UNITED CEREBRAL PALSY OF GREATER CLEVELAND

HEALTH AND WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

May 1, 2021

This document is not intended to provide legal advice and should not be relied upon in that regard. Accordingly, you should consult with your own legal advisers regarding compliance with applicable laws, including without limitation the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code.

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INTRODUCTION

United Cerebral Palsy of Greater Cleveland (the "Company") established the United Cerebral Palsy of Greater Cleveland Health and Welfare Benefit Plan (the "Plan") effective May 01, 2021. This summary describes the Plan and together with the incorporated documents, describes the benefits offered under the Plan (the "Included Benefits").

This Summary Plan Description supersedes any and all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document and Included Benefit Documents will prevail in the event of any inconsistency.

ADMINISTRATIVE INFORMATION

1. The Plan's name is United Cerebral Palsy of Greater Cleveland Health and Welfare Benefit Plan
   The Plan's number is 501
   The Plan Year End is the 12-month period ending on April 30

   The Plan is an "employee welfare benefit plan" for purposes of ERISA that includes a group health plan, a group dental plan, a group vision plan, a disability plan, a group life insurance plan, a group accident plan and group critical illness.

   Note: "group health plan" may include a medical, EAP, wellness, expat medical, and Health FSA.

2. The Plan Sponsor is United Cerebral Palsy of Greater Cleveland
   10011 Euclid Ave
   Cleveland, OH, 44106
   Phone: 216-453-4954
   Email: btaylor@ucpcleveland.org
   Employer Identification Number: 34-0753561

3. The Plan Administrator is the Company
   10011 Euclid Ave
   Cleveland, OH, 44106
   Phone: 216-453-4954
   Email: btaylor@ucpcleveland.org

4. The agent for legal service is the President of the Board
   10011 Euclid Ave
   Cleveland, OH, 44106
   Phone: 216-453-4954

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

5. The Plan is not funded by a trust.

6. Funding
   The cost of benefits offered under the Plan is either covered by contributions from the Company, contributions by you, or will be shared by you and the Company. Where you and the Company share the cost of coverage, the Company will contribute the difference between your premium and the amount required to pay benefits under the Plan.

   Any dividends, retroactive rate adjustments, rebates, or other refunds of any type that may become payable under any Included Benefit or in connection with an Included Benefit do not become assets of the Plan but are the property of, and will be retained by, the Company unless otherwise mandated by law.

7. The COBRA contact is the Plan Sponsor
   10011 Euclid Ave
   Cleveland, OH, 44106
   Phone: 216-453-4954

8. The Claims Administrators are identified in the Welfare Benefit Plan Chart Addendum at the end of this SPD or can be found in the benefit materials for the Included Benefits (as defined below).

ELIGIBILITY

Your eligibility for participation and for benefits under the Plan is described in the documents summarizing the Included Benefits. These documents are available from the Plan Administrator. See the addendum to this Plan document for the list of the eligibility requirements.

PAYMENTS FROM THIRD PARTIES

The Plan has a specific and first right of reimbursement from any payment, amount, or recovery you receive from a third party relating to expenses covered by the Plan. By accepting the benefits of the Plan, you agree to these rights of the Plan, which are described in the Plan document. Below is a summary of these rights. If the reimbursement provisions in this "Payments from Third Parties" provisions conflict with subrogation, right of recovery, or reimbursement provisions in an insurance contract or other document governing the Included Benefit at issue, the provisions in the other document will govern.

The Plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to the reduction. Further, the Plan's right to reimbursement will not be affected or reduced by any equitable defenses that may affect the Plan's right to reimbursement.

The Plan may enforce its rights by requiring you to assert a claim to any of the benefits to which you may be entitled. The Plan will not pay your attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Plan should become aware that a Participant has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and any covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant.

By participating in the Plan, you consent and agree:

- that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party.
- to cooperate with the Plan in reimbursing the Plan for costs and expenses.
- to notify the Plan if you have any reason to believe that the Plan may be entitled to recovery from any third party and to sign an agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you payment, amount or recovery from a third party.
- to not assign your rights to settlement or recovery against a third person or party to any other party, including your attorney(s), without the Plan's consent.

