

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

**As Effective January 1, 2018**

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

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## **Article I Definitions**

[Note that the Component Documents may contain their own definitions of terms used in those Component Documents.]

1.01 Benefit. “Benefit” means each of the benefits described in Article II through Article XIII.

1.02 Claims Administrator. The “Claims Administrator” is the plan fiduciary with final authority for determining the disposition of any claim for a Benefit under the Plan. With respect to Insured Benefits, the Claims Administrator will generally be the relevant Insurer.

1.03 Company. “Company” means Goodwill of Western Missouri and Eastern Kansas and any Affiliated Employer that adopts the Plan. For this purpose, the term "Affiliated Employer" means any trade or business (whether or not incorporated) that, along with the Company, is treated as a single employer under Sections 414(b), (c), (m), or (o) of the Internal Revenue Code.

1.04 Component Document. “Component Document” means a written document identified in an Appendix to this Plan and incorporated herein by reference, including, without limitation, any plan documents, insurance policies (or certificates) and Benefit descriptions.

1.05 Employee. “Employee” means any person employed by the Company as a common-law employee.

1.06 ERISA. “ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.07 Insured Benefit. “Insured Benefit” means any Benefit that is provided through a contract with an insurance company (or any contract with similar risk shifting characteristics).

1.08 Plan. “Plan” means this Goodwill of Western Missouri and Eastern Kansas Medical Plan.

1.09 Plan Administrator. “Plan Administrator” means Goodwill of Western Missouri and Eastern Kansas or such other person or committee as may be appointed from time to time by Goodwill of Western Missouri and Eastern Kansas to administer the Plan or to supervise the administration of any Benefit under the Plan.

Plan Year. “Plan Year” means the 12-month period beginning on January 1st and ending on the following December 31st.

## **Article II**

### **Medical and Prescription Drug Insurance Benefits**

2.01 General. The Plan provides medical and prescription drug benefits to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “Medical and Prescription Drug Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix A. The terms, conditions, and limitations applicable to the medical and prescription drug benefits are set forth in that Appendix.

2.02 Eligibility. 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 medical and prescription drug insurance policy and/or certificate of coverage) shall be eligible for medical and prescription drug benefits 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 insurance policy and/or certificate of coverage) 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.

2.03 Source of Payment. Because the Plan’s medical and prescription drug benefits are provided through an insurance policy, the Plan will pay medical and prescription drug claims only if they are covered under that policy. Thus, if the Medical and Prescription Drug Insurer is not obligated to pay a medical or prescription drug claim under the terms of the policy it issues, the Plan will not pay that claim.

2.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the Medical and Prescription Drug Insurer has the discretion and authority to construe and interpret the policy under which it provides medical and prescription drug benefits. This includes the authority to decide all questions concerning eligibility for medical and prescription drug benefits, and the amount of such benefits payable. In making any such decision, the Medical and Prescription Drug Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Medical and Prescription Drug Insurer’s interpretation of the policy will be binding and conclusive on all persons.

2.05 Special Enrollment Period Related to Children’s Health Insurance Program. If an Employee and/or his/her dependent(s) (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, the Employee (and/or his/her dependent(s)) will have 60 days from the date of that event in which to request enrollment in the medical and prescription drug benefits offered under this Plan.



**Article III**  
**Health Care Flexible Spending Account**

3.01 General. The Plan provides a health care flexible spending account program to certain eligible Employees. This program is provided through a self-funded arrangement, and therefore this portion of the Plan constitutes a Self-Funded Benefit. The health care flexible spending account program provided to eligible Employees is described in detail in the Goodwill of Western MO & Eastern Kansas Cafeteria Plan and Helping Hand of Goodwill Industries Extended Employment Cafeteria Plan (each of which are referred to individually as the “Flexible Benefits Plan”), copies of which is attached to this Plan as Appendix B.

3.02 Eligibility. 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 Flexible Benefits Plan) shall be eligible for health care flexible spending account program benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

3.03 Source of Payment. Because the Plan’s health care flexible spending account program is provided pursuant to the terms of the Flexible Benefits Plan, the Plan will pay health care flexible spending account claims only if they are covered under that Flexible Benefits Plan. Thus, if the Administrator of the Flexible Benefits Plan determines that the Company is not obligated to pay a health care claim under the terms of the Flexible Benefits Plan, the Plan will not pay that claim.

**Article IV**  
**Dental Insurance Benefits**

4.01 General. The Plan provides dental benefits to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “Dental Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix C. The terms, conditions, and limitations applicable to the dental benefits are set forth in that Appendix.

4.02 Eligibility. 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 dental benefit summary) shall be eligible for dental benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

4.03 Source of Payment. Because the Plan’s dental benefits are provided through an insurance policy, the Plan will pay dental claims only if they are covered under that policy. Thus, if the Dental Insurer is not obligated to pay a dental claim under the terms of the policy it issues, the Plan will not pay that claim.

4.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the Dental Insurer has the discretion and authority to construe and interpret the policy under which it provides dental benefits. This includes the authority to decide all questions concerning eligibility for dental benefits, and the amount of such benefits payable. In making any such decision, the Dental Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Dental Insurer’s interpretation of the policy will be binding and conclusive on all persons.

**Article V**  
**Vision Insurance Benefits**

5.01 General. The Plan provides vision benefits to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “Vision Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix D. The terms, conditions, and limitations applicable to the vision benefits are set forth in that Appendix.

5.02 Eligibility. 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 vision insurance policy and/or certificate of coverage) shall be eligible for vision benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

5.03 Source of Payment. Because the Plan’s vision benefits are provided through an insurance policy, the Plan will pay vision claims only if they are covered under that policy. Thus, if the Vision Insurer is not obligated to pay a vision claim under the terms of the policy it issues, the Plan will not pay that claim.

5.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the Vision Insurer has the discretion and authority to construe and interpret the policy under which it provides vision benefits. This includes the authority to decide all questions concerning eligibility for vision benefits, and the amount of such benefits payable. In making any such decision, the Vision Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Vision Insurer’s interpretation of the policy will be binding and conclusive on all persons.

