PRRC, INC. HEALTH AND WELFARE PLAN

Summary Plan Description

July 2023

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INTRODUCTION

This document, together with the various Benefits Booklets referenced herein which describe the benefits provided, constitutes a Summary Plan Description ("**SPD**") which summarizes and explains the important provisions of the PRRC, Inc. Health and Welfare Plan (the "**Plan**") as in effect July 1, 2023, that apply to eligible employees. This SPD provides information about the administration of the Plan and also describes certain rights you have under federal laws relating to employee welfare benefit programs. If there is a conflict between this SPD and the Plan document, the Plan document will control. Complete details of the Plan are found in the official Plan document and the benefits booklets, insurance contracts, certificates of coverage, and administrative services contracts relating to the benefit options offered under the Plan (each, a "**Benefits Booklet**").

The Plan document, Benefits Booklets and any written administrative procedures pertaining to the Plan may be reviewed by Plan participants and/or their legal representatives during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator. Copies of the Benefits Booklets are available to Plan participants upon request and some Benefits Booklets are also available on line.

PRRC, Inc. (the "**Company**") is the Plan sponsor. Other entities may adopt the Plan with the consent of the Company, referred to as Participating Employers. If Participating Employers have adopted this Plan, they are identified under **BASIC FACTS** (Section A)**.** All Participating Employers together with the Company are referred to in this Summary as the "Employer."

The Plan is not a contract of employment and does not guarantee continued employment. The benefits under the Plan are provided at the sole discretion of the Company. The Company makes no promises to continue Plan benefits in the future, and rights to future benefits will never vest. In addition, the Company reserves the right, in its sole discretion, to amend, modify or terminate the Plan, in whole or in part, at any time by action of the Company's Board of Directors (the "Board") or such other officer as the Board may designate, and without prior notification to Plan participants. In addition, certain officers may be delegated the authority to amend the Plan as necessary to comply with requirements of applicable law.

The Company believes the group health benefits identified in the **BENEFIT OVERVIEW** (Section B) as "grandfathered" constitute "grandfathered health plan" benefits under the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA"). As permitted by the Affordable Care Act, a grandfathered health plan benefit can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan benefit means that those Plan benefits may not include certain consumer protections of the Affordable Care Act that apply to other Plan benefits or other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plan benefits must comply with certain other consumer protections in the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan benefit and what might cause a plan benefit to change from grandfathered health plan status can be directed to the Plan Administrator at the address specified in **BASIC FACTS** (Section A). 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.

It is recommended that you read this SPD carefully so you can understand the Plan's operation and the benefits it offers. If you have any questions after reading this SPD or would like additional information, please contact the Plan Administrator at the address specified in **BASIC FACTS** (Section A).

Any communication required to be delivered to participants and beneficiaries under the Plan, including the dissemination of this SPD, may be made through electronic means in accordance with procedures established by the Plan Administrator and the Department of Labor Regulations set forth at 29 CFR §2520.104b-1(c).

Please retain this SPD for future reference.

A. BASIC FACTS

Plan Name	PRRC, Inc. Health and Welfare Plan
Plan Number	501
Plan Year	January 1- December 31
Plan Sponsor (the "Company") and Plan Sponsor's Address	PRRC, Inc. 160 Silas Dean Highway Wethersfield, CT 06109
Employer Identification Number	04-3311158
Participating Employers	☒ No entities in addition to the Company have adopted the Plan. ☐ The following entities (in addition to the Company) have adopted the Plan:
Plan Administrator	The Company
Service of Legal Process	Service of legal process may be made upon the Plan Administrator.
Plan Type	The Plan is an employee welfare benefit plan established under section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the Department of Labor Regulations thereunder.
Plan Funding and Administration	The benefits offered under the Plan are either provided through insurance and administered and paid by the insurers identified in **BENEFIT OVERVIEW** (Section B) or are self-insured by the Company and administered by the third-party administrator(s) identified in the **BENEFIT OVERVIEW** (Section B)

B. BENEFIT OVERVIEW

This **BENEFIT OVERVIEW** identifies the Benefits offered under the Plan and the eligibility conditions for each Benefit. A full description of the Benefits is set forth in the various Benefit Booklets for each Benefit referenced below.

1. ELIGIBLE EMPLOYEES AND ELIGIBLE DEPENDENTS

You are entitled to certain Benefits under the Plan depending upon whether you are a Full-Time Eligible Employee or an ACA Eligible Employee as described below:

a. A **Full-Time Eligible Employee** is an employee who is regularly working for the Employer at least the number of hours in the Employer's normal full-time work week. The Employer's normal full-time work week is at least 32 hours per week.

If you are a **Full-Time Eligible Employee**, your "**Eligible Dependents**" include your spouse and your children as defined in the Benefits Booklet; provided, however, that any restriction on dependent coverage described in a Benefits Booklet with respect to a group health plan subject to the ACA, other than attainment of age 26, will not apply. In addition, your Eligible Dependents include your civil union partner or domestic partner and his or her children as defined in the applicable Benefits Booklet and as required by law. Individuals covered under a Qualified Medical Child Support Order issued against you are also eligible for group health benefits as described under the Order (see Section E.5).

Your spouse is any person lawfully married to you in a jurisdiction whose laws authorize the marriage. An eligible civil union partner is one who is in a qualified civil union with a participant if the participant provides proof of such relationship by presenting to the Plan Administrator a civil union license or certificate issued by a state agency certifying that the participant and such partner have established a civil union pursuant to state law. An eligible domestic partner is a dependent that is a legally recognized domestic partnership of two eligible individuals as provided under applicable law.

b. An **ACA-Eligible Employee** is an employee who is not a Full-Time Eligible Employee and who works an average of at least 30 hours of service per week during a "measurement period."

If you qualify as an ACA-Eligible Employee during a 12-month measurement period, you and your eligible dependent children (as determined under the ACA and applicable guidance) will be eligible for medical plan coverage for a 12-month stability period.

The Employer will determine each employee's ACA-Eligible Employee status by looking back at a defined period of 12 consecutive calendar months (a "measurement period"), to determine whether during the measurement period the employee averaged at least 30 hours of service per week. If the employee were determined to be an ACA-Eligible Employee during the measurement period, then the employee would be treated as an eligible employee with respect to the medical plan during a subsequent "stability period," regardless of the employee's number of hours of service during the stability period, so long as he or she remained an employee. For an employee determined to be an ACA-Eligible Employee during the measurement period, the

stability period would be a period 12 consecutive calendar months that follows the measurement period and is no shorter in duration than the measurement period.