If you fail or refuse to execute the required agreement, the Plan may deny payment of any benefits until the agreement is signed. Alternatively, if you fail or refuse to execute the required agreement and the Plan nevertheless pays benefits to you, your acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

The Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

These rights apply even after you are no longer a Participant in the Plan. The Plan Administrator has the authority and discretion to resolve all disputes regarding the Plan's subrogation and reimbursement rights and to make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

CONTINUATION RIGHTS/COBRA NOTICE

The right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, 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 documents describing the Included Benefits, this Summary Plan Description, or contact the Plan Administrator.

If you are participating in an Included Benefit subject to COBRA and the Company is not a small

employer, then COBRA applies. A "small employer" is generally an employer that employs fewer than 20 employees, but you should contact the Plan Administrator who can inform you if the Company is a small employer not subject to COBRA and is not required to comply with these rules.

For Health FSA only - You, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Plan for the remainder of the Plan Year. You will be provided notice of your right to elect COBRA continuation coverage.

Should you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. 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.

Except as set forth in an Included Benefit document, the following shall apply only to the Included Benefits subject to COBRA:

Qualifying Events

You have the right to continue your coverage under the Plan if any of the following events results in your loss of coverage under the Plan:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Plan if any of the following events results in their loss of coverage under the Plan:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event.

However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

Length of Coverage

If your qualifying event is a loss of coverage due to a termination of employment or reduction in hours, you and your dependents may continue health coverage for up to 18 months. If your qualifying event is a loss of coverage due to divorce, legal separation, Medicare entitlement, or a dependent child losing dependent status under the Plan, your dependents may continue health coverage for up to 36 months.

The 18 months may be extended to 36 months from termination of employment if other events (such as death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period, but only if the second qualifying event would have caused the dependent to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must notify the Plan Sponsor, in writing, within 60 days after the second qualifying event occurs if he or she wants to extend his or her continuation coverage. In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

The 18 months also may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security disability purposes). The disability has 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. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment and who have elected continuation coverage. To benefit from this extension, a qualified beneficiary must notify the Plan Sponsor, in writing, of the disability determination within 60 days after the date of determination, and before the end of the original 18-month period. The affected individual must also notify the Plan Sponsor within 30 days of any final determination that the individual is no longer disabled.

Notice

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if he or she is not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of his or her COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Plan until the end of the Plan Year (or longer, in certain circumstances. See “Length of Coverage” above for more information) in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Plan;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides a Plan to any of its employees.

AMENDMENT AND TERMINATION

The Company intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan or an Included Benefit, in whole or in part, at any time and for any reason. No participant or beneficiary has a vested right in or to any future Plan benefits.

INCLUDED BENEFIT DOCUMENTS INCORPORATED BY REFERENCE

This Plan incorporates the terms of all welfare benefit plans subject to ERISA sponsored by Company and any affiliate who has adopted the Plan ("Included Benefits"). See the addendum to this Plan document for a list of these plans. Certain documents describing these Included Benefits include information about eligibility, benefits, and employee/employer contributions for each of the separate Included Benefits, which are incorporated by reference into this summary plan description. These documents may include summary plan descriptions for the Included Benefits, as well as summary benefit booklets, certificates of coverage, enrollment materials, etc. These documents, together with this document, constitute the entire summary plan description for the Plan.

CLAIMS PROCEDURES

In General

Unless the applicable Included Benefit specifies claims procedures, the following procedures will apply. In all cases, the Claims Administrator will administer claims in accordance with Section 503 of ERISA and the associated regulations. For insured benefits, the Claims Administrator is the insurer. For self-insured benefits, the Claims Administrator is the Third Party Administrator (TPA). The Claims Administrators are identified in the Welfare Benefit Plan Addendum.

You must submit your claim for benefits in accordance with the Claims Administrator's guidelines. Claims may also be submitted to the Claims Administrator at the address specified at the beginning of this document.

Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file the claim in accordance with these procedures. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under this section. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" for purposes of this section, unless the Claims Administrator determines that the inquiry is an attempt to file a claim. If the Claims Administrator or its delegate receives a claim, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

You may designate an authorized representative by providing to the Claims Administrator with written notice of the designation. In the case of a claim for medical benefits involving urgent care, your health care professional with knowledge of your medical condition may act as your authorized representative.

Timing of Notice of Claim

The Claims Administrator will notify you of a claim denial within a reasonable period of time, but not later than the time frames below. The time frames will vary depending on the type of Included Benefit and may be extended for any period of time necessary for you to respond to a request for additional information.

Group Health Plan Claims

The following procedures apply to the Included Benefits that are "group health plans."

A. Urgent Care Claims.

An "urgent care" claim is any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If you fail to follow the Plan's procedures for filing an urgent care claim, the Claims Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 24 hours following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication from you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You 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 Claims Administrator will notify you of the Plan's benefit 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 information, or (2) the end of the period given to you to provide the specified additional information.

B. Pre-Service Claims.

A "pre-service" claim is any claim where the Plan conditions receipt of the benefit on approval in advance of obtaining medical care. If you fail to follow the Plan's procedures for filing a pre-service claim, the Claims Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 5 days following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication by you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Claims Administrator will notify you if its determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Claims

Administrator for up to an additional 15 days. The Claims Administrator may only extend the deadline if they determine that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

C. Post-Service Claims.

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim. In the case of a post-service claim, the Claims Administrator will notify you of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Claims Administrator for up to an additional 15 days. The Claims Administrator may only extend the deadline if they determine that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

D. Concurrent Care Claims.

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute claim denial. The Claims Administrator will notify you of the denial at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a review of that denial before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will notify you of the denial, whether adverse or not, within 24 hours after the Plan receives the claim, provided that the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

<u>Disability Benefit Claims</u>

The Claims Administrator will provide you with notice of an adverse benefits determination within 45 days after receipt of the claim. This period may be extended for up to 30 days, provided that the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the

Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Claims Administrator notifies you prior to the expiration of the first 30-day extension period of the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section will explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

Non-Group Health Plan and Non-Disability Benefit Claims

For all other claims not described above, the Claims Administrator will provide you with a notice of claim denial within 90 days after receipt of the claim. This period may be extended one time by the Claims Administrator for up to an additional 90 days. The Claims Administrator may only extend the deadline if they determine that such an extension is necessary due to matters beyond the control of the Plan and they notify you of the extension prior to the expiration of the initial 90-day period.

Content of Notice of Adverse Benefit Determination

If your claim is denied, the Claims Administrator will provide you with a written notice identifying:

1. the reason(s) for the denial;
2. the Plan provisions on which the denial is based;
3. any material or information needed to grant the claim and an explanation of why the additional information is necessary; and
4. an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA.

In addition, if the denied claim is for a group health plan under the Plan, the following information will also be included in the written notice:

1. the specific rule, guideline, protocol, or other similar criterion, if any, that was relied upon in the denial; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or
2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that the explanation will be provided free of charge to you upon request.

If the denied claim is for a disability benefit under the Plan, the following information will also be included in the written notice:

1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding you presented by you to the Plan.
2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.
3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
4. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for disability benefits.

If the denied claim is for a group health plan benefit under the Plan, the following information will also be included in the written notice:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
3. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes.
4. The Plan must also:
    a. ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim; and
    b. provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In the case of a denied urgent care claim where the Included Benefit is a group health plan, the notice will include a description of the expedited review process applicable to such claims.

This information may be provided orally provided that a written or electronic notification is furnished to you not later than 3 days after the oral notification.

Appeal of Adverse Benefit Determination

You may appeal the denial of a claim (including a rescission of coverage) by filing a written appeal with the Claims Administrator on or before the 60th day after you receive the Claims Administrator's written notice that the claim has been denied. If the denial involves a claim under an Included Benefit that is a group health plan or disability plan, you may file a written appeal on or before the 180th day after your receive written notice of the denial.

