

**GOODWILL OF WESTERN MISSOURI
AND EASTERN KANSAS
MEDICAL PLAN**

**SUMMARY PLAN DESCRIPTION
SUPPLEMENT**

JANUARY 1, 2018

The information in this Supplement is in addition to, and/or supersedes, the information in the Certificates of Insurance and/or Benefit Summaries for the individual benefits offered under the Goodwill of Western Missouri and Eastern Kansas Medical Plan (the “Plan”), as well as any Comprehensive Benefit Summary regarding the benefits under the Plan. Collectively, the certificates/summaries and this Supplement constitute the Summary Plan Description (“SPD”) for the Plan.

**GOODWILL OF WESTERN MISSOURI AND EASTERN KANSAS
MEDICAL PLAN**

**SUMMARY PLAN DESCRIPTION SUPPLEMENT
JANUARY 1, 2018**

This Summary Plan Description (SPD) is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded a Plan Participant by the underlying Plan or by any state law that is not pre-empted by ERISA, those legal rights supersede the rights set forth in this SPD.

GENERAL INFORMATION

Plan Name: Goodwill of Western Missouri and Eastern Kansas Medical Plan

Plan Sponsor's Name: Goodwill of Western Missouri and Eastern Kansas

Plan Sponsor's Address: 1817 Campbell Street
Kansas City, MO 64108

Plan Sponsor's Identification Number (EIN): 43-1125281

The Plan Sponsor is referred to in this document as the "Employer" or the "Company."

Participating Employer: The Helping Hand of Goodwill Industries / Extended
Employment Services
1817 Campbell
Kansas City, MO 64108
EIN: 43-1195708

The Employer and the Participating Employer are collectively referred to in this document as the "Company."

Plan Number: 510

Plan Year End: The Plan Year is the 12-month period beginning on January 1
and ending on the following December 31.

Welfare Benefit Plan Type:

Medical and Prescription Drug
Health Care Flexible Spending Account
Dental
Vision
Employee Assistance Program
Life
Accidental Death and Dismemberment

Short Term Disability
Voluntary Life
Voluntary Accidental Death and Dismemberment
Voluntary Accident
Voluntary Critical Illness

Plan Administrator: Goodwill of Western Missouri and Eastern Kansas
1817 Campbell Street
Kansas City, MO 64108
(816) 842-7425

Agent for Service of Legal Process: Goodwill of Western Missouri and Eastern Kansas
c/o Human Resources
1817 Campbell Street
Kansas City, MO 64108
(816) 842-7425

Service of Legal Process may also be made upon
the Plan Administrator.

SOURCES OF CONTRIBUTIONS TO THE PLAN AND PLAN FUNDING MEDIUM

The Plan is funded through Company contributions and, in certain circumstances, employee contributions. The health care flexible spending account program benefits are self-funded, meaning that benefits are paid out of the Company's general assets. All other benefits are fully insured through insurance policies purchased from insurance companies.

If a health insurance issuer ("Issuer") is responsible in whole or in part for the financing or administration of a benefit, please refer to your Insurance Card for the full name and address of the Issuer. Please refer to the applicable Certificate of Insurance to determine whether and to what extent benefits under the Plan are guaranteed under a contract or policy of insurance issued by the Issuer, and the nature of any administrative services (e.g., claims payment) provided by the Issuer.

ELIGIBILITY FOR PARTICIPATION AND BENEFITS

All active employees of the Company (and their eligible dependents, as defined in the applicable Benefit Summary) shall be eligible for employee assistance program benefits under the Plan on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

All active employees of the Company who are regularly scheduled to work 20 hours or more per week (and their eligible dependents, as defined in the applicable Certificates of Insurance and/or Benefit Summaries) shall be eligible for dental, vision, life, AD&D, voluntary accident, and voluntary critical illness benefits under the Plan on

the first day of the month coincident with or next following their completion of 60 days of continuous employment.

All active employees of the Company who are regularly scheduled to work 30 hours or more per week (and their eligible dependents, as defined in the applicable Certificates of Insurance and/or Benefit Summaries) shall be eligible for medical, prescription drug, health care flexible spending account program, short term disability, voluntary life, and voluntary AD&D benefits under the Plan on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

Employees (including temporary and seasonal employees) who are not regularly scheduled to work 30 hours or more per week (and their eligible dependents, as defined in the medical and prescription drug Certificate of Insurance and/or Benefit Summary) will also be eligible for medical and prescription drug benefits, but only if they first meet the definition of “full-time employee” under the Affordable Care Act of 2010 (based on the measurement period selected by the Company from time to time) and only when the applicable stability period (as selected by the Company) begins.

SUMMARY OF PLAN BENEFITS

Please refer to the attached Certificates of Insurance and/or Benefit Summaries for a description of the Plan’s benefits.

SPECIAL PROVISIONS

(Applies Only to Medical/Prescription Drug, Dental and Vision Benefits)

Please refer to the applicable Benefit Summary (or Certificate of Insurance) for the following information:

- ⇒ A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which the Participant or beneficiary will be responsible;
- ⇒ Any annual or lifetime caps or other limits on benefits under the Plan;
- ⇒ The extent to which preventive services are covered under the Plan;
- ⇒ Whether and under what circumstances existing and new drugs are covered under the Plan;
- ⇒ Whether and under what circumstances coverage is provided for medical tests, devices, and procedures;
- ⇒ Provisions governing the use of network providers;
- ⇒ The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;

- ⇒ Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- ⇒ Any conditions or limits applicable to obtaining emergency medical care; and
- ⇒ Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

Please refer to the applicable Benefit Summary (or Certificate of Insurance) for a description of the Plan's provider network. *Provider lists are furnished automatically, without charge, as a separate document or available via a website.*

PATIENT PROTECTION NOTICE

Under the 2010 Health Care Reform legislation, individuals enrolled in a group health plan or health insurance coverage have the right to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; and (2) obtain obstetrical or gynecological care without prior authorization. These rights apply to group health benefits (other than "excepted benefits" that are not subject to Health Care Reform, such as stand-alone dental or vision benefits) that are not "grandfathered" from the new legislation (i.e., to plans that were not in existence on March 23, 2010, or to plans in existence on that date that have subsequently been modified in a manner which causes them to lose their "grandfathered" status).