**Article VI**  
**Employee Assistance Program Benefits**

6.01 General. The Plan provides employee assistance benefits to certain eligible Employees. Such benefits are provided under a contract (similar to an insurance policy) with a company (the “Employee Assistance Program Provider”), and therefore this portion of the Plan constitutes an Insured Benefit. The contract with the Employee Assistance Program Provider (or a description of the benefits) is attached to this Plan as Appendix E. The terms, conditions, and limitations applicable to employee assistance benefits are set forth in that Appendix.

6.02 Eligibility. All active Employees of the Company (and their eligible dependents, as defined in the employee assistance program benefit summary) shall be eligible for employee assistance program benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

6.03 Source of Payment. Because the Plan’s employee assistance benefits are provided under a contract, the Plan will pay employee assistance claims only if they are covered under that contract. Thus, if the Employee Assistance Program Provider is not obligated to pay an employee assistance claim under the terms of the contract, the Plan will not pay that claim.

6.04 Interpretation of Contract. Notwithstanding the provisions of Section 20.01, the Employee Assistance Program Provider has the discretion and authority to construe and interpret the contract under which it provides the employee assistance benefits. This includes the authority to decide all questions concerning eligibility for employee assistance benefits, and the amount of such benefits payable. In making any such decision, the Employee Assistance Program Provider may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Employee Assistance Program Provider’s interpretation of the contract will be binding and conclusive on all persons.

**Article VII**  
**Life Insurance Benefits**

7.01 General. The Plan provides life insurance benefits to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “Life Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix F. The terms, conditions, and limitations applicable to the life insurance benefits are set forth in that Appendix.

7.02 Eligibility. 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 life insurance policy and/or certificate of coverage) shall be eligible for life insurance benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

7.03 Source of Payment. Because the Plan’s life insurance benefits are provided through an insurance policy, the Plan will pay life insurance claims only if they are covered under that policy. Thus, if the Life Insurer is not obligated to pay a life insurance claim under the terms of the policy it issues, the Plan will not pay that claim.

7.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the Life Insurer has the discretion and authority to construe and interpret the policy under which it provides the life insurance benefits. This includes the authority to decide all questions concerning eligibility for life insurance benefits, and the amount of such benefits payable. In making any such decision, the Life Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Life Insurer’s interpretation of the policy will be binding and conclusive on all persons.

**Article VIII**  
**Accidental Death & Dismemberment Insurance Benefits**

8.01 General. The Plan provides accidental death and dismemberment insurance benefits (“AD&D insurance benefits”) to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “AD&D Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix F. (Note that the same policy/certificate covers the life insurance benefits described in Article XII.) The terms, conditions, and limitations applicable to the AD&D insurance benefits are set forth in that Appendix.

8.02 Eligibility. 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 AD&D insurance policy and/or certificate of coverage) shall be eligible for AD&D benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

8.03 Source of Payment. Because the Plan’s AD&D insurance benefits are provided through an insurance policy, the Plan will pay AD&D insurance claims only if they are covered under that policy. Thus, if the AD&D Insurer is not obligated to pay an AD&D insurance claim under the terms of the policy it issues, the Plan will not pay that claim.

8.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the AD&D Insurer has the discretion and authority to construe and interpret the policy under which it provides the AD&D insurance benefits. This includes the authority to decide all questions concerning eligibility for AD&D insurance benefits, and the amount of such benefits payable. In making any such decision, the AD&D Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The AD&D Insurer’s interpretation of the policy will be binding and conclusive on all persons.

**Article IX**  
**Short Term Disability Insurance Benefits**

9.01 General. The Plan provides short term disability insurance benefits to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “Short Term Disability Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix G. The terms, conditions, and limitations applicable to the short term disability insurance benefits are set forth in that Appendix.

9.02 Eligibility. All active Employees of the Company who are regularly scheduled to work 30 hours or more per week shall be eligible for short term disability benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

9.03 Source of Payment. Because the Plan’s short term disability insurance benefits are provided through an insurance policy, the Plan will pay short term disability insurance claims only if they are covered under that policy. Thus, if the Short Term Disability Insurer is not obligated to pay a short term disability insurance claim under the terms of the policy it issues, the Plan will not pay that claim.

9.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the Short Term Disability Insurer has the discretion and authority to construe and interpret the policy under which it provides the short term disability insurance benefits. This includes the authority to decide all questions concerning eligibility for short term disability insurance benefits, and the amount of such benefits payable. In making any such decision, the Short Term Disability Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Short Term Disability Insurer’s interpretation of the policy will be binding and conclusive on all persons.

**Article X**  
**Voluntary Life Insurance Benefits**

10.01 General. The Plan provides voluntary life insurance benefits to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “Voluntary Life Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix H. The terms, conditions, and limitations applicable to voluntary life insurance benefits are set forth in that Appendix.

10.02 Eligibility. 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 voluntary life insurance policy and/or certificate of coverage) shall be eligible for voluntary life insurance benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

10.03 Source of Payment. Because the Plan’s voluntary life insurance benefits are provided through an insurance policy, the Plan will pay voluntary life insurance claims only if they are covered under that policy. Thus, if the Voluntary Life Insurer is not obligated to pay a voluntary life insurance claim under the terms of the policy it issues, the Plan will not pay that claim.

10.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the Voluntary Life Insurer has the discretion and authority to construe and interpret the policy under which it provides the voluntary life insurance benefits. This includes the authority to decide all questions concerning eligibility for voluntary life insurance benefits, and the amount of such benefits payable. In making any such decision, the Voluntary Life Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Voluntary Life Insurer’s interpretation of the policy will be binding and conclusive on all persons.