The standard (ongoing) measurement period will run from November 1 through October 31. This period will determine eligibility for January 1st open enrollment. The initial measurement period will start with the hire date, and will span a 12-month period

2. HEALTH BENEFITS

a. *Medical Benefit*

The Plan provides medical and prescription drug coverage for participants and their eligible dependents and offers the following medical benefit options, as more fully described in the Benefit Booklets. For ACA-Eligible Employees and their eligible dependent children, the following program is available: Aetna Choice POS II – Basic Managed Care (Bronze). For Full-Time Eligible Employees and their Eligible Dependents, the following programs are available: Aetna Choice POS II – Basic Managed Care (Bronze)Aetna Managed Choice Premium Managed Care Gold Plus Plan, Aetna Health Fund HCRA Gold Plan, Aetna Choice POS II No Referral Gold Plan and Aetna Managed Care Silver-Plus Plan. Aetna Teladoc is included with these programs. All medical benefits are self-insured by the Company.

b. *Dental Benefit*

The Plan provides dental coverage for participants and their eligible dependents as indicated below and as more fully described in the Benefit Booklets. The dental benefit is provided under an insurance policy issued by MetLife. Coverage is available only to Full-Time Eligible Employees and their Eligible Dependents.

c. *Vision Benefit*

The Plan provides vision coverage for participants and their eligible dependents as indicated below and as more fully described in the Benefit Booklets. The vision benefit is provided under an insurance policy issued by EyeMed. Coverage is available only to Full-Time Eligible Employees and their Eligible Dependents.

d. Other Health Benefits

The Plan also provides the following programs that are more fully described on the PRRC Portal Page – Count Me In:

- Pinnacle Care health advisory program;
- Cancer care program through Memorial Sloan Kettering Cancer Center and Memorial Hospital for Cancer and Allied Diseases,
- Meru Health – a 12-week program clinically proven to reduce anxiety, stress and depression;

- Prudent RX specialty drug co-pay program which will automatically find and help Plan participants apply any relevant manufacturer copay assistance to the member's cost share. The PrudentRX program is described further in Appendix I;

- Aetna's One Choice Compassionate Care Program, which offers care management and services to Plan participants and their families who are managing the complex and emotional issues involved with advanced illness

3. LIFE INSURANCE BENEFIT

The Plan provides **basic** life and accidental death and dismemberment coverage to participants who are Full-Time Eligible Employees, as more fully described in the Benefit Booklets. The life insurance benefit is provided under an insurance policy issued by The Hartford. The Plan provides **optional** life and accidental death and dismemberment coverage to participants who are Full-Time Eligible Employees and their Eligible Dependents, as more fully described in the Benefit Booklets. The life insurance benefit is provided under an insurance policy issued by The Hartford.

4. DISABILITY BENEFIT

The Plan provides long-term disability insurance to participants who are Full-Time Eligible Employees as more fully described in the Benefit Booklet. The long-term disability benefit is provided under an insurance policy issued by The Hartford.

5. CORE AND ELECTIVE BENEFITS

"**Core Benefits**" refers to those benefits the cost of which is fully paid by the Employer. "**Elective Benefits**" are those benefits that an Eligible Employee has the opportunity to elect. The Core Benefits and Elective Benefits are indicated below. The required participant contributions for Elective Benefits may be paid for on a pre-tax basis under a cafeteria plan or flexible benefits plan as indicated in part 6 below and as discussed further in Section C.2 of this Summary.

Benefit	**Core or Elective**
Basic Life Insurance	Core
Long-Term Disability	Core
Medical	Elective
Dental	Elective
Vision	Elective
Optional Supplemental Group Life and Accidental Death & Dismemberment Insurance	Elective

6. CAFETERIA PLAN OR FLEXIBLE BENEFITS PLAN

☐ The Company **does not** maintain a cafeteria plan or flexible benefits plan.

☒ The Company maintains a cafeteria plan which allows participants to pay participant contributions on a pre-tax basis (or after-tax basis, as applicable) for health benefits and optional life and accidental death and dismemberment coverage (other than dependent life insurance coverage). Participant contributions for coverage of an eligible dependent of an ACA-Eligible Employee are made on an after-tax basis under the cafeteria plan.

☐ The Company maintains a flexible benefits plan which allows participants to pay participant contributions on a pre-tax basis (or after-tax basis, as applicable) for health benefits and optional life and accidental death and dismemberment coverage (other than dependent life insurance coverage) and which offers:

☐ Dependent care flexible spending account benefit (available only to participants who are Full-Time Eligible Employees):

Minimum per Period of Coverage:

Maximum per Period of Coverage:

Run-Out Date:

☐ Grace period shall apply

☐ Health care flexible spending account benefit (available only to participants who are Full-Time Eligible Employees):

Minimum per Period of Coverage:

Maximum per Period of Coverage:

Run-Out Date:

☐ Grace period applies (Do not select if Health FSA carryover selected)

☐ Health FSA carryover applies (Do not select if grace period selected)

Participant contributions to a flexible benefits plan for coverage of an eligible dependent of an ACA-Eligible Employee are made on an after-tax basis under the flexible benefits plan. Flexible spending account benefits are described further in Section D of this Summary.

7. INSURERS AND THIRD PARTY ADMINISTRATORS

Medical/Prescription Drug
Aetna
PO Box 981106
El Paso, TX 79998-1106
Member Services: 1-877-461-0933
RX Member Services: 1-800-238-6279

Dental
MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282
P: 800-942-0854

Vision
EyeMed Vision Care
4000 Luxottica Place
Mason, Ohio 45040
513-765-4094
For out of network claims, the following applies:

First American Administrators
Attn: OON Claims
PO Box 8504
Mason, OH 45040
EyeMed Email: OONClaims@eyemed.com
Fax: 866.293.7373

Long-Term Disability Claims:
The Hartford
PO Box 14869
Lexington, KY 40512
P: 888-301-5615

Life Claims:
The Hartford
PO Box 14299
Lexington, KY 40512-4299
P: 888-563-1124

C. ELIGIBILITY AND PARTICIPATION

1. IN GENERAL

Except as otherwise provided in a Benefits Booklet, you are eligible to participate in the Plan (an "Eligible Employee") if you are a Full-Time Eligible Employee or an ACA-Eligible Employee, as set forth in the **BENEFIT OVERVIEW** (Section B). You will commence participation in the Plan with respect to a specific Benefit on the first day of the month that coincides with or immediately follows completion of thirty (30) days of employment, subject to completion of the enrollment forms required by the Plan Administrator. For purposes of counting completed days of employment, each day you are employed by the Company is taken into account, even days of employment during which you did not qualify as either an ACA Eligible Employee or a Full-Time Eligible Employee.

If you are a Full-Time Eligible Employee, you are automatically covered by the Core Benefits for which you are eligible. If you are a Full-Time Eligible Employee or an ACA-Eligible Employee you may elect coverage under any of the Elective Benefits for which you are eligible, as specified in the **BENEFIT OVERVIEW** (Section B).

2. THE PRE-TAX ADVANTAGE

If specified in the **BENEFIT OVERVIEW** (Section B), your contributions for Elective Benefits may be made on a pre-tax basis under a cafeteria plan or flexible benefits plan, as the case may be, except for dependent life insurance and the cost of coverage provided for covered individuals who do not qualify as your dependents under Internal Revenue Code ("Code") rules (Section 152), in which case your contributions will be made on an after-tax basis under this Plan. For instance, contributions for civil union partners or domestic partners who are not your dependents under the Code must be made on an after-tax basis under this Plan.

You may select an Elective Benefit by completing the election and/or enrollment forms and a salary reduction agreement for benefits paid on a pre-tax basis and a payroll deduction agreement for benefits paid on a post-tax basis. During each open enrollment period prior to the beginning of the Plan Year you will receive information regarding the required participant contributions for Elective Benefits. Such information is incorporated herein by reference.