Group health benefits offered under the Plan are not "grandfathered" for purposes of Health Care Reform, and will be subject to the following:

If the Plan requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Insurer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers, including participating health care professionals who specialize in obstetrics or gynecology, contact the Insurer at the telephone number provided on your Insurance Card.

LOSS OR REDUCTION OF PLAN BENEFITS

Please refer to the applicable Certificate of Insurance and/or Benefit Summaries for a description of the circumstances which may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, or reduction of benefits.

**THE PLAN SPONSOR’S RIGHT TO TERMINATE THE PLAN,
OR AMEND OR ELIMINATE PLAN BENEFITS**

The Employer has the right, under the terms of the Plan, to modify or amend the Plan at any time. Any modification shall be effective as of the date of the amendment, or at such later date as the Employer shall determine. The Employer also has the right to terminate the Plan at any time. Any termination of the Plan shall be effective as of the date of the termination amendment or board resolution, or at such later date as the Employer shall determine. Termination of the Plan shall be binding on all Participants of the Employer and any Participating Employer.

The Certificates of Insurance and/or Benefit Summaries will disclose any Plan provisions governing the benefits, rights and obligations of Participants and beneficiaries upon Plan termination or the amendment or elimination of benefits under the Plan.

To the extent applicable, the Certificates of Insurance and/or Benefit Summaries will disclose any situations where the receipt of benefits is conditioned on the imposition of a fee or charge on a Participant or beneficiary, or on an individual account thereof.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS
*(Applies Only to Medical/Prescription Drug, Health Flexible Spending Account,
Dental, Vision and Employee Assistance Program Benefits)*

General. Medical child support orders may create or recognize the right of a child of an eligible employee to be covered for a particular benefit provided under the Plan. Typically, such orders are issued in divorce proceedings, though they may be issued outside of divorce proceedings to address issues such as whether a child who is not financially dependent on the employee may be covered, the child’s enrollment in the Plan by the parent who is not the employee, that parent’s right to information, enrollment by a state agency, termination of enrollment, and the right of the custodial parent, the provider or a state agency to submit claims and receive payments.

Definitions. Unless the context indicates otherwise, the following terms shall have the following meanings:

(a) “Alternate Recipient” means any child who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan.

(b) “Medical Child Support Order” means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of state law which —

(i) provides for child support with respect to a child or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan; or

(ii) enforces a Section 1908 State Law relating to medical child support.

(c) “Plan” means the medical and prescription drug, health flexible spending account, dental, vision, and employee assistance program benefits described in the Plan, but only to the extent required by law.

(d) “Qualified Medical Child Support Order” means a Medical Child Support Order which —

(i) creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which you or your beneficiary are eligible under the Plan;

(ii) clearly specifies —

(A) your name and the last known mailing address (if any) and the name and mailing address of each Alternate Recipient covered by the Order;

(B) a reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined;

(C) the period to which the Order applies; and

(D) the plan or benefit to which the Order applies; and

(iii) does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a Section 1908 State Law relating to medical child support.

(e) “Section 1908 State Law” means a law which a state is required to have in effect under Section 1902(a)(60) of the Social Security Act. As set forth in Section 1908 of the Social Security Act, these state laws —

(i) specify when a child may be enrolled under the health coverage of the child’s parent;

(ii) specify when a child’s health coverage provided by a parent as required by a court or administrative order may be eliminated;

(iii) require an employer to withhold from an employee’s compensation the employee’s share (if any) of premiums for health coverage if the employee is required by a court or administrative order to provide health coverage for a child;

(iv) provide rights to a child's custodial parent when the child has health coverage through the insurer of the noncustodial parent; and

(v) provide rights to state agencies, including the right to garnish the wages of individuals who are required by a court or administrative order to provide health coverage to a child.

Notice. Upon the Plan's receipt of a Medical Child Support Order with respect to you, the Plan Administrator shall promptly give notice of the receipt of the Order, and give notice of these Procedures, to you and to each person specified in the Order as eligible to receive benefits under the Plan. Notice shall be given at the address specified in the Order.

Determination.

(a) The Plan Administrator shall determine whether a Medical Child Support Order is a Qualified Medical Child Support Order within a reasonable time after it is received, and shall have the right to require such evidence as may reasonably be needed to make the determination.

(b) The Plan Administrator shall notify you and the Alternate Recipient of the determination within a reasonable time after that determination is made.

(c) You or an affected Alternate Recipient may appeal a determination by the Plan Administrator that a Medical Child Support Order is or is not "qualified." Such appeal shall be made by written application to the Plan Administrator. You or the Alternate Recipient may review any documents pertinent to the appeal and may submit comments in writing to the Plan Administrator. No appeal shall be considered unless it is received by the Plan Administrator within 180 days after receipt by you or the Alternate Recipient of written notice of the determination.

(d) The Plan Administrator shall decide the appeal within 60 days after it is received. The Plan Administrator's decision on appeal shall be in writing and shall include specific reasons for the decision, expressed in a manner calculated to be understood by you and the Alternate Recipient.

Benefits Pending Determination. During any period in which the issue of whether a Medical Child Support Order is a Qualified Medical Child Support Order is being determined (by the Plan Administrator, by a court of competent jurisdiction, or otherwise), the Plan shall not be obligated to make benefit payments to or on behalf of an Alternate Recipient. The Plan shall also not be obligated to make any benefit payments to or on behalf of an Alternate Recipient during any period in which you or the Alternate Recipient has a right to appeal a prior determination regarding whether the Medical Child Support Order is a Qualified Medical Child Support Order.

Representative of Alternate Recipient. An Alternate Recipient may, by written notice to the Plan Administrator, designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

Treatment of Alternate Recipient. A person who is an Alternate Recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the Plan for the purposes of ERISA. A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a participant under the Plan for the purposes of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA.