**Article XI**  
**Voluntary Accidental Death & Dismemberment Insurance Benefits**

11.01 General. The Plan provides voluntary accidental death and dismemberment insurance benefits (“Voluntary AD&D insurance Benefits”) to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “Voluntary AD&D Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix H. (Note that the same policy/certificate covers the voluntary life insurance benefits described in Article X.) The terms, conditions, and limitations applicable to voluntary AD&D insurance benefits are set forth in that Appendix.

11.02 Eligibility. 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 voluntary AD&D insurance policy and/or certificate of coverage) shall be eligible for voluntary AD&D insurance benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

11.03 Source of Payment. Because the Plan’s voluntary AD&D insurance benefits are provided through an insurance policy, the Plan will pay voluntary AD&D insurance claims only if they are covered under that policy. Thus, if the Voluntary AD&D Insurer is not obligated to pay a voluntary AD&D insurance claim under the terms of the policy it issues, the Plan will not pay that claim.

11.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the Voluntary AD&D Insurer has the discretion and authority to construe and interpret the policy under which it provides the voluntary AD&D insurance benefits. This includes the authority to decide all questions concerning eligibility for voluntary AD&D insurance benefits, and the amount of such benefits payable. In making any such decision, the Voluntary AD&D Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Voluntary AD&D Insurer’s interpretation of the policy will be binding and conclusive on all persons.

**Article XII**  
**Voluntary Accident Insurance Benefits**

12.01 General. The Plan provides voluntary accident insurance benefits to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “Voluntary Accident Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix I. The terms, conditions, and limitations applicable to voluntary accident benefits are set forth in that Appendix.

12.02 Eligibility. 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 voluntary accident insurance policy and/or certificate of coverage) shall be eligible for voluntary accident benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

12.03 Source of Payment. Because the Plan’s voluntary accident insurance benefits are provided through an insurance policy, the Plan will pay voluntary accident insurance claims only if they are covered under that policy. Thus, if the Voluntary Accident Insurer is not obligated to pay a voluntary accident insurance claim under the terms of the policy it issues, the Plan will not pay that claim.

12.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the Voluntary Accident Insurer has the discretion and authority to construe and interpret the policy under which it provides the voluntary accident insurance benefits. This includes the authority to decide all questions concerning eligibility for voluntary accident insurance benefits, and the amount of such benefits payable. In making any such decision, the Voluntary Accident Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Voluntary Accident Insurer’s interpretation of the policy will be binding and conclusive on all persons.

**Article XIII**  
**Voluntary Critical Illness Insurance Benefits**

13.01 General. The Plan provides voluntary critical illness insurance benefits to certain eligible Employees. Such benefits are insured through an insurance policy issued by an insurance company (the “Voluntary Critical Illness Insurer”), and therefore this portion of the Plan constitutes an Insured Benefit. The insurance policy (or a sample certificate of coverage) is attached to this Plan as Appendix J. The terms, conditions, and limitations applicable to voluntary critical illness benefits are set forth in that Appendix.

13.02 Eligibility. 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 voluntary critical illness insurance policy and/or certificate of coverage) shall be eligible for voluntary critical illness benefits on the first day of the month coincident with or next following their completion of 60 days of continuous employment.

13.03 Source of Payment. Because the Plan’s voluntary critical illness insurance benefits are provided through an insurance policy, the Plan will pay voluntary critical illness insurance claims only if they are covered under that policy. Thus, if the Voluntary Critical Illness Insurer is not obligated to pay a voluntary critical illness insurance claim under the terms of the policy it issues, the Plan will not pay that claim.

13.04 Interpretation of Policy. Notwithstanding the provisions of Section 20.01, the Voluntary Critical Illness Insurer has the discretion and authority to construe and interpret the policy under which it provides the voluntary critical illness insurance benefits. This includes the authority to decide all questions concerning eligibility for voluntary critical illness insurance benefits, and the amount of such benefits payable. In making any such decision, the Voluntary Critical Illness Insurer may rely on the accuracy and completeness of any information furnished by the Company or an insured individual. The Voluntary Critical Illness Insurer’s interpretation of the policy will be binding and conclusive on all persons.

## Article XIV Claims and Appeals Procedures

14.01 Applicability. 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.

14.02 Deciding the Claim. A claim is a request for a Plan Benefit made by a claimant on a form provided by the Claims Administrator or, in the case of an urgent care claim, either orally or on such a form. A claimant is a person who participates or claims to participate in the Plan. For such a form to be considered, the claimant must mail or deliver it, completed and executed, to the Claims Administrator. A person appointed by the Claims Administrator shall decide the claim. In the case of a claim for disability benefits made on or after April 1, 2018, the Claims Administrator will take additional steps to ensure the independence and impartiality of the persons involved in deciding the claimant's claim or appeal.

None of the following constitutes a claim:

(a) The presentation of a prescription to a pharmacy to be filled at a cost to the participant determined by reference to a formula or schedule established in accordance with the terms of the Plan and with respect to which the pharmacy exercises no discretion on behalf of the Plan;

(b) A request for prior approval of a benefit or service when the prior approval is not required under the terms of the Plan; or

(c) Interactions between participants and providers under arrangements by which the providers provide services or products at a predetermined cost to participants and with respect to which the providers exercise no discretion on behalf of the Plan.

14.03 Urgent Care Claims. A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Except as provided below in this Section 14.03, whether a claim is a "claim involving urgent care" within the meaning of this Article XIV is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care," within the meaning of this Article XIV, shall be treated as a "claim involving urgent care" for purposes of this Article. The nature of a claim or a request for review of an adverse benefit determination shall be judged as of

the time the claim or review is being processed. If requested services have already been provided between the time the claim was denied and the request for review was filed, the claim no longer involves urgent care. The Claims Administrator may request specific information from the claimant regarding whether and what medical circumstances exist that may give rise to a need for expedited processing of the claim. A post-service claim never constitutes a claim involving urgent care. In the case of a claim involving urgent care, the Claims Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this Section 14.03 shall be made in accordance with the provisions of Section 14.11. The Claims Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the claimant to provide the specified additional information.