If you elect coverage for which your contributions will be paid on a "pre-tax" basis, your gross earnings will be reduced by the amount you are required to pay for the benefits you selected. You will be taxed for federal income tax purposes only on the remaining amount of your gross earnings and not on the amounts used to pay for these benefits. The pre-tax contributions made for the benefits are not subject to Social Security taxes. Therefore, your Social Security benefits may be reduced if you elect these benefits, rather than taxable compensation. Generally, the reduction is a small one. However, the impact varies from case to case and cannot be predicted by the Company.

In return for this pre-tax advantage, the law provides that your election must be irrevocable for the year. You may make mid-year changes only in response to and consistent with certain events as described in Section F. Any amounts not expended for benefits during the

year will be forfeited.

3. CESSATION OF PARTICIPATION

Unless the applicable Benefits Booklet provides otherwise, your coverage for benefits under the Plan ends on the last day of the month in which you cease to be an Eligible Employee (because of retirement, termination of employment or any other reason) or if earlier, the date you begin an approved unpaid leave of absence (other than FMLA leave), your date of death or the date the Plan is terminated. Coverage also ceases upon your election subject to the rules in Section F or if you fail to make required contributions.

Coverage you have elected for your Eligible Dependents under any benefit ceases when your coverage ceases or, if earlier, when such individual ceases to be your Eligible Dependent. If you are required to make contributions for certain coverage that you have elected for yourself and your Eligible Dependent(s), then such coverage will cease if you fail to make the required contributions. Further, all health and welfare benefit coverage provided under this Plan will cease on the date the Plan is terminated.

Although health benefit coverage may otherwise cease, you may be entitled to elect COBRA continuation coverage for group health benefits as provided in Section E.1. You may also be able to convert some of the group insurance coverage to personal coverage. Please consult the applicable Benefits Booklet.

D. FLEXIBLE SPENDING ACCOUNT BENEFITS

1. HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

If the Company maintains a flexible benefits plan that offers health care flexible spending account benefits, as indicated in the **BENEFIT OVERVIEW** (Section B), you may elect to reduce your compensation on a pre-tax basis and have such amounts credited to a Health Care Flexible Spending Account under the Plan. Your contributions are made on a pre-tax basis so you avoid federal income and Social Security taxes on the amount you set aside.

The amount you contribute can then be used to reimburse you for otherwise unreimbursed qualified health care expenses that you, your spouse (as defined under federal law) and your dependents (who qualify as dependents for purposes of Internal Revenue Code section 152) incur during the Plan Year and during the time you are a participant with respect to such Account.

Grace Period. If the grace period option applies as indicated in the **BENEFIT OVERVIEW** (Section B), a participant who has a balance in his or her Account at the end of the Plan Year may continue to receive reimbursement for eligible expenses incurred within a 2½ month grace period following the end of the Plan Year (*i.e.,* until March 15). Any amounts not used to reimburse eligible expenses incurred before the end of any grace period are forfeited.

Carryover. If the Health FSA carryover option applies as indicated in the **BENEFIT OVERVIEW** (Section B), you may carry over up to $570 (or such higher limit as is permitted in applicable regulations and guidance) of unused amounts remaining in your health care flexible

spending account at the end of a Plan Year to be used for medical care expenses incurred during the next Plan Year. (This applies only to the health care flexible spending account; carryovers are not permitted under the dependent care flexible spending account.) No more than $570 (or such higher limit as is permitted in applicable regulations and guidance) of your unused health care flexible spending account amount for a Plan Year may be carried over for use in the next Plan Year. Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and they will not count toward the maximum dollar limit on annual salary reductions under the health care flexible spending account. If you are otherwise eligible for the health care flexible spending account for a Plan Year but you do not make a health care flexible spending account election for that Plan Year, you may still use any carryovers from the preceding Plan Year for current or preceding Plan Year medical care expenses (in accordance with Plan terms). However, you must be a participant in the health care flexible spending account as of the last day of the Plan Year to benefit from the carryover. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless a COBRA election is made.

You decide how much to contribute to your Account based on how much you expect to spend on qualified health care expenses during the calendar year up to the dollar limit indicated in the **BENEFIT OVERVIEW** (Section B). If you don't expect to have any qualified health care expenses in the calendar year, you may not want to contribute anything because amounts not used for eligible expenses during the year or any grace period following the end of the year, if applicable, are forfeited.

You may use your health care flexible spending account to pay health-related expenses for yourself, your spouse and your dependents regardless of the insurance coverage you have, whether through the Company or another source. As long as the expense is not reimbursed through any other source, you may submit the expense for reimbursement. The following are examples of eligible expenses --

- Health care plan deductibles, co-payments, and other out-of-pocket expenses which are not excludable. (See "Exclusions from Covered Expenses" below.)

- Medical expenses which generally are not covered until deductibles are met, such as doctors' office visits and prescription drugs.

- Medical, dental and vision expenses not covered under your health care plan but considered to be health care expenses under section 213(d) of the Internal Revenue Code -- e.g., vision exams and prescription eye wear; hearing exams and hearing aids; orthodontia, menstrual care products, etc.

- Charges for medicines, which generally include (1) prescription drugs, (2) insulin, and (3) over-the-counter drugs and medicines that are used to treat a medical condition.

Exclusions: There are certain expenses which may not be reimbursed by your Account. These include --

- expenses reimbursed through any other policy or plan, including any health insurance plan for your spouse or dependent child, Medicare, or any other Federal or state program;

- expenses specifically prohibited by the IRS, including medical insurance premiums paid by your spouse at his/her company or by you;

- expenses incurred before you became eligible to participate;

- expenses which are incurred in another calendar year (other than during any grace period, if applicable);

- expenses for which you claim a deduction or credit for federal income tax purposes;

- expenses for cosmetic surgery or similar procedures unless necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury from an accident or trauma, or disfiguring disease; and

- items that are merely beneficial to your general health such as dietary supplements and vitamins.

Your pre-elected contributions will be deducted in equal amounts throughout the year from your pay as long as you are eligible to participate. The amounts are then deposited in your Account. No single installment may exceed your gross pay for the pay period. Newly hired employees will normally have contributions deducted in equal installments during the remainder of the year unless otherwise noted.

Information regarding the procedures for reimbursement and the documentation required will be provided to you. Claims for expenses not considered eligible under IRS rules will be disallowed. You will be reimbursed for eligible expenses up to the amount you elected for the year regardless of the amount of your contributions as of such date. If you have any questions regarding the procedures for reimbursement, contact the Third-Party Administrator of Health Care Flexible Spending Account Benefits identified in **BENEFIT OVERVIEW** (Section B).

In order for an expense to be reimbursable for a particular calendar year (or any grace period), the expense must be for services that were rendered in that calendar year (or any grace period). It is important to remember that what determines whether an expense is reimbursable is when you incur the expense and <u>not</u> when you receive the bill for those services. Claims for eligible expenses incurred during a calendar year (and any grace period) must be submitted by the run-out date identified in **BENEFIT OVERVIEW** (Section B) following the end of such calendar year (and any grace period).

- Once you have made your health care flexible spending account election, you may not change the amount of your Health care flexible spending

account contributions until the next calendar year unless a revocation or change is permitted as provided under Section F.