Direct Provision of Benefits. Any payment for benefits made by the Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

COBRA CONTINUATION COVERAGE

(Applies Only to Medical/Prescription Drug, Dental, Vision and Employee Assistance Program Benefits)

Applicability. The following COBRA procedures will apply to medical and prescription drug, dental, vision, and employee assistance program benefits provided under the Plan. If coverage under the health flexible spending account program would otherwise end due to one of the qualifying events described below, you and your covered spouse and dependents may be able to continue coverage on an after tax-basis, depending on the nature of the event. Please refer to the summary of the Goodwill of Western MO & Eastern Kansas Cafeteria Plan or the Helping Hand of Goodwill Industries Extended Employment Cafeteria Plan, as applicable, for the rules for COBRA continuation coverage with respect to the health care flexible spending account.

Continuation of Coverage Under COBRA. This provision of the SPD Supplement contains important information about your (and any covered dependents') right to COBRA coverage, which is a temporary extension of group health coverage under the Plan. This provision also contains information about other coverage alternatives that may be available through the Health Insurance Marketplace.

The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to eligible employees and to other members of their family who are covered under the Plan when the eligible employee would otherwise lose group health coverage. This provision generally explains COBRA coverage, when it may become available, and how to protect your right to receive it.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health

Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Qualified Beneficiaries. COBRA coverage will be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. An individual is also eligible to elect COBRA coverage if:

- (a) He or she is a child born to, adopted by, or placed for adoption with an employee or former employee while the employee or former employee is receiving COBRA coverage; or
- (b) His or her coverage under the Plan is reduced or eliminated in anticipation of a qualifying event.

In the case of subparagraph (a), above, if coverage is elected for newborn or newly adopted children within 60 days of their birth or adoption, they will enjoy an independent right to maintain their COBRA coverage in the event that the employee or former employee drops his or her own COBRA coverage before the end of the maximum coverage continuation period.

In the case of subparagraph (b), above, a person whose coverage under the Plan is reduced or eliminated in anticipation of a qualifying event becomes eligible to elect COBRA coverage upon the occurrence of the qualifying event.

An individual is not eligible to elect COBRA coverage if, on the day before the qualifying event, the individual is covered under the Plan by reason of another person's election of COBRA coverage, and the individual is not otherwise eligible under the provisions of this provision describing COBRA qualified beneficiaries. If multiple individuals are eligible to elect COBRA coverage due to the same qualifying event, each individual has a separate right to elect such coverage.

COBRA Qualifying Events. COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." As an employee, you will become a qualified beneficiary if you would lose coverage under the Plan due to either of:

- (a) Your termination of employment, other than for gross misconduct;
or
- (b) Your reduction in work hours below the minimum needed to maintain his or her eligibility under the Plan or any benefit provided thereunder.

Your spouse will become a qualified beneficiary if he or she would lose coverage under the Plan due to any of:

- (a) Your death;
- (b) Your termination of employment, other than for gross misconduct;
- (c) Your reduction in work hours below the minimum needed to maintain your spouse's eligibility; or
- (d) Your divorce or legal separation.

Your child will become a qualified beneficiary if he or she would lose coverage under the Plan due to any of:

- (a) Your death;
- (b) Your termination of employment, other than for gross misconduct;
- (c) Your reduction in work hours below the minimum needed to maintain the child's eligibility;
- (d) Your divorce or legal separation; or
- (e) The child's ceasing to qualify as an "eligible child" under the Plan.

If you fail to return to work for the Company at the conclusion of an FMLA leave, the qualifying event will occur on the last day of the leave.

Coverage Continuation Periods. If you and your dependents would lose coverage because of your termination of employment or reduction in work hours, each of you may apply for continuation of coverage for up to 18 months after that event. A special rule applies if you become entitled to Medicare within 18 months prior to your termination of employment or reduction in work hours. In such a case, your subsequent termination of employment will entitle your dependents to continuation coverage that extends until the later of (a) 18 months after your termination of employment or reduction in work hours, or (b) 36 months after your Medicare entitlement. In no case will any cumulative period of continuation coverage exceed 36 months.

If your spouse or children would lose coverage as a result of your death, Medicare entitlement, divorce or legal separation, or a child's ceasing to be an "eligible child" under the Plan, the affected individuals may apply for up to 36 months of continuation of coverage.

Successive Qualifying Events. If your dependents elect continued coverage following your termination of employment or reduction in work hours, and then a second qualifying event that would otherwise entitle those dependents to 36 months of continued coverage occurs during that continuation period, they may elect to continue their

coverage for up to 36 months, rather than only 18 months. This 36-month period will be determined by adding an additional 18 months to the original 18-month coverage period. Should this situation arise, those dependents will be given another opportunity to elect or decline continued coverage for the remainder of the 36-month period. In order to be eligible for extended coverage under this paragraph, an individual must be eligible to elect COBRA coverage under the provisions of the provision describing COBRA qualified beneficiaries, at the time of the second qualifying event. A qualified beneficiary (or his or her representative) must notify the Plan Administrator within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

Social Security Disability. A special rule applies if you or a dependent is determined to have been disabled on the date of your termination of employment or reduction in work hours, or within the first 60 days of COBRA coverage provision resulting from that event. Subject to the conditions described in this and the following paragraph, such a disabled individual—and all other family members eligible for COBRA coverage due to the same qualifying event—may purchase up to 11 more months of coverage. This could produce a total of up to 29 months of COBRA coverage. The cost of such coverage may be higher, however, during these last 11 months than during the initial 18 months. The determination of disability must be made by the Social Security Administration, and must be issued within the disabled individual’s initial 18 months of continuation coverage. One of the persons eligible for this extension must then provide the Plan Administrator with a copy of the Social Security Administration’s disability determination within 60 days after the later of (a) your termination of employment or reduction in work hours, or (b) the date the disability determination is issued (and within the disabled individual’s first 18 months of continuation coverage).

If the Social Security Administration later determines that an individual described in the preceding paragraph is no longer disabled, that individual must notify the Plan Administrator within 30 days after the date of that second determination. The right to the 11-month extension of continuation coverage—for the individual and all other family members—will terminate as of the first day of the month that begins more than 30 days after this second determination is issued.