14.04 Pre-Service Claims. The term "pre-service claim" means any claim for benefits under Article II, Article IV, Article V, or Article VI of the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical, dental, and vision care. In the case of a pre-service claim, the Claims Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond control of the Plan, and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to 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. Notification of any adverse benefit determination pursuant to this Section 14.04 shall be made in accordance with Section 14.11.

14.05 Failure to Follow Pre-Service Claim Procedures. In the case of a failure by a claimant to follow the Plan's procedures for filing a pre-service claim, within the meaning of Section 14.04 of this Article, the claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant. This Section 14.05 shall apply only in the case of a failure that:

(a) Is a communication by a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(b) Is a communication that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

14.06 Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then any reduction or termination by the Plan of such course of treatment (other than by an amendment of the Plan or its termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Claims Administrator shall notify the claimant, in accordance with the provisions of Section 14.11, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Moreover, any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in compliance with the provisions of Section 14.11, and the appeal shall be governed by Sections 14.16 through 14.19, as appropriate.

14.07 Post-Service Claims. The term “post-service claim” means any claim for a benefit under Article II, Article III, Article IV, Article V, or Article VI of the Plan that is not a pre-service claim, as provided in Section 14.04. In the case of a post-service claim, the Claims Administrator shall notify the claimant, in accordance with Section 14.11, of the Plan’s adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator 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 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of a 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.

14.08 Disability Claims.

(a) In the case of a claim for disability benefits, the Claims Administrator shall notify the claimant, as provided in Section 14.11, of its adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Claims Administrator. This period may be extended by the Claims Administrator for up to 30 days, provided that the Claims Administrator 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 45-day period, of the circumstances requiring an extension of time and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent the decision on the claim, and the additional information needed to resolve those issues. The claimant shall be afforded at least 45 days within which to provide the specified information.

(b) Effective for claims made on or after April 1, 2018, if the Claims 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 Claims 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:

- (i) De minimis (*i.e.*, a minor violation);
- (ii) Non-prejudicial (*i.e.*, the violation does not cause, and is not likely to cause, harm or prejudice to the claimant);
- (iii) Attributable to a good cause or matters beyond the Plan's control;
- (iv) In the context of an ongoing good-faith exchange of information between the claimant and the Plan; and
- (v) 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.

14.09 Notification for Other Claims. In the case of any other claim for benefits under the Plan, the Claims Administrator shall notify the claimant, as provided in Section 14.11, of the Claims Administrator's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Claims Administrator. This period may be extended by the Claims Administrator for up to 90 days, provided that the Claims Administrator

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 90-day period, of the circumstances requiring an extension of time and the date by which the Claims Administrator expects to render a decision.

14.10 Calculating Time Periods for Claims. For purposes of Sections 14.03 through 14.09, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures set forth in Section 14.02, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event a period of time is extended as permitted by Sections 14.04, 14.07, 14.08, or 14.09 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 the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

14.11 Content of Notification of the Decision. The Claims Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by regulations issued by the Department of Labor under ERISA. The notification shall set forth, 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 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 on appeal;
- (e) In the case of an adverse benefit determination with respect to a claim involving health benefits,
  - (i) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or
  - (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;

(f) 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;

(g) 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).

In the case of an adverse benefit determination concerning a claim involving urgent care, the information described in this Section may be provided to the claimant orally within the time frame prescribed in Section 14.03, provided that a written or electronic notification in

accordance with this Section 14.11 is furnished to the claimant not later than three days after the oral notification.

14.12 Authorized Representative. An authorized representative of the claimant may act on his or her behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Claims Administrator may require, as a prerequisite to dealing with a representative, that the claimant verify, in writing, the authority of the representative to act on behalf of the claimant. In the case of a claim involving urgent care, a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law, with knowledge of the claimant's medical condition, may act as the authorized representative of the claimant. An assignment of benefits by a claimant to a health care provider does not constitute the designation of an authorized representative.

14.13 Consistency. The Claims Administrator shall conduct, or have conducted on its behalf, periodic reviews to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan's provisions have been applied consistently with respect to similarly-situated claimants.

14.14 Deciding the Appeal. A claimant may appeal an adverse benefit determination by mailing or delivering to the Claims Administrator a written notice of appeal. No action at law or in equity shall be brought to recover any benefit under the Plan until the rights to appeal described in this Article XIV have been exercised and the benefits requested in the appeal have been denied in whole or in part. The claimant may submit written comments, documents, records, or other information relating to the claim for benefits to the Claims Administrator. The Claims Administrator shall provide to the claimant, 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 in accordance with standards issued by the Department of Labor.

In the case of a claim for disability benefits made on or after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review, the Claims 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 Claims 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 Claims 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 decision on review will be made by a person designated by the Claims Administrator, other than the person who made the initial decision to deny the claim. The Claims Administrator's decision 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 Claims Administrator will not, however, consider a claimant's appeal unless the Claims Administrator receives it within 60 days (180 days in the case of benefits described under Article II, Article III,

Article IV, Article V, Article VI, or Article IX) following receipt by the claimant of a notification of an adverse benefit determination. The appeal will be considered by the Claims Administrator without deference to the original decision made by the Claims Administrator. In deciding an appeal of any adverse benefit determination where the determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Claims Administrator shall, when requested to do so by a claimant, identify the 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. Any health care professional engaged for purposes of a consultation under this Section 14.14 shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

14.15 Appeal of Urgent Care Claims. In the case of a claim involving urgent care:

(a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(b) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

14.16 Notification of the Decision on Appeal; Urgent Care Claims. In the case of an appeal involving urgent care, the Claims Administrator shall notify the claimant, in accordance with the provisions of Section 14.21, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.