If the denial involves a claim for disability benefits, a denial includes a cancellation or discontinuance of coverage that has retroactive effect (unless it is due to your failure to pay required premiums).

Your written appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will lose the right to appeal if your appeal is not timely made.

The Plan will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefit. You may submit written comments, documents, records, and other information relating to the claim for benefits. The Plan will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial claim. The Claims Administrator will consider the merits of your written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claims Administrator may deem relevant.

If the claim is for group health plan or disability plan benefits the following will apply:

1. The review will not afford deference to the initial claim denial. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of that individual.
2. In deciding an appeal of any denial that is based on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the claim denial that is the subject of the appeal, nor the subordinate of any such individual.
3. The Plan will, upon the request of the claimant, identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in the denial.

4. In the case of an urgent care claim, the Plan will expedite review of the claim and you may submit a request for an expedited appeal of a denial orally or in writing. All necessary information, including the Plan's benefit determination on review, will be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

Additionally, if the claim is for group health plan or disability benefits under the Plan, the following will apply:

1. Before the Plan issues any adverse benefit determination, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or additional rationale must be provided to you as soon as possible and sufficiently in advance of the date on which the Plan must provide you with the notice of final adverse benefit determination so that you have a reasonable opportunity to respond prior to that date.
2. If the determination is based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for you to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until you have had reasonable opportunity to respond. After you respond, or had a reasonable opportunity to respond but failed to do so, the Claims Administrator will notify you of the Plan's benefit determination as soon as a Claims Administrator acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

The Claims Administrator will ordinarily rule on an appeal of a claim denial within 60 days following receipt of the claim. The time frame will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, if special circumstances require an extension and the Claims Administrator furnishes you with a written extension notice during the initial period, the Claims Administrator may extend this period of time by 60 days if written notice of the extension is furnished to you prior to the termination of the initial 60-day period. In the event that the extension is due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will start on the date that you respond to the request for additional information.

If the claim is for group health plan benefits, the Claims Administrator will notify you of the Plan's benefit determination on review as follows:

1. Urgent Care Claims. The Claims Administrator will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not

later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.

2. Pre-Service Claims. The Claims Administrator will notify you of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.
3. Post-Service Claims. The Claims Administrator will notify you of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt by the Plan of your request for review of an adverse benefit determination.

If the claim is for disability benefits, the Claims Administrator will ordinarily rule on an appeal of a claim denial within 45 days following receipt of the claim. The time frame will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, if special circumstances require an extension and the Claims Administrator furnishes you with a written extension notice during the initial period, the Claims Administrator may extend this period of time by 45 days if written notice of the extension is furnished to you prior to the termination of the initial 45-day period. In the event that the extension is due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will start on the date that you respond to the request for additional information.

All claims and appeals involving group health plan benefits and disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will be made based upon the likelihood that the individual will support the denial of benefits.

The following applies to any claim for group health plan benefits (or appeal of a claim for group health plan benefits):

1. the Plan must ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. the Plan must provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review;
3. the Plan must ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if

any, that was used in denying the claim. In the case of a notice of final adverse benefit determination, this description must include a discussion of the decision;

4. the Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
5. the Plan must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes.

Denial of Appeal

If an appeal is wholly or partially denied, the Claims Administrator will provide you with a notice identifying:

1. the reason or reasons for such denial;
2. the Plan provisions on which the denial is based;
3. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
4. a statement describing your right to bring an action under section 502(a) of ERISA. The determination rendered by the Claims Administrator will be binding upon all parties.

If the denied claim is for a group health plan benefit under the Plan, the following information will also be included in the written notice:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
3. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes; and
4. The Plan must also:
    a. ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim and a discussion of the decision if the notice is a final adverse benefit determination; and
    b. provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In the case of a group health plan or a plan providing disability benefits, the notice will also include:

1. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
3. the following statement will be included in a group health plan claim: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

In the case of a claim involving disability benefits, the notice will also include:

1. Any applicable contractual limitations period that applies to your right to bring an action under section 502(a) of ERISA, including the calendar date that the contractual limitations period expires for the claim.
2. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding you presented by you to the Plan.
3. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.
4. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

External Claims Process

State Process. To the extent the Plan is required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the Plan will comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

Federal Process. To the extent the Plan is not required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with the State external claims process, then the Plan will comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d).