Notification Requirements. You or a dependent must notify the Plan Administrator, in writing, within 60 days of any divorce, legal separation, or child’s ceasing to be an “eligible child” under the terms of the Plan. If such timely notice is not received, the provisions of this provision will not apply with respect to that event.

When the qualifying event is an employee’s death, termination of employment, reduction in work hours, or Medicare entitlement, the Company will notify the Plan Administrator within 30 days of the event.

Cost of COBRA Continuation Coverage. The monthly charge for continued coverage will be determined by the Plan Administrator, and will be the same for all similarly situated individuals electing the same type of coverage under this provision.

Benefits Subject to Continuation. The coverage that you and your dependents are entitled to continue under this provision will be the same as that provided to active employees and their dependents under the relevant provisions of the Plan. Except in connection with an annual enrollment period, an individual may continue only the type of coverage he or she is receiving on the date of the COBRA qualifying event provision.

Election of Continued Coverage. Each individual who is eligible to continue coverage under this provision will be sent an application for continued coverage within 14 days after the Plan Administrator is notified of a qualifying event. Any individual who wishes to continue his or her coverage, must complete the application and return it to the Plan Administrator (or the Plan Administrator's designee) within 60 days from the later of the date it is sent to the individual or the date his or her coverage would otherwise terminate.

Special COBRA rights, including a second opportunity to elect COBRA, apply to employees who have been terminated or experienced a reduction of hours and who qualify for trade adjustment assistance under the Trade Act of 1974. An employee who believes he or she might qualify for such assistance should contact the Plan Administrator.

Payment for Continued Coverage. If an individual elects continued coverage under this provision, he or she must make payment for the period from the date coverage would otherwise terminate. If the individual waits the full 60 days to respond, he or she would still have to make payment from that coverage termination date. Payment for this pre-election period must be made within 45 days after the individual elects to continue coverage. Thereafter, payments must be made by the first day of each month for which coverage is to be provided—subject to a 30-day grace period.

If an individual makes payment for continued coverage under this provision of an amount that is less than the amount due for that month's premium, but the shortfall is no more than the lesser of \$50 or 10% of the premium due, the Plan Administrator will notify the individual of the deficiency. To maintain coverage, the individual must then pay that deficiency within 30 days.

Termination of Continued Coverage. Continued coverage under this provision is subject to automatic termination prior to the end of the maximum coverage period upon the occurrence of any of the following events:

- (a) If a required payment is not made by the end of the 30-day grace period described above;
- (b) If, after an individual elects continued coverage, he or she becomes covered under another employer group health plan (as an employee or otherwise);
- (c) If, after an individual elects continued coverage, he or she becomes entitled to Medicare benefits;

(d) If the Company ceases to maintain any group health plan on behalf of its active employees; or

(e) If coverage has been extended for up to 29 months due to disability and there is a final determination that the individual is no longer disabled.

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

CONTINUATION OF COVERAGE UNDER THE FMLA
*(Applies Only to Medical/Prescription Drug, Dental, Vision and
Employee Assistance Program Benefits)*

Applicability. The following authorized leave of absence procedures shall apply to medical and prescription drug, dental, vision, and employee assistance program benefits provided under the Plan. Please refer to the summary of the Goodwill of Western MO & Eastern Kansas Cafeteria Plan or the Helping Hand of Goodwill Industries Extended Employment Cafeteria Plan, as applicable, for the authorized leave of absence procedures with respect to the health care flexible spending account. Your rights to other benefits while on FMLA leave depend on the Company's established policies, but any benefits that you are entitled to while on non-FMLA leave (including paid leave that is taken as a substitute for FMLA leave) must also be provided to you while you are on FMLA leave.

Continuation of Coverage. If you take a period of leave authorized by the Family and Medical Leave Act ("FMLA Leave"), you may continue coverage for yourself and your dependents under the Plan during the period of FMLA Leave. You would do so by making the same contribution you would have made had you not taken FMLA Leave, but had instead continued your active employment and your participation in the Plan.

Timing of Payment for Coverage.

(a) Paid FMLA Leave. If you are on a period of FMLA Leave that is, at either your or the Company's election, paid leave substituted for FMLA Leave, your contributions for coverage will be made in the same manner that they would have been made had you not taken FMLA Leave (but had instead continued your employment and your participation in this Plan). Because active employees make their contributions through salary reduction, your contributions during your paid leave would be made through salary reduction.

(b) Unpaid FMLA Leave. If your FMLA Leave is unpaid, you must make your contributions no later than the time they would have been made had

you not taken FMLA Leave (but had instead continued your employment and your participation in this Plan).

(c) Termination of Coverage. If you are entitled to a period of FMLA Leave, you may elect not to continue coverage under this Plan during your leave. In that case, your coverage would terminate on the last day of the month for which you paid advance contributions. However, if you elect to continue coverage during a period of FMLA Leave, your coverage will continue until the earliest of:

(i) The date you fail to return to work for the Company after your period of FMLA Leave, and after your employment is thereby terminated;

(ii) The date you exhaust your entire FMLA Leave;

(iii) The 30th day following the date your contribution was due and unpaid (if that contribution remains unpaid on the 30th day) or, if later the 15th day after the Company provides written notice that your contribution has not been received; or

(iv) The date the Plan terminates.

(d) Restoration of Coverage. If you are on FMLA Leave and you do not continue your coverage under this Plan (whether due to your failure to pay the required contributions or your election not to continue coverage during your period of leave), your coverage under the Plan will be reinstated upon your return from FMLA Leave. You will be entitled to receive the same coverage you had prior to your commencement of FMLA Leave.

(e) Special Rules for Key Employees.

(i) Key Employee. Special rules apply to Key Employees. For this purpose, a “Key Employee” is a salaried employee who is among the highest paid 10 percent of all employees employed by the Company within 75 miles of one of the Company’s worksites, and who is FMLA-eligible (who, for example, meets the minimum hour requirements, and works for a large enough facility, to be covered under the FMLA). Determinations of whether an employee is a Key Employee will be made under certain technical rules set forth in government regulations, found at 29 C.F.R. Section 825.217.