14.17 Notification of the Decision on Appeal; Pre-Service Claims. In the case of a pre-service appeal that is not a claim involving urgent care, the Claims Administrator shall notify the claimant, in accordance with Section 14.21, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. That notification shall be provided not later than 30 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

14.18 Notification of the Decision on Appeal; Post-Service Claims. In the case of a post-service appeal, the Claims Administrator shall notify the claimant, in accordance with Section 14.21, of the Plan's benefit determination on review within a reasonable period of time. That notification shall be provided not later than 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

14.19 Notification of the Decision on Appeal; Disability Claims. In the case of an appeal for disability benefits, the Claims Administrator shall notify the claimant, in accordance with Section 14.21, of the Plan's benefit determination on review within a reasonable period of

time. That notification shall be provided not later than 45 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination. This period may be extended by the Claims Administrator for up to 45 days, provided that the Claims Administrator both determines that such an extension is necessary due to special circumstances, and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring an extension of time and the date by which the Claims Administrator expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent the decision on the appeal, and the additional information needed to resolve those issues. The claimant shall be afforded at least 45 days within which to provide the specified information.

14.20 Notification of the Decision on Appeal; Other Claims. In the case of any other appeal for benefits under the Plan, the Claims Administrator shall notify the claimant, in accordance with Section 14.21, of the Plan's benefit determination on review within a reasonable period of time. That notification shall be provided not later than 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination. This period may be extended by the Claims Administrator for up to 60 days, provided that the Claims Administrator both determines that such an extension is necessary due to special circumstances, and notifies the claimant, prior to the expiration of the initial 60-day period, of the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render a decision.

14.21 Content of Notification of the Decision on Appeal. The Claims Administrator shall provide a claimant with written or electronic notification of the Plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by the Department of Labor by regulations issued under ERISA. In the case of an adverse benefit determination, the notice shall set forth, 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 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 an adverse benefit determination with respect to a claim involving health benefits:

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

(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) 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;"

(f) In the case of notification of an adverse benefit determination for a disability claim:

(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.

In the case of an adverse benefit determination on review, the Claims Administrator shall provide access to, and copies of, documents, records, and other information described in subsections 14.21(c), (e)(i) and (ii), and (f)(ii) and (iii), as is appropriate.

14.22 Calculating Time Periods on Appeal. For purposes of Sections 14.16 through 14.21, 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 Section 14.14, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to Section 14.18 or Section 14.19 due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

14.23 Extensions of Time. A claimant may voluntarily agree to provide the Plan additional time within which to make a decision on a claim or an appeal.

14.24 One-Year Limitation on Legal Action. Neither the claimant nor his or her representative may bring any lawsuit against the Plan, or a representative or fiduciary of the Plan, more than one year from the later of: (i) the date the claim is first filed, or (ii) the date the Plan renders a decision on the claim or, if a timely appeal is filed with the Plan, on the appeal. Refer to Section 14.14 for a statement of the requirement that a claimant may not bring a lawsuit against the Plan unless he or she fully pursues his or her right to appeal under this Article XIV.

14.25 Additional Claims and Appeals Procedures Under the Affordable Care Act. Under the Affordable Care Act of 2010, additional claims and appeals procedures (and a new external review requirement) apply to group health 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 (other than "excepted benefits" that are not subject to Health Care Reform, such as a stand-alone dental or vision benefits) are not "grandfathered" for purposes of the Affordable Care Act requirements and will be subject to the following additional requirements:

- (a) If a claimant appeals a denied claim, he or she will be able to review the claim file and present evidence and testimony as part of the appeals process. In considering the appeal, the Claims Administrator will provide the claimant with any new or additional evidence that is considered, relied upon, or generated by the Plan in connection with the claim. The Claims 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 resolution of the claimant's appeal. In addition, before the Claims Administrator issues an adverse 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.

(b) The Claims Administrator will take additional steps to ensure the independence and impartiality of the persons involved in deciding the claimant's claim or appeal.

(c) The claimant will be entitled to continue coverage pending the outcome of an internal appeal. If the claimant is in an urgent care situation or is receiving an ongoing course of treatment, he or she 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 the claimant 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 the Claims 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 Claims 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:

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

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

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

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

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

In addition, the claimant is 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 the claimant's request for immediate review on the basis that the Plan met this standard, the claimant has the right to resubmit and pursue the internal appeal of the claim.

(f) There will be an opportunity for review of the claimant's denied appeal by a party outside the Plan (or the plan sponsor or insurer), as described 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 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.

**Article XV**  
**Qualified Medical Child Support Orders**

15.01 General. Medical child support orders may create or recognize the right of a child of an eligible Employee to be entitled to a particular Benefit provided under this Plan. Typically, such orders are issued in divorce proceedings, though they also may be issued outside of such proceedings to address certain 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.

15.02 Definitions. As used in this Article, unless the context indicates otherwise, the following terms shall have the following meanings:

(a) "Alternate Recipient" means any child of an eligible Employee 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 of an eligible Employee 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 benefits described in Article II, the health care flexible spending account described in Article III, the dental benefits described in Article IV, the vision benefits described in Article V and the employee assistance program benefits described in Article VI of this 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 an Employee or beneficiary is eligible under the Plan;

(ii) Clearly specifies —

(A) The name and the last known mailing address (if any) of

the Employee 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.

15.03 Notice. Upon the Plan’s receipt of a Medical Child Support Order with respect to an eligible Employee, the Plan Administrator shall promptly give notice of the receipt of the Order, and give notice of these Procedures, to the Employee 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.

15.04 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 the Employee and the Alternate Recipient of the determination within a reasonable time after that determination is made.

(c) The Employee 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. The Employee or 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 the Employee or 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 the Employee and the Alternate Recipient.

15.05 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 the 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 the Employee or Alternate Recipient has a right to appeal a prior determination regarding whether the Medical Child Support Order is a Qualified Medical Child Support Order.

15.06 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.

15.07 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.

15.08 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.

**Article XVI**  
**Continuation of Coverage Under the FMLA**

16.01 Applicability. The Plan's authorized leave of absence procedures shall apply to the group health Benefits provided under Article II, Article IV, Article V, and Article VI of this Plan. The authorized leave of absence procedures with respect to the health care flexible spending account program described in Article III are described in the summary of the Flexible Benefits Plan which is attached as Appendix B of this Plan. A participant's rights to Benefits, other than the group health Benefits listed above, while on FMLA leave depend on the Company's established policies. However, any Benefits that would be maintained while a participant is on other forms of leave, including paid leave that is taken as a substitute for FMLA leave, must be maintained while the participant is on FMLA leave.

