The Employer has no authority or control over the funds deposited in your HSA. As such, the HSA identified in this summary Plan description and offered through this plan is not subject to the ERISA.

B. Eligibility Requirements. HSA eligibility is determined under IRS rules and the applicable terms and conditions of any Custodial or Trust agreement. You are eligible for Plan contributions to your HSA during any month if you satisfy the following conditions on the first day of that month:

    1. You are covered under a qualifying High Deductible Health Plan (as defined in Code 223) maintained by Employer.

    2. You certify, in accordance with policies and procedures established by the Employer, that you satisfy all of the requirements to be an Eligible Individual as set forth in Code Section 223. You are required to notify the Employer if you fail to satisfy these conditions on the first day of any month following the date that you first certify that you meet these requirements. In addition to being covered under a qualifying High Deductible Health Plan maintained by Employer, you must not be (i) covered under any other health plan or program that is not a qualifying High Deduction Health Plan unless that coverage is limited to "permitted coverage," "permitted insurance," and/or preventive care as defined in Code Section 223 and related guidance, (ii) entitled to Medicare; or (iii eligible to be claimed as a Dependent of any other taxpayer.

    3. You are otherwise eligible for this Plan.

**Section 19: Health Savings Accounts (Continued)**

C. Account Beneficiary. An Account Beneficiary is an eligible participant who has properly enrolled in their own HSA in accordance with the terms of the applicable Custodial Agreement.

D. Withdrawals. Funds may be withdrawn tax-free to pay for qualified medical expenses, which include all Section 213(d) expenses. HSA funds may be used to pay premiums only for long-term care insurance, COBRA premium, or other health insurance premiums for people receiving unemployment benefits. Non-medical withdrawals are permitted but are subject to a 10% penalty and income tax.

E. Carryover of Funds and Portability. Amounts not used for medical expenses at the end of the year may be carried over to future years. HSAs are portable. Employees may take the funds in the account when they leave.

**Section 20: Patient Protection and Affordable Care Act – Grandfathering Status**

Some of the component benefit plans of this welfare benefit plan may be "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Please refer to Section 3: Benefit Plan Information to confirm the grandfathered status of each component benefit plan. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the plan administrator identified in Section 2 of this Summary Plan Description. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**Section 21: Definitions**

A. Affiliated Employer**.** An entity that is considered with the Employer to be a single Employer according to Code Section 414(b), (c), or (m).

B. Board of Directors. The Board of Directors or other governing body of the Employer (the "Board"). Upon adopting this Plan, the Board of Directors appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

C. Code. The Internal Revenue Code of 1986, as amended, and where applicable, the regulations thereunder.

D. Dependent. A Dependent of the Participant within the meaning of Code Section 152 and the regulations issued under Code Section 106. A Spouse is an individual who is legally married to a Participant and who is treated as a spouse under the Code.

E. Employee. An individual who is a common-law employee of the Employer and is treated as an employee for income and employment tax purposes.

F. Employer. The Employer indicated in the Plan Information and any Affiliated Employer who is authorized by the Employer to adopt the Plan. Affiliated Employers who adopt the Plan are bound by the terms of the Plan unless they clearly withdraw from participation. Affiliated Employers who have adopted the Plan are set forth in the Plan Information of this document.

G. ERISA. The Employee Retirement Income Security Act of 1974, as amended.

H. Highly Compensated Individual. An individual defined under Code Section 105(h), as amended, as a "highly compensated individual" or a "highly compensated employee."

I. Participant. An Employee or Dependent who becomes a Participant according to the terms of Article II of this Plan document.

J. Plan Administrator. The person(s) or Committee identified in the Plan Information section that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator is the Employer.

**Section 22: General Plan Information and Plan Administration**

A. Tax Qualification. The benefits provided by the Plan are intended to qualify as a health and welfare benefits and meet the requirements for qualification under Code Section 79, Section 105(b) and Section 106(a), and that benefits paid Employees hereunder be excludible from their gross incomes by virtue of Section 79, Section 105(b) and Section 106(a).