- Any amount remaining in your Account after all eligible claims for that calendar year (and any grace period, if applicable) have been reimbursed will be forfeited (unless the carry over option has been selected in **BENEFIT OVERVIEW** (Section B)). You cannot receive any of your deposits back if you do not use the full amount you have contributed, and you cannot carry unused amounts forward into another calendar year beyond any grace period, if applicable (unless otherwise indicated in **BENEFIT OVERVIEW** (Section B)). For these reasons, it is important to estimate your anticipated expenses carefully before you commit a portion of your pay to the Plan.

Expenses incurred during a Plan Year will be reimbursed first from your unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year (to the extent the carry over option has been selected in **BENEFIT OVERVIEW** (Section B)). Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay your preceding Plan Year expenses, cannot exceed $500, and will count against the $500 maximum carryover amount. Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it.

If you terminate employment with the Company for any reason, your health care flexible spending account can only be used to pay expenses incurred prior to your termination unless you have a right to, and elect, continuation coverage. All claims, however, must be submitted by the run-out date identified in **BENEFIT OVERVIEW** (Section B) of the following calendar year.

If you die, your surviving spouse or dependents may continue to use any balance in your health care flexible spending account to obtain reimbursements for covered expenses that were incurred prior to your death. These claims must be submitted by the run-out date identified in **BENEFIT OVERVIEW** (Section B) of the year following the year in which you die.

If coverage under the Account would cease, you, your spouse and/or dependents may also have a right to elect continuation coverage. See "Your Rights under COBRA" in Section E.1, and in particular, the health care flexible spending account rule at the end thereof.

2. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

If the Company maintains a flexible benefits plan that offers dependent care flexible spending account benefits, as indicated in the **BENEFIT OVERVIEW** (Section B), you may elect Dependent Care Flexible Spending Account coverage. Under this coverage, you use your Dependent Care Flexible Spending Account to pay dependent care expenses for children under age 13, or certain other dependents, incurred so that you can work, provided you can claim a deduction for these individuals on your federal income tax return. The Plan can be used to cover expenses for babysitters and eligible day care centers (to be eligible, a day care center must meet

all applicable state and local regulations, provide care for more than six non-resident people, and receive a fee for such services, whether or not for profit).

Dependent care expenses are covered only if (i) the dependent (your child, grandchild, sibling or stepsibling or their descendant) lives with you (for more than one-half of the year), is under age 13 and provides less than one-half of his or her support; or (ii) the individual is your spouse who is physically or mentally incapable of self-care and lives with you (for more than one-half of the year); or (iii) the dependent, regardless of age, is physically or mentally incapable of self-care, lives with you (for more than one-half of the year) and has gross income less than the exemption amount and you provide over one-half of his or her support. If services are provided outside your home, an incapacitated spouse or dependent who is age 13 or over must regularly spend at least eight hours a day in your household.

Your deposits for dependent care expenses are limited to the maximum amount identified in **BENEFIT OVERVIEW** (Section B). Reimbursement for dependent care is limited to employment-related expenses as defined by the Internal Revenue Code which are excludable from your income. The following limitations for dependent care reimbursements apply --

(1) Both you and your spouse (unless your spouse is a full-time student or is disabled) must work in order for dependent care expenses to be excludable from your income for Federal income tax purposes.

(2) Dependent care expenses are not excludable to the extent they exceed the lesser of--

- your earned income; or
- the earned income of your spouse.

For example, if you earn more than your spouse and your spouse earns $3,000 per year working part-time, $3,000 is the maximum you can exclude for dependent care costs (assuming you have allocated at least that amount to your Account).

(3) Your Dependent Care Flexible Spending Account may not be used to exclude payments to anyone who can be claimed as a dependent on your or your spouse's tax return, or to your own child or stepchild under age 19. For example, you cannot exclude payments you make to your 17-year-old daughter for babysitting your three-year-old son.

(4) There are certain other expenses which may not be reimbursed. These include --

- expenses reimbursed through any other policy or plan;
- expenses incurred before you became eligible to participate;
- expenses which are incurred in another calendar year (except for any grace period, if applicable);

- expenses for which you claim a deduction or credit for federal income tax purposes; and

- expenses that the IRS would not permit to be claimed as a deduction or credit for federal income tax purposes.

Note: For many people, making contributions to their Dependent Care Flexible Spending Account will be more tax-effective to cover dependent care expenses than taking a dependent care tax credit. Others may find that it is more tax-effective to take a dependent care tax credit on their Federal income tax return at the end of the year. Employees who use the Dependent Care Flexible Spending Account (or who take a tax credit) will be required to provide the name and taxpayer ID number of each provider on their tax return. **For specific advice about your personal situation, you should consult your own tax advisor.**

Your pre-elected contributions will be deducted in equal amounts throughout the year from your pay as long as you are eligible to participate. The amounts are then deposited in your Account. No single installment may exceed your gross pay for the pay period. Newly hired employees will normally have contributions deducted in equal installments during the remainder of the year unless otherwise noted.

Information regarding the procedures for reimbursement and the documentation required will be provided to you. Claims for expenses not considered eligible under IRS rules will be disallowed. You will be reimbursed up to the balance in your Account and any excess amount will be carried over to the next reimbursement period. If you have any questions regarding the procedures for reimbursement, contact the Plan Administrator.

The amount you elect for a Plan Year is used to reimburse expenses incurred in that Plan Year (the calendar year) and while you are a participant with respect to the Dependent Care Flexible Spending Account.

Grace Period. If the grace period option applies as indicated in the **BENEFIT OVERVIEW** (Section B), a participant who has a balance in his or her Account at the end of the Plan Year may continue to receive reimbursement for eligible expenses incurred within a 2½ month grace period following the end of the Plan Year (*i.e.,* until March 15). Any amounts not used to reimburse eligible expenses incurred before the end of the Plan Year (and any grace period) are forfeited.

In order for an expense to be reimbursable for a particular calendar year (and any grace period, if applicable), the expense must be for services that were rendered in that calendar year (and any grace period, if applicable). It is important to remember that what determines whether an expense is reimbursable is when you incur the expense and not when you receive the bill for those services. Claims for eligible expenses incurred during a calendar year (and any grace period, if applicable) must be submitted by the run-out date identified in **BENEFIT OVERVIEW** (Section B) following the end of such calendar year.

Any amount remaining in your Account after all eligible claims for that calendar year (and

any grace period, if applicable) have been reimbursed will be forfeited. You cannot receive any of your deposits back if you do not use the full amount you have contributed, and you cannot carry unused amounts forward into another calendar year. For these reasons, it is important to estimate your anticipated expenses carefully before you commit a portion of your pay to the Plan.

E. LEGAL RIGHTS WITH RESPECT TO GROUP HEALTH BENEFITS

1. YOUR RIGHTS UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT COBRA

You have a right to choose continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") for yourself and your covered spouse and dependent children if you lose group health plan coverage (your Health Benefits) under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). (A child who is born to or placed for adoption with a participant during a period of COBRA coverage is also considered a covered dependent child.) If required under applicable law, the Company will also extend continuation coverage on the same basis to a covered eligible civil union partner or domestic partner and a covered eligible civil union partner's or domestic partner's dependent.