REFUNDS/INDEMNIFICATION

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

MILITARY SERVICE

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving benefits. Please see the FMLA policy in our Employee Handbook for more information, copies of which may be obtained through Human Resources or through our internal website.

YOUR RIGHTS UNDER ERISA

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). This federal law provides that you have the 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 Employee Benefits Security Administration.

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

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

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (“QMCSO”). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

To the extent required by the Women's Health and Cancer Rights Act (“WHCRA”) of 1998, this Plan provides coverage for all stages of reconstruction of the breast on which the mastectomy has been

performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage. Written notice of the availability of such coverage shall be delivered to Participants upon enrollment and annually thereafter. Contact the Plan Administrator for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

You may be able to enroll for medical coverage outside of normal enrollment periods if you experience a "special enrollment event."

New Dependents. If you acquire a new dependent during the Plan Year as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your dependents in the medical coverage during the Plan Year. However, you must give notice to the Plan Sponsor within 30 days of the event. For birth, adoption, or placement of adoption coverage will be effective retroactive to the date of the event. For marriage, coverage will be effective as soon as practicable following the request for coverage. If you fail to request enrollment within 30 days of the event, you must wait until the following annual enrollment period to elect coverage for the new dependent.

Waiver of Medical Coverage. If you waive medical coverage under the Plan for yourself or your dependents as a result of being covered under another employer's medical plan, you may elect medical coverage under this Plan upon termination of the other coverage, if you previously declined coverage because you or your dependents had other coverage, you request enrollment in this Plan within 30 days of the termination, and one of the three following requirements is met:

- The other coverage was COBRA continuation coverage that terminated for any reason other than the failure to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

- The other coverage terminated because you or your dependents are no longer eligible under the terms of the other plan for any reason other than your or your dependent's failure to pay premiums on a timely basis or the termination of coverage for cause.

- The other coverage terminated due to the termination of employer contributions.

If you request enrollment within 30 days of the termination of the other coverage, the coverage under this Plan will be effective as soon as practicable following the request for coverage.

- ***Eligibility for Medicaid or State Children Health Insurance Program.***

    - If you or your dependents are eligible for medical coverage, but not enrolled in such coverage, you may enroll for medical coverage if you are covered under a Medicaid plan or a State children health insurance plan and coverage is terminated as a result of loss of eligibility for such coverage. You must request coverage under this Plan within 60 days after the date of termination of the other coverage.

    - If you or your dependents become eligible for premium assistance with respect to coverage under this Plan under a Medicaid plan or a State children health insurance plan, you or your dependents may enroll for coverage in this Plan. You must request coverage under this Plan within 60 days after the date you or your dependents become eligible for assistance.

- ***Loss of Coverage for Medicaid or a State Children's Health Insurance Program.***

    - If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

MENTAL HEALTH PARITY ADDICTION AND EQUITY ACT ("MHPAEA")

All group health plans that provide both medical/surgical benefits and mental health or substance use disorder benefits, shall provide such benefits subject to the following:

- The financial requirements applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan, and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits;
- The treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits; and,
- The Plan Administrator or issuer must make available to participants or beneficiaries, upon request, the criteria for medical necessity determinations for mental health and substance use disorder benefits and provide the reason for any denial of reimbursement or payment for services. Under the ACA, group health plans are prohibited from imposing annual or lifetime dollar limits on Essential Health Benefits, including mental health and substance use disorder services and behavioral health treatment.

GENETIC INFORMATION NONDISCRIMINATION ACT ("GINA")

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits group health plans from discriminating based on genetic information with respect to eligibility, premiums, and contributions. GINA generally prohibits employers with more than 15 employees from the collection or use of genetic information unless in an aggregate form that does not identify the individual. When GINA applies, genetic information is treated as Protected Health Information (PHI) under HIPAA.