16.02 Continuation of Coverage. If a participant takes a period of leave authorized by the Family and Medical Leave Act ("FMLA Leave"), he or she may continue coverage for himself or herself and his or her dependents under the Plan during the period of FMLA Leave. The participant would do so by making the same contribution he or she would have made had he or she not taken FMLA Leave, but had instead continued his or her active employment and his or her participation in the Plan.

16.03 Timing of Payment for Coverage.

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

(b) Unpaid FMLA Leave. If a participant's FMLA Leave is unpaid, the participant must make his or her contributions no later than the time they would have been made had he or she not taken FMLA Leave (but had instead continued his or her employment and his or her participation in this Plan).

(c) Termination of Coverage. If a participant is entitled to a period of FMLA Leave, the participant may elect not to continue coverage under this Plan during his or her leave. In that case, the participant's coverage would terminate on the last day of the month for which he or she paid advance contributions. However, if the participant elects to continue coverage during a period of FMLA Leave, the participant's coverage will continue until the earliest of:

(i) The date the participant fails to return to work for the Company after his or her period of FMLA Leave, and after his or her employment is thereby terminated;

(ii) The date the participant exhausts his or her entire FMLA Leave;

(iii) The thirtieth day following the date the participant's contribution was due and unpaid (if that contribution remains unpaid on such thirtieth day) or 15 days after the Company provides written notice that the contribution has not been received, if later; or

(iv) The date the Plan terminates.

(d) Restoration of Coverage. If the participant is on FMLA Leave and does not continue his or her coverage under this Plan (whether due to his or her failure to pay the required contributions or his or her election not to continue coverage during his or her period of leave), the participant's coverage under the Plan will be reinstated upon his or her return from FMLA Leave. The participant will be entitled to receive the same coverage he or she had prior to his or her 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 a participant is a key employee, special rules will apply. In that event, if the participant is entitled to FMLA Leave, and the Company properly notifies the participant that it does not intend to restore him or her to his or her job at the end of his or her leave because doing so would cause substantial and grievous economic injury to the Company's operations, and if the participant nevertheless does not, within a reasonable time after receiving that notice, terminate his or her FMLA Leave and return to work for the Company, the participant's coverage (and that of his or her dependents) will continue until the earliest of:

(A) The date the participant gives notice to the Company that he or she no longer wishes to return to work;

(B) The date the Company denies the participant's reinstatement to employment at the end of his or her FMLA Leave;

(C) The thirtieth day following the date the participant's contribution was due and unpaid (if that contribution remains unpaid on such thirtieth day) or 15 days after the Company provides written notice that the contribution has not been received, if later; or

(D) The date the Plan terminates.

16.04 Construction in Accordance With FMLA. The rules in this Article XVI 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.



**Article XVII**  
**Continuation of Coverage During and Reemployment After Military Service**

17.01 Applicability. The Plan's military leave of absence procedures shall apply to the Benefits provided under Article II, Article III, Article IV, Article V, and Article VI of this Plan.

17.02 Military Leave of Absence. 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) 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) may elect to continue his or her Plan coverage (and that of his or her eligible dependents) by giving notice and paying the required amounts. The charges an eligible Employee will have to pay will be determined by the Plan Administrator. If any single period of "Qualified Uniformed Service," as defined in subsection (e), is for a period of less than 31 days, the Company will pay the amount it would pay for the eligible Employee's coverage, and the eligible Employee will pay the amount he or she would pay for his or her coverage, as if he or she had not entered Qualified Uniformed Service. In other cases, the premiums will reflect both the eligible Employee's portion and the Company's portion, determined in the same manner as COBRA premiums under Article XVIII of this Plan. The maximum period and the conditions of such continued coverage shall be governed by the applicable provisions of Article XVIII, except that the 18-month maximum period of continuation coverage shall be increased to 24 months.

(b) An eligible Employee on a period of USERRA leave will be eligible for Benefits on the first day of his or her reemployment once he or she returns from that leave, in the same class of coverage he or she had when his or her USERRA leave began, but only if each of the following requirements is met:

(i) He or she has reemployment rights under USERRA;

(ii) He or she is reemployed by the Company; and

(iii) He or she was eligible for Benefits immediately prior to the commencement of the USERRA leave.

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

(c) Neither the eligible Employee nor, if they had been protected persons at the time the USERRA leave commences, the eligible Employee's 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) Qualified Uniformed Service. An 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 an Employee is absent from employment for the purpose of an examination to determine the fitness of the Employee to perform any such duty, a period for which an Employee is absent from employment for the purpose of performing funeral honors duty as authorized by law, and a period for which an Employee is 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) The Employee had coverage under this Plan at the time his service began.

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

## **Article XVIII**

### **Continuation of Coverage Under COBRA**

18.01 Applicability. The following COBRA procedures shall apply to the Benefits provided under Article II, Article IV, Article V, and Article VI of this Plan, but only to the extent that such procedures are not provided under the applicable Component Documents. The rules for COBRA continuation coverage with respect to the health care flexible spending account program described in Article III are described in the summary of the Flexible Benefits Plan which is attached as Appendix B.

18.02 Continuation of Coverage Under COBRA. This Article XVIII contains important information about the right of eligible Employees and certain of their dependents to COBRA coverage, which is a temporary extension of group health coverage under the Plan, as well as other coverage alternatives that may be available to eligible Employees 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 Article XVIII generally explains COBRA coverage, when it may become available, and how to protect the right to receive it.

18.03 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 Article II, Article IV, Article V, or Article VI of 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 subsection (a), above, so long as newborn or newly adopted children elect COBRA coverage 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 subsection (b), above, a person whose coverage under Article II, Article IV, Article V, or Article VI of 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 relevant Articles of the Plan by reason of another person’s election of COBRA coverage, and the individual is not otherwise eligible under the provisions of this Section 18.03. 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.