If you are the participant's spouse (or if required under applicable law, if you are the participant's eligible domestic partner/civil union partner) you have the right to choose COBRA continuation coverage for yourself and your covered dependent children if you lose group health plan coverage under the Plan for any of the following four reasons, known as "qualifying events":

- the death of the participant;
- a termination of the participant's employment (for reasons other than gross misconduct) or reduction in the participant's hours of employment;
- divorce or legal separation from your spouse or, if required under applicable law, cessation of the eligible civil union partner or domestic partner relationship; or
- entitlement of the participant to Medicare.

A covered "dependent child" of a participant has the right to continue coverage under COBRA if health coverage under the Plan ends because of any of the following five qualifying events:

- death of the participant;
- termination of the participant's employment (for reasons other than gross misconduct) or reduction in the participant's hours of employment with the Employer;
- divorce or legal separation of the participant and spouse or, if required under applicable law, cessation of the participant's civil union or domestic partner

relationship*;*

- entitlement of the participant to benefits under Medicare; or
- ineligibility for coverage as a dependent child under this Plan.

You or a family member or legal representative must inform the Plan Administrator within 60 days of the date of a divorce, legal separation, or loss of dependent child status under this Plan. If the Plan Administrator is not notified within 60 days, you will lose the right to continue coverage. You must provide notice in writing to the Plan Administrator.

The notice must state the nature of the event, the date of the event, the covered individuals who are affected, and the identity of the person providing the notice and his or her relationship to the affected individual(s). The Plan Administrator may require copies of documents evidencing the event, such as the court order evidencing divorce or legal separation.

When the Plan Administrator is notified on a timely basis that a qualifying event has occurred, you will be notified that you have the right to choose COBRA continuation coverage. You have 60 days from the later of the date you are notified about COBRA or the date of loss of your coverage to inform the COBRA Administrator that you want to continue your coverage by completing and submitting the required forms. If you do not choose COBRA continuation coverage, your group health coverage under this Plan will END.

Generally, if you choose to continue your coverage, you may be charged up to 102 percent of the full cost to the Plan for your coverage. You will be required to pay your first premium payment within 45 days from the date you choose to continue your coverage. If you lose health coverage under the Plan due to a reduction in the hours of the participant's employment or the termination of the participant's employment, you may continue your coverage for 18 months. However, the 18-month coverage period for covered spouses, eligible civil union or domestic partners, and dependent children may be extended to 36 months if another event (death, divorce or legal separation, Medicare entitlement, or ineligibility for dependent coverage) occurs during the initial 18-month period. For all other qualifying events, coverage may be continued for up to 36 months. You or a family member or legal representative must inform the COBRA Administrator in writing if you believe that you, your covered spouse, covered eligible civil union or domestic partner, or covered dependent children are entitled to extend the period of continuation coverage. The notice must meet the requirements set forth above.

Your entitlement to Medicare will not be a qualifying event for your family members if they remain covered by the Plan because you are still employed. However, if they later lose coverage under the Plan because you terminate employment or have a reduction in hours, their continuation coverage period will be 36 months from the date that you previously became entitled to Medicare (if that date would be longer than the 18-month period measured from your termination or reduction in hours). If you are eligible for 18 months of COBRA continuation coverage, coverage may be extended for up to an additional 11 months if you are (or a covered spouse, eligible civil union partner, domestic partner or child is) determined to be disabled under the rules for Social Security benefits within 60 days of the date of your termination of employment or reduction in hours of employment. You may be charged up to 150 percent of the cost of the

coverage for the 19th through the 29th month of coverage. To extend coverage, you must notify the Plan Administrator in writing at the mailing address or email address set forth above of a determination of disability within 60 days after the later of the date the determination is made or the date coverage would be lost as a result of the qualifying event and before the end of the first 18 months of COBRA coverage. The notice must state the identity of the covered individual determined to be disabled, the date the disability was determined to have commenced, and the identity of the person providing the notice and his or her relationship to the disabled individual. The notice must be accompanied by a copy of the Social Security disability determination.

Your COBRA continuation coverage will end on the first to occur of the following:

- the Company no longer provides group health benefits coverage to any of its employees;
- the premium for your continuation coverage is not timely paid;
- you become covered under another group health plan that does not contain any exclusion or limitation with respect to a pre-existing condition that you have and that would apply to deny you coverage;
- you become entitled to Medicare; or
- coverage is extended for up to 29 months due to a disability and there has been a final determination that the disabled individual is no longer disabled. You must notify the COBRA Administrator within 30 days of the date of any final determination that disability has ended.

Health Care Flexible Spending Account Rule. If the Company maintains a flexible benefits plan that offers health care flexible spending account benefits as indicated in the **BENEFIT OVERVIEW** (Section B) and if you, your covered spouse, eligible civil union partner, or dependent loses coverage under the Health Care Flexible Spending Account as a result of one of the qualifying events specified above, the right to elect continuation coverage applies only to continued coverage for the remainder of the Plan Year (the calendar year) and only if the amount that could be received for the remainder of such year exceeds the amount required to be paid for such coverage for the remainder of the year. If the Health FSA carryover option applies as indicated in the **BENEFIT OVERVIEW** (Section B), qualified beneficiaries who continue coverage through December 31 may carry over up to $500 of unused health care flexible spending account amounts remaining at the end of a Plan Year in accordance with the Plan's provisions regarding health care flexible spending account carryovers.

2. YOUR RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Plan, as required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), provides the following benefits for a Plan participant or beneficiary who is receiving health care benefits in connection with a mastectomy:

- 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 treatment of physical complications at all stages of mastectomy, including lymphedemas.

Coverage for these benefits or services will be provided in consultation with the participant's or beneficiary's attending physician.

Coverage for the mastectomy-related services or benefits required under the WHCRA are subject to the same deductibles and coinsurance or co-payment provisions that apply with respect to other medical or surgical benefits provided under your medical coverage described above at Part E. Contact the Plan Administrator for more information.

3. YOUR RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights relating to group health benefits. These provisions apply to your Health Benefits (referred to as "medical coverage" below).

a. Special Enrollment Rights. HIPAA amended the Code, ERISA, and the Public Health Service Act to provide special enrollment rights to certain individuals who earlier declined group health coverage and later wish to elect enrollment for themselves, one or more Eligible Dependents, or both themselves and their dependents. Group health plans and any insurer offering group health coverage must provide special enrollment periods to certain individuals eligible for group health coverage.

An employee who is eligible, but not enrolled for medical coverage under the terms of the Plan (or his or her dependent if the dependent is eligible but not enrolled for coverage) is permitted to enroll for medical coverage under the Plan if:

- the employee or dependent was covered under a group health plan or had health insurance coverage at the time the Plan's medical benefits were previously offered to the employee or individual;
- the employee stated in writing at the time he or she declined coverage that the reason for declining medical coverage under the Plan during enrollment was due to coverage under another group health plan or health insurance coverage;
- the coverage of the employee or dependent who has lost the coverage was (i) under COBRA continuation coverage and the COBRA coverage was exhausted, or (ii) was not covered under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated; and
- the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contribution (as described in (ii) above).

In addition, if the employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her dependents, provided that the employee requests enrollment not later than 30 days after the marriage, birth, adoption or placement for adoption.