"Genetic information" includes any information about an individual's own genetic tests, the genetic tests of an individual's family members, and the manifestation of a disease or disorder in the individual's family members. For this purpose, a genetic test is any analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes (essentially, anything used to predict whether an individual has a predisposition to a disease, disorder, or pathological condition).

WELLNESS PROGRAMS

The Plan Sponsor may offer one or more voluntary wellness programs or disease management programs (each a Program) under this Plan that are reasonably designed to promote the health and wellbeing of covered individuals. Such Programs offer certain incentives or rewards for participation in a Program or for satisfying certain health standards. If the Plan Sponsor chooses to offer a Program or Programs, its terms and conditions will be communicated to you and it will be administered in compliance with all applicable laws.

PATIENT PROTECTION AND AFFORDABLE CARE ACT ("ACA")

Certain group health plans have become subject to provisions of the ACA. Notwithstanding anything in the Plan to the contrary, the Plan shall comply with the ACA and all applicable regulations, as may be amended from time to time.

Essential Health Benefits

The ACA generally defines Essential Health Benefits to include the following broad categories of health care benefits.

- Ambulatory patient services (i.e. outpatient care received without being admitted to the hospital)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care
- Prescription drugs

Essential Health Benefits covered under this Plan are subject to certain additional requirements under the ACA. ACA regulations further define Essential Health Benefits based on state-specific "benchmark" plans, or for self-insured plans, on the Federal Employees Health Benefit Program.

Lifetime and Annual Dollar Limits

Under the ACA, this Plan is prohibited from imposing lifetime or annual limits on the dollar value of Essential Health Benefits provided to any individual, regardless of whether the benefits are provided in-network or out-of-network. This Plan is not prohibited, however, from placing lifetime or annual dollar limits on specific covered benefits that are *not* Essential Health Benefits to the extent such limits are otherwise permitted under applicable federal or state law.

Cost-Sharing Maximum Limit

The ACA requires non-grandfathered group health plans to apply a uniform maximum limit for out-of-pocket expenses (deductibles, co-insurance, co-pays, or similar charges) on all Essential Health Benefits of no greater than the maximum amounts set annually by the Internal Revenue Service (IRS) for high-deductible health plans as adjusted for inflation using the "premiums adjustment percentage."

- The overall cost-sharing limit only applies to benefits provided in-network. A plan may include out-of-network expenses at its discretion.
- Plans are not required to apply the annual limitation on out-of-pocket maximums to benefits that are not Essential Health Benefits. See above in this Section for a list of Essential Health Benefits.

Patient Protections

Primary Care Provider Designation. If a nongrandfathered group health plan requires or allows participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a participant, then the participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the participant or participant's family members.

Access to Pediatric Care. If a non-grandfathered group health plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties) as the child's primary care provider if such provider participates in the network of the Plan or Issuer.

Access to Obstetrical or Gynecological Care. A participant, regardless of age, shall not need prior authorization from a non-grandfathered group health plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology.

Emergency Services. A non-grandfathered group health plan that provides emergency services may not require preauthorization for those services. Emergency services must be provided regardless of whether the provider is in- or out-of-network without any time limit within which treatment must be sought. In addition, the plan generally cannot impose any copayment or coinsurance for out-of-network emergency services that is greater than what would be imposed if the services were provided in-network.

Mandated Coverage

Preventive Care Services. Non-grandfathered group health plans subject to the preventive services coverage mandate must provide coverage for all the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements. If the attending provider determines that the service is medically necessary, a plan must provide coverage regardless of sex

assigned at birth, gender identity, or gender of the individual, as recorded by the plan. Updated lists of the preventive services covered under this provision are available at www.healthcare.gov/coverage/preventive-care-benefits.

Coverage for Clinical Trials. Non-grandfathered group health plans must provide benefit coverage (including physician charges, labs, x-rays, professional fees, and other routine medical costs) for certain routine patient costs for qualified individuals who participate in an approved clinical trial. Approved clinical trials must be covered for the treatment of cancer and other life threatening diseases or conditions. If a participant experiences complications as a result of the clinical trial, any treatment of those complications must be covered on the same basis that the treatment would be covered for individuals not in the clinical trial.