(ii) Continuation of Coverage. If you are a Key Employee, special rules will apply. In that event, if you are entitled to FMLA Leave, and the Company properly notifies you that it does not intend to restore you to your job at the end of your leave because doing so would cause substantial and grievous economic injury to the Company’s operations, and if you nevertheless do not, within a reasonable time after receiving

that notice, terminate your FMLA Leave and return to work for the Company, your coverage (and that of your dependents) will continue until the earliest of:

- (A) The date you give notice to the Company that you no longer wish to return to work;
- (B) The date the Company denies your reinstatement to employment at the end of your FMLA Leave;
- (C) The 30th day following the date your contribution was due and unpaid (if that contribution remains unpaid on the 30th day) or, if later, the 15th day after the Company provides written notice that your contribution has not been received; or
- (D) The date the Plan terminates.

Construction in Accordance with FMLA. The rules in this section will be interpreted and applied in a manner consistent with the provisions of the Family and Medical Leave Act and regulations the government issues under that Act.

**CONTINUATION OF COVERAGE DURING AND REEMPLOYMENT
AFTER MILITARY SERVICE**

*(Applies Only to Medical/Prescription Drug, Health Flexible Spending Account,
Dental, Vision and Employee Assistance Program Benefits)*

Federal law ensures that an eligible employee may continue his or her coverage and coverage for his or her eligible dependents while on leave for the purpose of military training or service.

(a) If you are an eligible employee on a leave of absence that meets the applicable requirements of the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), you may elect to continue your Plan coverage (and that of your eligible dependents) by giving notice and paying the required amounts. The charges you will have to pay will be determined by the Plan Administrator. If any single period of “Qualified Uniformed Service,” as defined below, is for a period of less than 31 days, the Company will pay the amount it would pay for your coverage, and you will pay the amount you would pay for your coverage, as if you had not entered Qualified Uniformed Service. In other cases, the premiums will reflect both your portion and the Company’s portion, determined in the same manner as COBRA premiums under the Plan. The maximum period and the conditions of such continued coverage shall be governed by the applicable COBRA provisions described in this SPD Supplement, except that the 18-month maximum period of continuation coverage shall be increased to 24 months.

(b) If you are an eligible employee on a period of USERRA leave, you will be eligible for benefits on the first day of your reemployment once you return

from that leave, in the same class of coverage you had when your USERRA leave began, but only if each of the following requirements is met:

- (i) You have reemployment rights under USERRA;
- (ii) You are reemployed by the Company; and
- (iii) You were eligible for benefits immediately prior to the commencement of your USERRA leave.

In determining your continuing eligibility and that of your dependents, your USERRA leave will be disregarded for the purpose of computing your hours worked in earlier months.

(c) Neither you nor, if they had been protected persons at the time the USERRA leave commences, your eligible dependents, shall be subject to any new qualification period or evidence of good health requirement prior to restoration of participation described in the preceding paragraph; provided, however, that this sentence shall not apply to the coverage of any illness or injury that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of military service while on USERRA leave.

(d) The Plan's provisions on military service shall be construed and applied to be consistent with the requirements of USERRA.

(e) Your absence from employment shall be considered "Qualified Uniformed Service" only if the following rules are satisfied:

(i) The service constitutes the performance of duty on a voluntary or involuntary basis under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard Duty, a period for which you are absent from employment for the purpose of an examination to determine your fitness to perform any such duty, a period for which you are absent from employment for the purpose of performing funeral honors duty as authorized by law, and a period for which you are absent from employment for the purpose of training or performing intermittent disaster response services of the National Disaster Medical System (NDMS).

(ii) The service is in one of the "Uniformed Services." "Uniformed Services" means the Armed Forces of the United States, the Army National Guard and the Air National Guard when engaged in active duty for training or inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency. For purposes of USERRA coverage only, service as an intermittent disaster response appointee of the NDMS when

federally activated or attending authorized training is deemed service in the uniformed services.

(iii) You had coverage under this Plan at the time your service began.

(iv) Your period of service does not exceed 60 months or such other period as may be required by applicable law.

**CLAIMS PROCEDURES
FOR GROUP HEALTH BENEFITS**
*(Applies Only to Medical/Prescription Drug, Health Flexible Spending Account,
Dental, Vision and Employee Assistance Program Benefits)*

The following Claims procedures shall apply to both the Self-Funded Benefits and to the Insured Benefits provided under this Plan, but only to the extent that Claims procedures are not otherwise provided under the applicable Component Document.

A Claim is defined as any request for a Plan benefit made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims, and each one has a specific timetable for approval, payment, request for further information, or denial. If you have any questions regarding this procedure, please contact the Plan Administrator.

Urgent Care Claim. A Claim involving "Urgent Care" is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant, the ability of the claimant to regain maximum function or, in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

⇒ Notification to claimant of benefit determination: 72 hours from date of Claim.

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

- ⇒ Notification to claimant, orally or in writing: 24 hours from date of Claim.
- ⇒ Response by claimant, orally or in writing: not less than 48 hours from receipt of request.
- ⇒ Benefit determination, orally or in writing: 48 hours after the Plan's receipt of the specified information or the end of the period afforded to the claimant to provide additional information.

Ongoing courses of treatment, notification of:

- ⇒ Any decision by the Plan to terminate or reduce benefits that have already been granted with the potential of causing disruption to ongoing care, course of treatment, or number of treatments before the end of such treatments shall constitute a denied Claim. The Plan will provide a notice of denial to the claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.
- ⇒ Determination as to extending course of treatment: 24 hours for a Claim involving Urgent Care (provided that the Claim is made at least 24 hours prior to the expiration of the initially prescribed period).

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

- ⇒ Time to file appeal: 180 days from notice of initial adverse decision.
- ⇒ Appeal decision: 72 hours from date of appeal.

Pre-Service Claim. A "Pre-Service Claim" means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical, dental, or vision care. These are, for example, Claims subject to pre-certification.