If the employee or dependent is covered under a Medicaid plan or a state children's health insurance program ("CHIP") and that coverage is terminated as a result of loss of eligibility, or the employee or dependent becomes eligible for a premium assistance subsidy for the Plan under Medicaid or a state CHIP, the employee must request enrollment in the Plan within 60 days after such loss of coverage or new eligibility.

b. Nondiscrimination Based on Health Factor. The Plan generally may not establish any rule for eligibility to enroll in the Plan (including continued eligibility) that discriminates against an employee or dependent because of a Health Factor or charge higher premiums on account of a Health Factor. "Health Factors" include with respect to an individual (i) health status; (ii) medical condition (including both physical and mental illnesses); (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information; (vii) evidence of insurability (includes conditions arising out of acts of domestic violence and activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities); or (viii) disability.

c. Privacy Rules. HIPAA (including the Health Information Technology for Economic and Clinical Health Act) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the privacy notice, which was previously distributed to you. You can obtain a copy of the privacy notice from the Plan Administrator. Privacy notices for the insured benefits are also available from the insurers.

This Plan, and the Company, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please contact the HIPAA Privacy Official at the Plan Sponsor's address identified under **BASIC FACTS** (Section A).

4. YOUR RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 ("NMHPA")

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).

5. QUALIFIED MEDICAL CHILD SUPPORT ORDERS ("QMCSOs")

The Plan is required to provide health benefits in accordance with the applicable provisions of any "qualified medical child support order" ("QMCSO") as required under ERISA. In general, the term qualified medical child support order means a "medical child support order" which requires the Plan to provide a child of a participant with health coverage under the Plan where the child would not otherwise be covered; for example, if the child would lose coverage as a result of a parent's divorce. A medical child support order is a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction. It also includes a National Medical Support Notice that meets the requirements of the regulations of the Department of Labor set forth at 29 CFR §2590.609-2. Under a QMCSO, the Plan can be ordered to enroll the child in any available health care expense coverage option and deduct the applicable cost from the participant's wages. Accordingly, the Plan Administrator has the right to make any necessary changes to the participant's medical coverage elections in order to provide the child(ren) with the coverage required by the QMCSO, and to authorize on the participant's behalf the payment of any additional premium costs from the participant's wages. The Plan Administrator has established procedures for qualifying medical support orders. Participants and beneficiaries may obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

6. SPECIAL RULES REGARDING MILITARY LEAVES

An employee on leave will be entitled to coverage no less favorable than as required under the Uniformed Services Employment and Reemployment Right Act ("USERRA") provided, however, that coverage pursuant to the terms of USERRA and COBRA coverage will run concurrently.

F. PRE-TAX ELECTIONS

1. ELECTION CHANGES

As provided above and if specified in the **BENEFIT OVERVIEW** (Section B), you may elect to reduce your compensation on a pre-tax basis to pay your required contributions for your medical, prescription, dental and vision benefits for yourself and your Eligible Dependents. In return for the pre-tax advantage, your election is generally binding for the year. The Plan provides that the time period for making changes is determined by the Plan Administrator. Currently, you are permitted to make election changes provided you notify the Plan Administrator within **30 days**

of the event and timely submit your election change form and **only if** you meet the circumstances set forth below. Benefit election changes take effect as of the later of the date that you complete and return the election change form, or the date the applicable event occurs. However, if the election change is due to the birth or adoption of a child (or the placement of a child for adoption), the election change will take effect as of the date of the birth or adoption (or placement for adoption).

a. Change in Status. The events that constitute a "change in status" include the following:

- Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.
- Events that change your number of dependents, including birth, death, adoption, and placement for adoption. (Note: Gaining or losing a dependent who is not a tax dependent such as a parent will not be considered an allowable event for an election change.)
- Events that change your employment status or the employment status of your spouse or dependents that affect your eligibility for benefits, including a termination or commencement of employment, reduction or increase in hours, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in work site.
- Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage.
- A change in your place of residence, the place of residence of your spouse or dependent that affect eligibility for benefits under the plan.

General Consistency Rules: You may only make an election change pursuant to a change in status if your requested election change is consistent with that change in status. The Plan Administrator has sole discretion to determine whether a requested change is consistent with the change in status. Your election change will be consistent with the change in status only if the change is on account of and corresponds with a change in status *that affects eligibility for coverage under the Plan*. A change in status that affects eligibility under the Plan includes a change in status that results in an increase or decrease in the number of an employee's family members or dependents who may benefit from coverage under the Plan. *Please note that it is possible to experience a "change in status" event, but not have the change affect your eligibility to participate in the Plan's benefits or change benefit elections. In such case, you will not be able to make a change in your elections.*

Exception for COBRA Qualifying Events: If you, your spouse or dependent become eligible for continuation coverage under the Plan due to a COBRA qualifying event, you may elect to increase your contributions in order to pay for the continuation of coverage.

b. Judgment, Decree or Order. If there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a

Qualified Medical Child Support Order, *see* Section E.5, that requires a change in accident or health coverage for your child or foster child who qualifies as your dependent, you or the Plan Administrator may make an election change to add or drop coverage consistent with the terms and scope of the order.

c. Entitlement to Medicare or Medicaid. If you or your spouse or dependent becomes entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines), you may make a corresponding prospective election change to cancel or reduce coverage under the Plan. Similarly, if you or your spouse or dependent loses eligibility for Medicare or Medicaid, you may make a corresponding prospective election change to commence or increase coverage under the Plan.

d. Significant Cost or Coverage Changes.

- *Automatic Changes:* If there is an increase or decrease in the cost of a benefit, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective change to your premium election, to cover the change in cost.

- *Significant Cost Changes:* If the cost charged to employees significantly increases or decreases during the Plan Year, as determined by the Plan Administrator, you may be allowed to make a new election for the option with the decreased cost or with respect to the higher cost option to revoke your election, but you must elect similar coverage if available under the Plan.

- *Significant Curtailment without Loss of Coverage*: If coverage for you, your spouse or dependent is significantly curtailed under a benefit option during the Plan Year (without a total loss of coverage), you may revoke your election and make a new prospective election for similar coverage that is offered under the Plan. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided under the benefit option that constitutes reduced coverage generally. Thus, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

- *Significant Curtailment with Loss of Coverage*: If you, your spouse or dependent lose coverage under a benefit option during the Plan Year, you may revoke your election and make a new prospective election for similar coverage that is offered under the Plan, or drop coverage if no similar benefit is available. A substantial decrease in the medical care providers available under a benefit option or a reduction in the benefits for a specific type of medical condition or treatment with respect to which you or your spouse or dependent is receiving treatment may constitute a loss of coverage.

- *Addition or Improvement of a Benefit Option*: If the Plan adds a new benefit type or new option under an existing benefit during the Plan Year, or if coverage under an existing benefit or option is significantly improved during the Plan Year (i) Eligible Employees who are not participants may prospectively elect the new benefit; and (ii) current participants may revoke their existing elections of similar benefits and prospectively elect the new benefit or option.

- *Change in Coverage under Another Employer Plan*: You may make a prospective election change that is on account of and corresponds to a change made under another employer plan if such other plan is a cafeteria plan that permits election changes or has a plan year that is different from that of the Plan.