Prohibition on Rescissions of Coverage. Under the ACA, group health plans (other than "excepted benefits" under HIPAA) are generally prohibited from rescinding (that is, cancelling retroactively) the coverage of a participant. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals procedures. A cancellation or discontinuance is *not* a prohibited rescission if it is initiated by an individual and no actions are taken to influence the individual's decision or to otherwise retaliate against the individual; it only has a prospective effect; or, it is effective retroactively due to a failure to timely pay required premiums or contributions towards the cost of coverage, including nonpayment of COBRA premiums. In addition, rescissions are permitted for fraud or the intentional misrepresentation of fact by the participant. The Plan must provide at least 30 days' advance notice to the affected participant before coverage may be rescinded, and only as permitted under Section 2702(c) or Section 2742(b) of the ACA.

LOSS OF BENEFIT

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

NON-ALIENATION

You may not alienate, anticipate, commute, pledge, encumber, or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

PLAN ADMINISTRATOR DISCRETION

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation, or application of the Plan by the Plan Administrator is final, conclusive, and binding on all parties.

WELFARE BENEFIT PLAN CHART ADDENDUM

If there is a conflict in the information provided by this addendum and the applicable contract, policy, or benefit booklet, the applicable contract, policy or benefit booklet will control, except with regard to the benefit, funding and contributions information. For terms and definitions used in this addendum, please see the applicable contract, policy, or benefit booklet.

Benefit	Contact Information (Questions, Claims & Appeals)	Eligibility	Funding & Contributions
Medical	Medical Mutual of Ohio 2060 E 9th St. Frnt Ste Cleveland, Ohio 44115 (440) 572-6358	Full-Time Employees, Spouses and Eligible Dependents	Fully Insured Employer and employee contributions
Dental	Lincoln Financial Group Fort Wayne, IN Dawn.Courie@lfg.com 216-392-4767	Full-Time Employees, Spouses and Eligible Dependents	Fully Insured Employer and employee contributions
Vision	Lincoln Financial Group Fort Wayne, IN Dawn.Courie@lfg.com 216-392-4767	Full-Time Employees, Spouses and Eligible Dependents	Fully Insured Employer and employee contributions
Life	Lincoln Financial Group Fort Wayne, IN Dawn.Courie@lfg.com 216-392-4767	Full-Time Employees	Fully Insured Employer contributions
Voluntary Life	Lincoln Financial Group Fort Wayne, IN Dawn.Courie@lfg.com 216-392-4767	Full-Time Employees, Spouses and Eligible Dependents	Fully Insured Employee contributions
Accidental Death & Dismemberment (AD&D)	Lincoln Financial Group Fort Wayne, IN Dawn.Courie@lfg.com 216-392-4767	Full-Time Employees	Fully Insured Employer contributions
Voluntary AD&D	Lincoln Financial Group Fort Wayne, IN Dawn.Courie@lfg.com 216-392-4767	Full-Time Employees, Spouses and Eligible Dependents	Fully Insured Employee contributions
Long Term Disability	Lincoln Financial Group Fort Wayne, IN Dawn.Courie@lfg.com 216-392-4767	Full-Time Employees	Fully Insured Employer contributions
Short Term Disability	Lincoln Financial Group Fort Wayne, IN Dawn.Courie@lfg.com 216-392-4767	Full-Time Employees	Fully Insured Employer contributions

Group Accident	Reliance Standard Life Insurance Company 1700 Market St., Ste. 1200 Philadelphia, PA 19103 800-441-9157	Full-Time Employees, Spouses and Eligible Dependents	Fully Insured Employee contributions
Group Critical Illness	Reliance Standard Life Insurance Company 1700 Market St., Ste. 1200 Philadelphia, PA 19103 800-441-9157	Full-Time Employees, Spouses and Eligible Dependents	Fully Insured Employee contributions