In the case of a Pre-Service Claim, the following timetable applies:

- ⇒ Notification to claimant of benefit determination: 15 days from date of Claim.
- ⇒ Extension due to matters beyond the control of the Plan: 15 days from date of request (claimant must be notified prior to the expiration of the initial 15-day period).

Insufficient information on the Claim:

- ⇒ Notification of: 15 days from date of the Claim.
- ⇒ Response by claimant: 45 days from receipt of notice.

Review of adverse benefit determination:

- ⇒ Time to file appeal: 180 days from notice of initial adverse decision.
- ⇒ Appeal decision: 30 days from the date of appeal.

Post-Service Claim. A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

- ⇒ Notification to claimant of benefit determination: 30 days from date of Claim.
- ⇒ Extension due to matters beyond the control of the Plan: 15 days from date of request (claimant must be notified prior to the expiration of the initial 30-day period).

Insufficient information on the Claim:

- ⇒ Notification of: 30 days from date of Claim.
- ⇒ Response by claimant: 45 days from receipt of notice.

Review of adverse benefit determination:

- ⇒ Time to file appeal: 180 days from notice of initial adverse decision.
- ⇒ Appeal decision: 60 days from date of appeal.

Notice to Claimant of Adverse Benefit Determinations. Except with Urgent Care Claims, where the notification may be made orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (a) The specific reason or reasons for the adverse determination.
- (b) Reference to the specific Plan provisions on which the determination is based.

(c) 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.

(d) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include 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.

(e) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or criterion; or a statement that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination, and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

(f) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge upon request.

(g) In the case of an adverse benefit determination concerning a claim involving Urgent Care, a description of the expedited review process applicable to such claims.

Appeals. When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (a) Was relied upon in making the benefit determination;
- (b) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(c) Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary, other than the individual who made the adverse determination or a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the named fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

**ADDITIONAL CLAIMS AND APPEALS PROCEDURES UNDER THE
AFFORDABLE CARE ACT**
(Applies Only to Medical/Prescription Drug Benefits)

Under the Affordable Care Act of 2010, additional Claims and appeals procedures (and a new external review requirement) apply to group health benefits (other than “excepted benefits” that are not subject to Health Care Reform, such as stand-alone dental or vision benefits) that are not “grandfathered” from the new legislation (i.e., plans that were not in existence on March 23, 2010, or plans in existence on that date that have subsequently been modified in a manner which causes them to lose their “grandfathered” status).

Group health benefits offered under the Plan are not “grandfathered” for purposes of the Affordable Care Act requirements, and will be subject to the following additional requirements:

(a) If you are appealing a denied Claim, you will be able to review the Claim file and present evidence and testimony as part of the appeals process. In considering your appeal, we will provide you with any new or additional evidence that is considered, relied upon, or generated by the Plan in connection with your Claim. We will provide this evidence as soon as possible and sufficiently in advance of the date by which we are required to provide notice of the resolution of your appeal. In addition, before we issue an adverse determination based on a

new or additional rationale, we will provide you with such rationale as soon as possible so that you will have reasonable opportunity to respond to such new evidence or rationale.

(b) We will take additional steps to ensure the independence and impartiality of the persons involved in deciding your Claim or appeal.

(c) You will be entitled to continue coverage pending the outcome of an internal appeal. If you (or a dependent) are in an urgent care situation or are receiving an ongoing course of treatment, you will be allowed to proceed with expedited external review at the same time as the internal appeals process.

(d) Any notice of adverse benefit determination will include the following additional content:

(i) Information sufficient to identify the Claim involved, including the date of the service, the health care provider, and the Claim amount (if applicable);

(ii) A description of the Plan's standard, if any, that was used in denying the Claim;

(iii) A statement that you may receive, upon request and free of charge, reasonable access to all diagnosis and treatment codes (and their meanings) relevant to the Claim, including the right to copies of those diagnosis and treatment codes;

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

(v) Information regarding the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.

(e) If we do not strictly adhere to the Plan's Claims and appeal procedures, you will be "deemed" to have exhausted the Plan's internal Claims and appeals process, regardless of whether we assert that we have "substantially complied" with those procedures, and you will be able to initiate any available external review process or remedies available under ERISA or under state law, unless the violation was all of the following:

(i) De minimis (i.e., a minor violation);

(ii) Non-prejudicial (i.e., the violation does not cause you, and is not likely to cause you, harm or prejudice);

(iii) Attributable to a good cause or matters beyond the Plan's (or the Issuer's) control;

(iv) In the context of an ongoing good-faith exchange of information between you and the Plan; and

(v) Not reflective of a pattern or practice of non-compliance.

In addition, you are entitled, upon written request, to an explanation of the Plan's basis for asserting that it meets this standard. If the external reviewer or the court rejects your request for immediate review on the basis that the Plan met this standard, you have the right to resubmit and pursue the internal appeal of the Claim.

(f) There will be an opportunity for review of your denied appeal by a party outside the Plan (i.e., an external review procedure), as set forth below, but only with respect to Claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer or (2) a rescission of coverage:

(i) The claimant, or the claimant's authorized representative, may request an external review of a denied Claim by making a written request to the Plan Administrator (or its designee) within four months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. The Plan Administrator (or its designee) may charge a filing fee to the claimant requesting an external review, subject to applicable laws and regulations.

(ii) Within five business days of receipt of the request, the Plan Administrator (or its designee) will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

(A) Medical judgment; or

(B) Rescission of coverage under this Plan.

(iii) The Plan Administrator (or its designee) shall provide the claimant (or authorized representative) with a written notice of the decision as to whether the Claim is eligible for external review within one business day after completion of the preliminary review. The Notice of Final External Review shall include the following:

(A) The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review;

(B) If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the claimant to perfect the external review request by the later of the following:

(1) the four-month filing period; or

(2) within the 48-hour time period following the claimant's receipt of notification.

(iv) An Independent Review Organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review.

(v) The assigned IRO shall provide the Plan Administrator (or its designee) and the claimant with a written notice of the final external review decision within 45 days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the claimant, the Plan, and the Plan Administrator, except to the extent that other remedies may be available under state or federal law.