- *Loss of Coverage under Other Group Health Insurance*: You may make a prospective election change to add coverage for a spouse or dependent if you or your spouse or dependent lose coverage under a group health plan sponsored by a governmental or educational institution.

e. Special Family Medical Leave Act Requirements. An employee who takes leave under the Family Medical Leave Act of 1993 (FMLA) may either continue participation or revoke his election of any benefit.

f. HIPAA Special Enrollment Rights. If you gain the right to enroll in medical coverage or to add coverage for a family member under the special enrollment rights of HIPAA, *see* Section E.3, you may revoke an election for medical coverage during the Plan Year and make a new election.

g. Reduction of Hours. (Applies to only to Medical Benefits). If you were reasonably expected to average 30 hours of service or more per week and experience an employment status change such that you are no longer reasonably expected to average 30 hours of service or more per week, you may prospectively revoke your election for medical plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform that is effective no later than the first day of the second month following the month that includes the date the medical plan coverage is revoked.

h. Exchange Enrollment. (Applies to only to Medical Benefits.) If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for medical plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the medical plan coverage.

2. OPEN ELECTION PERIOD

You may change your elections during the open election period prior to the beginning of

each Plan Year, in accordance with such procedures as the Plan Administrator prescribes, which may include, in the Plan Administrator's discretion, an automatic renewal of your prior year elections (other than any Health Care Flexible Spending Account Benefit or Dependent Care Flexible Spending Account Benefit).

3. INITIAL ELECTION PERIOD

If you are newly hired during the Plan Year, in order to elect Elective Benefits for the remainder of the current Plan Year, you must return a completed election form to the Plan Administrator or its delegate before the end of the 30-day period following the date on which you first meet the eligibility requirements. If you are a newly eligible employee and do not enroll in an Elective Benefit during the above election period, you will be deemed to have elected no coverage with respect to that Elective Benefit under the Plan.

4. SPECIAL RULES REGARDING FMLA LEAVES

You are required to pay for benefits continued during an unpaid FMLA leave on a "pay-as-you-go" basis or provided the Plan Administrator so permits by advance withholding or catch-up payments upon return. Payments made during an unpaid FMLA leave on a "pay-as-you-go" basis must be made on the same schedule and in the same manner as payments would be made if you were not on FMLA leave but will be made on a post-tax basis.

If you revoke your elections for health benefits coverage during FMLA leave and then return to work in the same Plan Year as an Eligible Employee, you may reinstate your election(s) which were in effect immediately before the FMLA leave with respect to these benefits.

G. CLAIMS AND APPEALS UNDER THE PLAN

1. OVERVIEW

Claims for benefits must be submitted in writing to the Insurer or Third Party Administrator for the particular benefit (referred to in this Section as the "**processor**"), as identified in Section B.7. The participant or beneficiary who submits a claim is referred to as the "**claimant**." The processor may provide Benefits Booklets that set forth its own claim and appeal procedures that differ from those that appear below. Their procedures however, must, at a minimum, meet the time periods and criteria set forth below in order to comply with applicable law. In some instances, the processor's procedures may provide shorter processing periods. The claim and appeal procedures set forth herein are intended to comply with the regulations of the Department of Labor set forth at 29 CFR §2560.503-1 and shall be construed accordingly.

2. INITIAL CLAIM DETERMINATION

The processor shall make initial determinations as to the right of any claimant to a benefit under the Plan.

a. Group Health Claims. These include your Health Benefits claims. Health care claims can be urgent, pre-service or post-service claims and each has different response periods. In general urgent care claims are decided in 72 hours and pre-service claims in 15 days

but more detailed information is provided in your Benefits Booklets. Post-care claims must be decided not later than 30 days after receipt of the claim. The pre-service and post-care claims periods may be extended one time by the Plan for up to 15 days, provided that the processor both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15- or 30-day period, as applicable, 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 a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

b. Disability Claims. In the case of a disability claim, the processor must generally notify the claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. Additional procedures are described in the Benefits Booklet. If an extension of time for processing is required, the claimant will be notified of the extension prior to the termination of the initial 45-day period. In no event will the extension exceed the period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the processor expects to issue its determination.

c. Other Claims. With respect to all other claims, the processor shall notify the claimant of an adverse determination in a reasonable period of time, not to exceed 90 days from receipt of the claim unless the processor determines that special circumstances require an extension. In such case, the period may be extended an additional 90 days if written notice is given to the claimant prior to the end of the initial 90-day period. The notice shall set forth the special circumstances and the date by which a decision is expected.

3. MANNER AND CONTENT OF NOTIFICATION OF INITIAL CLAIM DETERMINATION

The processor shall provide a claimant with written or electronic notification of any adverse benefit determination made under the Plan. All such notifications shall set forth, in a manner calculated to be understood by the claimant:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- with respect to group health and disability claims, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol, or

other similar criterion was relied upon in making the adverse determination and the a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

- with respect to group health and disability claims, if the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- a description of the Plan's review procedures and the time limits applicable to such procedures (or with respect to group health claims involving urgent care, a description of the expedited review process applicable to such claims) and a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

Notifications of an adverse benefit determination involving a disability claim shall also include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (3) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

- if none exists, a statement that no specific internal rule, guideline, protocol, or other similar criterion exists which could have been relied upon in making the adverse determination; and

- a statement that the claimant is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Additional information may be required for medical/prescription/vision or disability benefits. Please see the applicable Benefits Booklet.

4. APPEAL PROCEDURE

With respect to time and manner for filing an appeal, a claimant or his authorized representative may request that the Appeals Administrator (the contact information for the Appeals Administrator will be designated in the claim denial) review the denial of a claim by the processor. Such request shall be made in writing and shall be presented to the Appeals Administrator not more

than 180 days with respect to a group health or disability claim or 60 days with respect to all other claims after receipt by the claimant of written notification of the denial of a claim. In the case of the denial of a group health claim involving urgent care, a request for a review may be made orally or in writing and all necessary information may be transmitted by telephone, facsimile, or other available similarly expeditious method. All claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All claimants shall also have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits, and the Appeals Administrator shall take into account all such information submitted without regard to whether such information was submitted or considered in the initial benefit determination.

In addition to the above, the Appeals Administrator who conducts the review of group health and disability claims shall be neither the processor who made the adverse determination nor a subordinate of that processor and the Appeals Administrator shall not give deference to the processor's initial adverse benefit determination. With respect to the review of a group health or disability claim that involves a medical judgment, including whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Appeals Administrator will consult with a healthcare professional who has appropriate training and experience in the relevant field of medicine, who was not consulted in connection with the denial of the claim and who is not that person's subordinate. If the advice of a medical or vocational expert is obtained in connection with the adverse benefit determination of a group health or disability claim, the claimant will have the right to learn the identity of such individual. Before an adverse benefit determination on review of a disability claim is issued, the claimant shall be provided, free of charge, as soon as possible and sufficiently in advance of the date on which such notice is required to be provided: (1) any new or additional evidence considered, relied upon or generated by the Plan, the insurer or other person making the benefit determination in connection with claim; and (2) any new or additional rationale on which an adverse benefit determination on review will be based.

Additional rules may also apply as described in the Benefits Booklets.

5. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL

The Appeals Administrator shall notify a claimant of the Plan's benefit determination on review as follows:

a. Group Health Claims

- *Urgent care claims*. The Appeals Administrator shall notify the claimant of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review.

- *Pre-service claims*. The Appeals Administrator shall notify the claimant of the benefit determination on review within a reasonable period of time

appropriate to the medical circumstances but not later than 30 days after receipt of the claimant's request for review.