B. Not an Employment Contract. None of the plans or benefits discussed on the preceding pages should be considered contracts for employment between the employee and the Employer/Plan Sponsor. This Plan does not guarantee any employee or plan participant the right of continued employment nor do they limit the Employer/Plan Sponsor's right to discharge any employee.

C. Reduction of Coverage to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any requirement imposed by the Code, the Plan Administrator shall take appropriate action(s), under rules uniformly applicable to similarly situated Participants, to assure compliance with the requirement or limitation. Action may include, without limitation, modifying or terminating a Highly Compensated Employee's coverage under this HRA without the consent of the Employee.

D. Provision for Third-Party Plan Service Providers. The Plan Administrator, along with the approval of the Employer/Plan Sponsor, may employ services in connection with the operation of the Plan, and rely upon its tables, valuations, certificates, reports, and opinions. These services may be provided by a Third Party Administrator, identified in the SPD. Unless otherwise provided in the Service Agreement, obligations under this Plan shall remain the obligation of the Employer/Plan Sponsor.

E. Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for those that involve the Plan Administrator's own gross negligence, willful neglect, willful misconduct, or willful breach of this Plan.

F. Allocation of Authority. The Board of Directors or applicable governing body of the Employer/Plan Sponsor (or an authorized officer of the Employer/Plan Sponsor) may appoint a Plan Administrator who keeps the records for the Plan, and controls and manages the operation and administration of the Plan. The Plan Administrator has the exclusive right to interpret and decide all matters of the Plan. The Plan Administrator's determinations are conclusive and binding. Without limitation, the Plan Administrator has the following powers and duties:

(a) To require any person to provide information in order to properly administer the Plan;
(b) To make and enforce rules and regulations necessary to efficiently administer the Plan;
(c) To decide all questions concerning the Plan, the eligibility of the Plan, according to the Plan's provisions;
(d) To determine the amount of benefits payable, according to the Plan's provisions; to inform the Employer/Plan Sponsor and insurer as appropriate, of the amount of the benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;
(e) To designate persons to carry out any duty or power which may or may not be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan;
(f) To keep all records, books of account, data and other documents necessary to properly administer the Plan; and
(g) To do everything necessary to operate and administer the Plan according to its provisions.

G. Compensation of Plan Administrator. Unless determined by the Employer/Plan Sponsor and permitted by law, any Plan Administrator who is also an Employee of the Employer/Plan Sponsor, will not receive compensation for services rendered as the Plan Administrator, but the Employer/Plan Sponsor will pay all reasonable expenses incurred in the performance of their duties.

H. Bonding. Unless otherwise determined by the Employer/Plan Sponsor, or required by any federal or state law, the Plan Administrator is not required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

I. Payment of Administrative Expenses. The Employer/Plan Sponsor may decide to pay the Plan's administrative expenses, or pass the expenses on to the Plan's Participants.

J. Funding Policy. The Employer/Plan Sponsor has the sole discretion to determine if benefits will be paid from a trust (taxable or non-taxable), established according to applicable law, or from the Employer/Plan Sponsor's general assets.

K. Indemnification. The Plan Administrator shall be indemnified by the Employer/Plan Sponsor against claims, and the expenses of defending against these claims, resulting from any action or conduct relating to the administration of the Plan, except claims arising from gross negligence, willful neglect, or willful misconduct.

**Section 22: General Plan Information and Plan Administration (Continued)**

L. Applicable Laws. The provisions of the Plan shall be construed, administered, and enforced according to applicable federal law and the laws of the State of California to the extent not preempted.

M. Post-Mortem Payments. Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving Spouse, otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights are determined, without liability for any interest.

N. Non-Alienation of Benefits. Except as expressly provided by the Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

O. Mental or Physical Incompetency. Every person receiving or claiming benefits under the Plan is presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in acceptable form, that a person is mentally or physically incompetent or a minor, and that a guardian, conservator, or other person legally vested with the care of his estate has been appointed.

P. Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant, or other person who is due payment under the Plan, because he cannot ascertain that person's identity or whereabouts, and reasonable efforts have been made to identify or locate this person, all payments due will be forfeited after a reasonable time, and after the date payment first became due.

Q. Requirement for Proper Forms. All communications in connection with the Plan, made by a Participant, shall become effective only when executed using the required forms, which may be furnished by, and are filed with, the Plan Administrator.

R. Source of Payments. The Employer/Plan Sponsor and any insurance company contracts held by the Employer/Plan Sponsor or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or Beneficiary shall have any right to, or interest in, any assets of the Employer/Plan Sponsor upon termination of employment or otherwise, except as specifically provided for under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or Beneficiary.

S. Tax Effects. Neither the Employer/Plan Sponsor, nor the Plan Administrator makes any warranty or other representation as to whether any benefits made to or on behalf of any Participant will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator, the Employer/Plan Sponsor or the Third Party Administrator, with respect to any increased taxes or other losses or damages suffered by the Employee.

T. Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

U. Headings. The headings and titles contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

V. Severability. Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder of the Plan shall be given effect to the maximum extent possible.

W. Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer/Plan Sponsor from Compensation paid by the Employer/Plan Sponsor.

## Section 23: Statement of Your Rights under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you to the certain rights and protections as a participant in your Employer/Plan Sponsor's employee benefit plan. ERISA provides that all plan participants shall be entitled to the following rights.

A. Receive Information about the Plan. You have a right to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

B. Obtain Copies of Plan Documents. You have a right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining

agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

C. Continue Group Health Plan Coverage. You have a right to continue health care coverage for yourself, spouse or dependents if there is loss of coverage under the plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation rights. Additional information about COBRA may be found in Section 12 of this Summary Plan Description.

D. Credit for Pre-existing Condition Exclusion Periods. You have a right to the reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## Section 24: Protection of Your Rights under ERISA

A. Fiduciaries. In addition to creating rights of plan participants, ERISA imposes special obligations and duties upon the people (called fiduciaries) who are responsible for the operation of your Employer/Plan Sponsor’s welfare benefit plan. The fiduciaries of the plan have a duty to operate the plan prudently and in the interest of you and other plan participants and beneficiaries. The fiduciaries also have a duty to protect any plan assets for the benefit of plan participants. No one, including your Employer/Plan Sponsor or any other person, may fire you or otherwise discriminate against you in any way to prevent you from receiving a welfare plan benefit or from exercising your rights under ERISA.

B. Claim Review. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. ERISA gives you the right to file suit in a state or federal court if your claim for benefits under the employee benefit plan is denied or ignored. You can also file suit in a federal court if you request plan documents and do not receive them within 30 days. In such a situation, the court will require the Plan Administrator to give you the plan documents you requested. In some cases the court could also require the Plan Administrator to pay you up to $110 a day until you receive the requested materials, unless the materials were not sent because of reasons beyond the control of the administrator. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court.

C. Assertion of Rights. If it should happen that the fiduciaries have misused the plan's money or assets, or that you have been discriminated against for asserting your rights, you can ask for help from the U.S. Department of Labor. You can also file suit in a federal court. If you file a suit, the court will decide who must pay those costs and legal fees. If you are successful, the court may order the person you have sued to pay those fees. If you lose, the court may order you to pay those costs and fees, if, for example, it finds your claim is frivolous.

## Section 25: Questions about the Plan or ERISA

A. Questions. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), a division of the U.S. Department of Labor. Phone listings for the EBSA may be found in your local telephone directory. Alternatively, you may contact the national office of the EBSA. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

B. Contact Information. Contact information for the San Francisco regional office and national offices of the EBSA are listed below:

San Francisco Regional Office
EBSA
90 7th Street, Suite 11300
San Francisco, CA 94103
Phone: (415) 625-2481

Division of Technical Assistance and Inquiries
EBSA
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

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