(vi) The Plan Administrator (or its designee) shall provide the claimant the right to request an expedited external review upon the claimant's receipt of either of the following:

(A) A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the claimant or the claimant's ability to regain maximum function and the claimant has filed an internal appeal request; or

(B) A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the claimant or the claimant's ability to regain maximum function or if the final determination involves any of the following:

(1) an admission;

(2) availability of care;

(3) continued stay; or

(4) a health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

(vii) Immediately upon receipt of the request for expedited external review, the Plan Administrator (or its designee) will do both of the following:

(A) Perform a preliminary review to determine whether the request is eligible for an external appeal review; and

(B) Send a notice of the Plan's decision.

(viii) Upon determination that a request is eligible for external review, the Plan Administrator (or its designee) will do both of the following:

(A) Assign an IRO; and

(B) Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

(ix) The assigned IRO will provide notice of final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after receipt of the expedited external review request. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the Plan Administrator (or its designee) and the claimant written confirmation of its decision within 48 hours after the date of providing that notice.

CLAIMS PROCEDURES

FOR DISABILITY AND OTHER BENEFITS

(Applies Only to Life, AD&D, Short Term Disability, Voluntary Life, Voluntary AD&D, Voluntary Accident and Voluntary Critical Illness Benefits)

The following Claims procedures shall apply to the benefits (other than group health benefits, discussed above) provided under the Plan, but only to the extent that Claims procedures are not otherwise provided under the applicable Certificate of Insurance and/or Benefit Summary.

Filing Claims. Claims for benefits under the Plan may be filed in writing with the Plan Administrator. The Plan Administrator will evaluate a Claim to determine if benefits are payable under the terms of the Plan. In the case of a claim for disability benefits made on or after April 1, 2018, the Plan Administrator will take additional steps to ensure the independence and impartiality of the persons involved in deciding the

claimant's Claim or appeal. The Administrator may solicit additional information from the claimant if such information is necessary to evaluate the Claim. If the Plan Administrator determines a Claim is valid, then the claimant will receive a statement describing the amount of the benefit, the method or methods of payment, the timing of distributions, and other information relevant to the payment of the benefit.

A written request for Plan benefits will be considered a Claim for Plan benefits, and it will be subject to a full and fair review. If a Claim is wholly or partially denied, the Plan Administrator will furnish the claimant with a written notice of this denial within a reasonable period of time, but no later than 90 days after the Plan's receipt of the Claim. If the Plan Administrator determines that an extension of time for processing the Claim is needed, the Plan Administrator will notify the claimant of the reasons for the extension and the extended due date before the end of the 90-day period after the filing of the Claim. The extended period may not exceed 180 days after the date of the filing of the Claim.

In the case of a disability Claim for Plan benefits, special timeframes apply. If a Claim is wholly or partially denied, the Plan Administrator will furnish the claimant with a written notice of this denial within a reasonable period of time, but no later than 45 days after the Plan's receipt of the Claim. If the Plan Administrator determines that an extension of time for processing the Claim is needed due to matters beyond the control of the Plan, the Plan Administrator will notify the claimant of the reasons for the extension and the extended due date before the end of the 45-day period after the filing of the Claim. The extended period may not exceed 75 days after the date of the filing of the Claim. If the Plan Administrator determines that a second extension of time for processing the Claim is needed due to matters beyond the control of the Plan, the Plan Administrator must notify the claimant of the reasons for the extension and the extended due date before the end of the 75-day period after the filing of the Claim. The second extended period may not exceed 105 days after the date of the filing of the Claim. During the extension process, the Plan Administrator may request additional information from the claimant. If additional information is requested, the time period for making a benefit decision is frozen from the date on which the request is sent to the claimant until the date the claimant responds to the request. The claimant will have 45 days from receipt of the information request to submit the requested information.

In the case of a disability Claim for Plan benefits made on or after April 1, 2018, if the Plan Administrator does not strictly adhere to the Plan's claims and appeal procedures, the claimant will be "deemed" to have exhausted the Plan's internal claims and appeals process, regardless of whether the Plan Administrator asserts that it has "substantially complied" with those procedures, and the claimant will be able to initiate any available external review process or remedies available under ERISA or under state law, unless the violation was all of the following:

- (a) De minimis (i.e., a minor violation);
- (b) Non-prejudicial (i.e., the violation does not cause, and is not likely to cause, harm or prejudice to the claimant);

- (c) Attributable to a good cause or matters beyond the Plan's control;
- (d) In the context of an ongoing good-faith exchange of information between the claimant and the Plan; and
- (e) Not reflective of a pattern or practice of non-compliance by the Plan.

In addition, the claimant may request a written explanation of the Plan's basis for asserting that it meets this standard. The Plan must provide the explanation within 10 days of the claimant's request. If the court rejects the claimant's request for immediate review on the basis that the Plan met this standard, the Plan shall consider the Claim as re-submitted upon the Plan receiving notice of such rejection and shall notify the claimant of the re-submission.

If a Claim is wholly or partially denied, the written notice provided to the claimant will contain the following information:

- (a) The specific reason or reasons for the denial;
- (b) Specific reference to those Plan provisions on which the denial is based;
- (c) A description of any additional information or material necessary to correct the Claim and an explanation of why such information or material is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination upon review;
- (e) In the case of notification of an adverse determination for disability claims:
 - (i) Effective for claims made on or after April 1, 2018, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - (A) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
 - (B) The views of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(C) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(ii) If the adverse benefit determination was 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;

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

(iv) Effective for claims made on or after April 1, 2018, 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 (whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to regulations issued under ERISA by the Department of Labor).

If a Claim has been denied, a claimant can file for a Claim review pursuant to "Claims Review Procedure" below.

Claims Review Procedure. Upon the denial of a Claim for benefits, a claimant may file a Claim for review, in writing, with the Plan Administrator. A claimant must file the Claim for review no later than 60 days after receipt of written notification of the denial of the Claim. In the case of a disability Claim denial, the 60-day period set forth in the preceding sentence shall be a 180-day period.