- *Post-service claims*. The Appeals Administrator shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time but not later than 60 days after receipt by the Plan of the claimant's request for review.

b. Disability Claims. The Appeals Administrator shall notify the claimant of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the request for review, unless the Appeals Administrator determines that special circumstances require an extension. The extension cannot exceed an additional 45 days and notice must be provided to the claimant prior to the end of the initial 45-day period setting forth the special circumstances and the date by which a decision is expected.

c. Other Claims. The Appeals Administrator shall notify the claimant of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the request for review, unless the Appeals Administrator determines that special circumstances require an extension. The extension cannot exceed an additional 60 days and notice must be provided to the claimant prior to the end of the initial 60-day period setting forth the special circumstances and the date by which a decision is expected.

6. MANNER AND CONTENT OF NOTIFICATION OF APPEAL DETERMINATION

All decisions on review made by the Appeals Administrator shall be written, and in the case of an adverse determination, it shall be written in a manner calculated to be understood by the claimant, and shall include the following:

- the specific reasons for the adverse determination;
- the specific references to the pertinent Plan provision(s) on which the decision is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, or other information relevant to the claimant's claim for benefits;
- a statement describing any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring an action under section 502(a) of ERISA;
- with respect to group health and disability claims, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and the a

copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

- with respect to group health and disability claims, if the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- with respect to group health claims, the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Decisions on review of an adverse benefit determination involving a disability claim shall also include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (3) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

- if none exists, a statement that no specific internal rule, guideline, protocol, or other similar criterion exists which could have been relied upon in making the adverse determination; and

- in the statement regarding the claimant's right to bring an action under Section 502(a) of ERISA, any applicable contractual limitations period that applies to the claimant's right to bright such an action, including the calendar date on which the contractual limitations period expires for the claim.

Additional information may also be required for certain medical and disability claims. Please see the Benefits Booklets.

7. CONCURRENT CARE CLAIMS

If an ongoing course of treatment was previously approved for a specific period of time or a number of treatments and your request to extend the treatment is an urgent care claim, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to

the end of the approved treatment. If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to the applicable time frames.

8. EXTERNAL REVIEW

Under certain circumstances, you may have the right to obtain external review (that is, review outside of the Plan). The Benefit Booklets provide additional details regarding this right to external review.

9. CALCULATING TIME PERIODS

For purposes of this Section G, the period of time within which a benefit determination is required to be made shall begin at the time the claim or appeal is filed with the processor or Appeals Administrator in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies said filing. In the event the processor or Appeals Administrator extends a period of time due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

H. LOSS OF BENEFITS

1. TERMINATION OF COVERAGE

Section C.3 describes circumstances under which your coverage will cease. As stated in the "Introduction," the Company has reserved the right to amend or terminate the Plan and thus you will lose the right to future benefits if a benefit is eliminated or reduced or the Plan is terminated.

2. COORDINATION OF BENEFITS

If you (and/or your Eligible Dependents) incur expenses for which benefits are payable under the Plan and at the same time benefits are payable under any other plan, this Plan will coordinate benefits. The rules for determining the coordination of benefits are set forth in the applicable Benefits Booklets.

I. SUBROGATION AND REIMBURSEMENT

Unless otherwise provided in the applicable Benefits Booklet, in the event of any payment under this Plan, the Plan will be subrogated to all the rights of recovery of the participant or beneficiary (a "covered individual") arising out of any claim or cause relating to the injuries or illness for which benefits are being paid. By participating in and accepting benefits under the Plan, a covered individual agrees that (1) any amounts recovered from a third party will constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the covered individual),

(2) the covered individual will be a fiduciary of the Plan with respect to such amounts, (3) the covered individual will be liable for and agrees to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce these rights, and (4) the covered individual agrees to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of these rights.

J. YOUR ERISA RIGHTS

Plan participants, Eligible Employees, and all other employees of the Company are entitled to certain rights and protections under ERISA and the Code which apply generally to participants in employee benefit plans like the Plan. These laws provide that participants, Eligible Employees, and all other employees are entitled to:

Receive Information about Your Plan and Benefits

Specifically, you are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including Benefits Booklets, and if the Plan is required to file it, 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. If the Plan is required to file the Form 5500, you are also entitled to receive a summary of the Plan's annual financial report. Please note that if the Plan covers less than 100 employees, the Company is not required to file a Form 5500 annual report.

You are also entitled to obtain copies of all Plan documents governing the operation of the Plan, including Benefits Booklets, and an updated summary plan description upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and

reconsidered, and receive, free of charge, copies of the documents relating to the decision, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, you may file suit in a federal court if you request materials from the Plan in writing and do not receive them within thirty (30) days. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them (unless the materials were not sent because of reasons beyond the Plan Administrator's control). If your claim for benefits is denied, in whole or in part, or ignored, you may file suit in a state or federal court (after you exhaust the claims and appeals procedures in Section G). If Plan fiduciaries misuse the Plan's money, or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court. If you are successful, the court may order the person you have sued to pay court costs and legal fees. If you lose, the court may order you to pay; for example, if it finds your claim is frivolous.

Assistance with Your Questions

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, you should contact the nearest Area 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 hot line of the Employee Benefits Security Administration.

K. FUNCTION OF THE PLAN ADMINISTRATOR

The Plan Administrator (or its designees) shall have the authority to interpret the Plan, decide all questions of eligibility of persons to participate in the Plan, make findings of fact, correct any defect, and construe any uncertain or disputed term or provision in the Plan and this SPD, unless this function is the responsibility of an insurance company. The determinations made in the exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, you, your estate, your beneficiaries, and the Company. To the extent an insurer or other provider or a contract administrator exercises discretionary authority or discretionary responsibility over claims for specified benefits, it shall have the authority and discretion to construe any uncertain or disputed term or provision in its contracts, booklets, and certificates governing such benefits, or to determine the amount to be paid pursuant to a claim for such benefits.

Additionally, the Plan Administrator has the authority and responsibility to (i) adopt such regulations, rules, procedures, and forms consistent with the Plan that are deemed necessary or desirable for the administration of the Plan; and (ii) employ individuals and firms to provide legal and actuarial advice and counsel, as necessary, to assure that the provisions of the Plan are properly interpreted and administered.

L. LIMITATION ON ASSIGNMENT

To the extent permitted by law, no benefit, right or interest of any participant or beneficiary under the Plan will be subject to assignment, anticipation, alienation, sale, transfer, pledge, encumbrance, charge, garnishment, execution or levy of any kind (either voluntary or involuntary) by anyone (including but not limited to providers of benefits), except as otherwise required by law, such as a qualified medical child support order, and any such attempt shall be void. Notwithstanding the foregoing, any payment of benefits made directly by the claims administrator to a provider of benefits, if at all, shall be done as a convenience to the Plan, the participant or beneficiary and shall not constitute an assignment of benefits or an assignment of any other rights under the Plan.

Appendix I

PrudentRx Solution for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the PRRC, Inc. Health and Welfare Plan has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance, after satisfaction of any applicable deductible. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call 1-800-578-4403. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your deductible or out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to

be “essential health benefits” under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an “essential health benefit” under the Affordable Care Act is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.