18.04 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.”

An Employee will become a qualified beneficiary if he or she would lose coverage under Article II, Article IV, Article V, or Article VI of the Plan because either of the following qualifying events occurs:

(a) The Employee’s termination of employment, other than for gross misconduct; or

(b) The Employee’s reduction in work hours below the minimum needed to maintain his or her eligibility under Article II, Article IV, Article V, or Article VI of the Plan or any Benefit provided thereunder.

A dependent spouse of an Employee will become a qualified beneficiary if he or she would lose coverage under Article II, Article IV, Article V, or Article VI of the Plan because any of the following qualifying events occur:

(a) The death of an Employee;

(b) The termination of an Employee’s employment, other than for gross misconduct;

(c) A reduction in an Employee’s work hours below the minimum needed to maintain the dependent’s eligibility under Article II, Article IV, Article V, or Article VI of the Plan or any Benefit provided thereunder; or

(d) The divorce or legal separation of an Employee.

A dependent child of an Employee will become a qualified beneficiary if he or she would lose coverage under Article II, Article IV, Article V, or Article VI of the Plan because any of the following qualifying events occur:

(a) The death of an Employee;

(b) The termination of an Employee’s employment, other than for gross misconduct;

(c) A reduction in an Employee’s work hours below the minimum needed to maintain the dependent child’s eligibility under Article II, Article IV, Article V, or Article VI of the Plan or any Benefit provided thereunder;

(d) The divorce or legal separation of an Employee; or

(e) A child's ceasing to qualify as an "eligible child" under Article II, Article IV, Article V, or Article VI of the Plan.

In the event an Employee fails to return to work for the Company at the conclusion of his or her FMLA Leave, the qualifying event occurs on the last day of the Leave.

**18.05 Coverage Continuation Periods.** If an Employee and his or her dependents would lose coverage because of the Employee's termination of employment or reduction in work hours, the Employee and his or her dependents may apply for continuation of coverage for up to 18 months after that event. A special rule applies if an Employee becomes entitled to Medicare within 18 months prior to the termination of employment or reduction in work hours below the minimum needed to maintain his or her dependent's eligibility under the Plan. In such a case, the Employee's subsequent termination of employment or reduction in work hours will entitle his or her dependents to continuation coverage that extends until the later of (a) 18 months after the Employee's termination of employment or reduction in work hours, or (b) 36 months after the Employee's Medicare entitlement. In no case will any cumulative period of continuation coverage exceed 36 months.

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

**18.06 Successive Qualifying Events.** If an Employee's dependents elect continued coverage following the Employee's termination of employment or reduction in work hours, and then a second qualifying event that would otherwise entitle the Employee's dependents to 36 months of continued coverage occurs during that continuation period, those dependents 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, 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 Section 18.03, above, at the time of the second qualifying event. A qualified beneficiary (or his or her representative) must also notify the Plan Administrator within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator, Goodwill of Western Missouri and Eastern Kansas Medical Plan, 1817 Campbell Street, Kansas City, Missouri 64108.

**18.07 Social Security Disability.** A special rule applies if an Employee or his or her dependent is determined to have been disabled on the date of the Employee's termination of employment or reduction in work hours, or within the first 60 days of such Employee's or dependent's COBRA coverage under this Article XVIII. Subject to the conditions described in this and the following paragraph, such a disabled individual (and other family members who are eligible for COBRA coverage due to the same qualifying event) may purchase up to 11 more months of coverage — for a total of 29 months. 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 notify the Plan Administrator of the Social Security Administration's disability determination within 60 days after the later of (a) the date of the Employee's termination of employment or reduction in work hours, or (b) the date the disability determination is issued (and within the individual's first 18 months of continuation coverage). This notice must be sent to the Plan Administrator, Goodwill of Western Missouri and Eastern Kansas Medical Plan, 1817 Campbell Street, Kansas City, Missouri 64108.

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. This notice must be sent to the Plan Administrator, Goodwill of Western Missouri and Eastern Kansas Medical Plan, 1817 Campbell Street, Kansas City, Missouri 64108. The individual's right to the 11-month extension of continuation coverage (as well as that of any family members) will terminate as of the first day of the month that begins more than 30 days after the second determination is issued.

18.08 Notification Requirements. An Employee or dependent must notify the Plan Administrator within 60 days of any divorce, legal separation, or child's ceasing to be an "eligible child" under the terms of the Plan. This notice must be sent to the Plan Administrator, Goodwill of Western Missouri and Eastern Kansas Medical Plan, 1817 Campbell Street, Kansas City, Missouri 64108. If such timely notice is not received, the provisions of this Article XVIII 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 that event.

18.09 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.

18.10 Benefits Subject to Continuation. The coverage that Employees and their dependents are entitled to continue will be the same as that provided to 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 qualifying event by which he or she becomes entitled to continued coverage under this Article XVIII.

18.11 Election of Continued Coverage. An individual eligible to continue coverage under this Article XVIII will be sent an application for continued coverage within 14 days after the Plan Administrator is notified of a qualifying event. If that individual wishes to continue his or her coverage, he or she must complete the application and return it 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 assistance under the Trade Act of 1974 should contact the Plan Administrator.

18.12 Payment for Continued Coverage. If an individual elects continued coverage under this Article XVIII, 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 of the date 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 Article XVIII of an amount that is less than the amount due for that month's premium, and the shortfall is no more than the lesser of 10% of the premium or \$50, the Plan will notify the individual of the deficiency. To maintain coverage, the individual must pay that deficiency within 30 days of the date the Plan notifies the individual of it.

18.13 Termination of Continued Coverage. Continued coverage under this Article XVIII for any Employee or dependent 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 before the end of the 30-day grace period described in Section 18.12, 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.

**Article XIX**  
**Disclosures of Protected Health Information**

19.01 General. The Plan will disclose protected health information that is created or received under the 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 provisions in this Article XIX 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 Article XIX.