A claimant may submit written comments, documents, records, and other information related to the benefit Claim on review. A claimant will be provided, upon request and free of charge, access to and copies of all documents, records, and other information relevant to the benefit Claim. A document, record, or other information shall be considered relevant to a Claim if it:

- (a) Was relied upon in making the benefit determination;
- (b) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- (c) Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made

in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

A Claim for review must be given a full and fair review. The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary, other than the individual who made the adverse determination or a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the named fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

In the case of a claim for disability benefits made on or after April 1, 2018, before the Plan Administrator issues an adverse benefit determination on review, the Plan Administrator will provide the claimant, free of charge, with any new or additional evidence that is considered, relied upon, or generated by the Plan, insurer, or other person in connection with the claim. The Plan Administrator will provide this evidence as soon as possible and sufficiently in advance of the date by which it is required to provide notice of the adverse benefit determination. In addition, before the Plan Administrator issues an adverse benefit determination based on a new or additional rationale, it will provide the claimant with such rationale as soon as possible so that the claimant will have reasonable opportunity to respond to such new evidence or rationale.

The Plan Administrator will notify the claimant of the review decision (whether adverse or not) within a reasonable period of time, but no later than 60 days after the Plan's receipt of the Claim for review. If the Plan Administrator determines that an extension of time for processing the Claim is needed, the Plan Administrator must notify the claimant of the reasons for the extension and the extended due date before the end of the 60-day period after the filing of the Claim for review. The extended period may not exceed 120 days after the date of the filing of the Claim for review. In the case of a disability Claim for review, special expedited timeframes apply. Specifically, the Plan Administrator must notify the claimant of the review decision (whether adverse or not) within a reasonable period of time, but no later than 45 days after the Plan's receipt of the Claim for review. If the Plan Administrator determines that an extension of time for processing the Claim is needed, the Plan Administrator must notify the claimant of the reasons for the extension and the extended due date before the end of the 45-day period

after the filing of the Claim for review. The extended period may not exceed 90 days after the date of the filing of the Claim for review.

The Plan Administrator's decision on a Claim for review will be communicated to the claimant in writing. If the determination is adverse, the claimant will be provided the following information:

- (a) The specific reason or reasons for the adverse determination;
- (b) Reference to the specific Plan provisions on which the benefit determination is based;
- (c) 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 (whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to regulations issued under ERISA by the Department of Labor);
- (d) A statement of the claimant's right to bring an action under Section 502(a) of ERISA; including, in the case of a disability claim made on or after April 1, 2018, a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- (e) In the case of a Claim for disability benefits,
 - (i) Effective for claims made on or after April 1, 2018, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - (A) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
 - (B) The views of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - (C) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
 - (ii) If the adverse benefit determination was 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

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

If a claimant has a Claim for benefits which is denied upon review or not responded to within the appropriate Claims procedure timeframe, in whole or in part, such claimant may file suit in a state or federal court.

Voluntary Appeals, Including Voluntary Arbitration. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after exhaustion of appeals of an adverse benefit determination as explained in the section above, entitled, "Appeals." However, this voluntary appeal may be conducted as one of the two appeals available to the claimant.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decisionmaker; and give circumstances, if any, that may affect the impartiality of the decisionmaker.

**SPECIAL ENROLLMENT PERIOD RELATED TO
CHILDREN'S HEALTH INSURANCE PROGRAM
(Applies Only to Medical/Prescription Drug Benefits)**

If you or your dependents (i) become eligible for premium assistance under the Children's Health Insurance Program (CHIP) or Medicaid, or (ii) become ineligible for CHIP or Medicaid and lose coverage under such program, you will have sixty (60) days from the date of that event in which to request enrollment in any group health benefit offered under this Plan.

DISCLOSURES OF PROTECTED HEALTH INFORMATION
*(Applies Only to Medical/Prescription Drug, Health Flexible Spending Account,
Dental, Vision and Employee Assistance Program Benefits)*

General. The Plan will disclose protected health information that is created or received under the medical, prescription drug, health care flexible spending account, dental, vision, or employee assistance programs to the Company only to the extent permitted by the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and its regulations (the “Privacy Rule” and the “Security Rule”). The rules in this section of the SPD Supplement will be interpreted and applied in a manner consistent with the Privacy Rule and the Security Rule. For purposes of those Rules, the Plan elects to be treated as a “hybrid entity,” such that only the benefit programs listed above shall be subject to the Rules and the provisions of this section of the SPD Supplement.

Obligations of the Plan Sponsor. The Plan will disclose protected health information (“PHI”) to the Company only upon receipt of a certification from the Company that the Plan documents have been amended to incorporate the following provisions:

- (a) The Company agrees to:
 - (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
 - (ii) not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
 - (iii) ensure that any agents, including a subcontractor, to whom the Company provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI, including the implementation of reasonable and appropriate security measures to protect electronic PHI;
 - (iv) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
 - (v) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Company unless authorized by an individual;
 - (vi) report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware, including any security incident of which it becomes aware;

(vii) make PHI available to an individual in accordance with the Privacy Rule's access requirements;

(viii) make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rule;

(ix) make available the information required to provide an accounting of disclosures;

(x) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Rule;

(xi) if feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

(xii) ensure that adequate separation between the Plan and the Company is established and supported by reasonable and appropriate security measures with respect to electronic PHI.

(b) Access to and use and disclosure of PHI will be limited to only those employees who have a need for the PHI in conjunction with their performance of plan administration functions for the Plan, including any employee who receives PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The Company anticipates that the following employees (identified by Department) will have access to PHI in connection with the administration of the Plan:

(i) Human Resources; and

(ii) Risk Management.

(c) If the persons described in subsection (b) of this section of the SPD Supplement do not comply with the conditions set forth in subsection (a) of this section of the SPD Supplement, the Company will provide a mechanism for resolving issues of noncompliance, including appropriate disciplinary sanctions.

ERISA RIGHTS

(Applies to All Benefits Under the Plan)

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits.

- ⇒ Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- ⇒ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- ⇒ Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage.

- ⇒ 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 Supplement and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

Enforce Your Rights. If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or

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

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