19.02 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 19.02 do not comply with the conditions set forth in subsection (a) of this Section 19.02, the Company will provide a mechanism for resolving issues of noncompliance, including appropriate disciplinary sanctions.

**Article XX**  
**Administration of Plan**

20.01 Administration. The administration of the Plan will be under the supervision of the Plan Administrator. It will be a principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan, and without discrimination among them. The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

- (a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;
- (b) To exercise discretion in interpreting the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming Benefits under the Plan;
- (c) To exercise discretion in deciding all questions concerning the Plan and the eligibility of any person to participate in it;
- (d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan;
- (e) To allocate and delegate its responsibilities under the Plan and to designate any persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be in writing; and
- (f) To enter into contracts and agreements for carrying out the terms of this Plan and for the administration thereof, any such contracts and agreements to be binding and conclusive on the parties hereto and any Employees concerned.

Notwithstanding the foregoing, any claim which arises under an Insured Benefit will be the responsibility of the relevant Claims Administrator, and will not be subject to review by the Plan Administrator, nor will the Plan Administrator have the power or authority to interpret, construe, or administer the provisions of an Insured Benefit.

20.02 Reliance on Tables, etc. In administering the Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, any insurance company that has issued an insurance policy to underwrite an Insured Benefit, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

## **Article XXI General Provisions**

21.01 Governing Law. The Plan is established in the State of Missouri. To the extent federal law does not apply, any questions arising under the Plan will be determined under the laws of that State.

21.02 Contributions. The Company will determine from time to time the required contribution amounts, if any, for each Benefit. Prior to the beginning of each Plan Year, the Company will determine the portion, if any, of the required contribution amount it will contribute each pay period. To obtain coverage under the Plan, an Employee must pay the required contribution amount, as reduced by any contribution made on his or her behalf by the Company. The Company will inform eligible Employees of their portion of the costs of the Benefits available to them under the Plan.

21.03 Alienation. No Benefits under this Plan may be assigned, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for an Employee's debts or obligations, except that an Employee may assign Benefits to a provider of medical services or supplies. The Plan Administrator may, if it deems appropriate, direct that Benefits under this Plan be paid directly or in whatever manner it authorizes. If a person who is entitled to receive a payment under the Plan is, in the Plan Administrator's opinion, incapable of giving a valid receipt for the payment, and if no guardian has been appointed for that person, the Plan Administrator may make the payment to the person or persons who, in the Plan Administrator's opinion, have assumed the obligations of caring for the person on whose behalf the payment is made.

21.04 Termination and Amendment. The Company may terminate this Plan at any time, or may amend or modify it from time to time, as it deems proper. In addition, the Company may, at any time, (i) amend, modify or terminate any Benefit described herein, or (ii) amend the Plan to add one or more new benefits. Any amendment or modification will be in writing and as formal as this Plan.

21.05 Gender and Number. In the construction of this Plan, the masculine will include the feminine and the singular the plural in all cases where those meanings would be appropriate.

21.06 Plan Not in Place of Workers' Compensation. This Plan is not in place of, and does not affect any requirement for coverage by, workers' compensation insurance.

21.07 Effective Date. The effective date of this Plan is January 1, 2018.

**Article XXII**  
**Health Care Reform Requirements**

22.01 General. The group health benefits under the Plan will be subject to the provisions of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act (P.L. 111-152) (hereinafter referred to collectively as “Health Care Reform”).

30.02 Requirements Applicable to Non-Grandfathered Benefits. Notwithstanding any provision in the Plan (or any Component Document) to the contrary, group health benefits offered under the Plan (other than “excepted benefits” that are not subject to Health Care Reform, such as stand-alone dental or vision benefits) are not “grandfathered” for purposes of Health Care Reform and shall comply with the following requirements:

- (a) The prohibition on lifetime limits, and the limitations on annual limits, on reimbursements under the Plan;
- (b) The prohibition on exclusions based on pre-existing condition;
- (c) The restrictions on rescissions;
- (d) The requirement that dependent coverage, if offered, be extended to age 26, regardless of the child’s marital status, student status, residency or source of support (even if the child is eligible for coverage under another employer plan);
- (e) The “patient protection” provisions of Health Care Reform, which include:
  - (i) The right to designate any network physician;
  - (ii) The right to see an OB-gyn without authorization or referral; and
  - (iii) Certain rights with respect to emergency care;
- (f) The claims and appeals (and external review) provisions set forth in Section 14.25; and
- (g) The rules requiring coverage of certain preventive services.

IN WITNESS WHEREOF, Goodwill of Western Missouri and Eastern Kansas, by action of its duly-authorized representative, hereby adopts this Goodwill of Western Missouri and Eastern Kansas Medical Plan on this \_\_\_\_\_ day of \_\_\_\_\_, 2018, the same to be effective as of January 1, 2018.

**Goodwill of Western Missouri and Eastern  
Kansas  
(the “Company”)**

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

**Appendix A**  
**Medical and Prescription Drug Policy (or Certificate)**

**Appendix B**  
**Goodwill of Western MO & Eastern Kansas Cafeteria Plan and Helping Hand of Goodwill**  
**Industries Extended Employment Cafeteria Plan**

**Appendix C**  
**Dental Insurance Policy (or Certificate)**



**Appendix D**  
**Vision Insurance Policy (or Certificate)**

**Appendix E**  
**Employee Assistance Program Benefits Contract**

**Appendix F**  
**Life and Accidental Death & Dismemberment Insurance Policy (or Certificate)**

**Appendix G**  
**Short Term Disability Insurance Policy (or Certificate)**

**Appendix H**  
**Voluntary Life and Voluntary Accidental Death and Dismemberment Insurance Policy**  
**(or Certificate)**

**Appendix I**  
**Voluntary Accident Insurance Policy (or Certificate)**

**Appendix J**  
**Voluntary Critical Illness Insurance Policy (or Certificate)**