SUMMARY PLAN DESCRIPTION

OF THE

CONSOLIDATED COMMUNICATIONS, INC. HEALTH BENEFITS PLAN

(Amended and Restated Effective as of January 1, 2019)

Revision Date: January 1, 2022

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TABLE OF CONTENTS

Page

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Consolidated Communications Holdings, Inc. (the "**Plan Sponsor**") maintains the Consolidated Communications, Inc. Health Benefits Plan (the "**Plan**") for the benefit of the eligible Employees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers. The Plan Sponsor amended and restated the Plan effective as of January 1, 2019.

The Plan is an "employee welfare benefit plan", as defined in the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"). The Plan provides benefits to Participants, in accordance with the terms, conditions and limitations of the Plan. Terms of the Plan pertaining to eligibility, coverage, exclusions and limitations on coverage, and other rules pertaining to the benefits available under the Plan, are set forth in this Summary Plan Description of the Plan (the "**SPD**") and the Welfare Program Documents (as defined herein) which are incorporated into this SPD in their entirety by reference and attached hereto as Appendix C.

Please review this SPD carefully, including the Welfare Program Documents, before you assume that any expense you incur will be eligible for payment or reimbursement under the Plan. You should pay particular attention to the provisions in this SPD and the Welfare Program Documents concerning exclusions, limitations on coverage and precertification requirements.

The masculine gender of words used in this document includes the feminine gender, and words used in the singular include the plural, and vice-versa, when applicable. Terms with initial capital letters used in this SPD are defined in Article I.

FOREWORD

The benefits provided under the Plan are for the exclusive benefit of the eligible Employees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers of the Plan. These benefits are intended to be continued indefinitely, however, the Plan Sponsor reserves the unilateral right and discretion to make any changes, without advance notice, to the Plan which it deems to be necessary or appropriate, in its discretion, to comply with applicable law, regulation or other authority issued by a governmental entity. The Plan Sponsor also reserves the unilateral right and discretion to amend, modify, or terminate, without advance notice, all or any part of the Plan and to make any other changes that it deems necessary or appropriate in its discretion. Changes in the Plan may occur in any or all parts of the Plan, including, but not limited to, benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like, under any or all of the Welfare Programs identified in Appendix B. You should not, therefore, assume that the benefits which are provided under the Plan will continue to be available and remain unchanged, and you should disregard any information or communication (written or oral) that would seem to limit the Plan Sponsor's absolute right and discretion to terminate, suspend, discontinue or amend such benefits. Furthermore, the Plan Administrator and the Claims Fiduciary, as applicable, each reserve the absolute right, authority and discretion to interpret, construe, construct and administer the terms and provisions of the Plan, in their discretion, including correcting any error or defect, supplying any omission, reconciling any inconsistency, and making all findings of fact including, without limitation, any factual determination that may impact eligibility or a claim for benefits. Benefits under the Plan will be paid only if the Plan Administrator or Claims Fiduciary, as applicable, determines in its discretion that the Participant is entitled to them. All decisions, interpretations and other determinations of the Plan Administrator or Claims Fiduciary, as applicable, will be final, binding and conclusive on all persons and entities subject only to the claims appeal procedures of the Plan. There will be no *de novo* review of any such decision, interpretation or determination by any court. Any review of such decision, interpretation or determination will be limited to determining whether the decision, interpretation or determination was so arbitrary and capricious as to be an abuse of discretion under ERISA's standards.

ARTICLE I
DEFINITIONS

The following terms, where capitalized, will have the meanings set forth below when used in this SPD and thus supersede any other meanings for the same terms set forth in the Welfare Programs, unless a different meaning is plainly required by the context:

1.1 **Active Service** means performance by the Employee of all the regular duties of his occupation at an established business location of the Employer, or at another location to which he may be required to travel to perform the duties of his employment. An Employee will be deemed to be in Active Service (a) if the Employee is absent from work due to a health factor, or (b) on any day which is not one of the Employer's scheduled work days, provided that the Employee met the criteria above for "Active Service" on the preceding scheduled work day. In no event will an Employee be considered in Active Service if he has effectively terminated employment with the Employer.

1.2 **Affiliate** means a corporation or other entity which is controlled by the Plan Sponsor, or under common control with the Plan Sponsor, as determined by the Plan Sponsor after taking into consideration the common control rules under Section 3(40)(B) of ERISA (multiple employer welfare associations).

1.3 **Affordable Care Act** means the federal Patient Protection and Affordable Care Act of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010 and subsequent amendments, and the authoritative guidance issued thereunder by the appropriate governmental entities.

1.4 **Beneficiary** means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

1.5 **Board of Directors** means the Board of Directors of the Plan Sponsor.

1.6 **CEO** means the then current Chief Executive Officer of the Plan Sponsor.

1.7 **Claims Administrator** means the third party administrator, insurance company or other entity, as set forth in Appendix D, designated by the Plan Administrator to process claims and perform other administrative duties under the Plan or a Welfare Program.

1.8 **Claims Fiduciary** means the person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding claims under a Welfare Program. The Claims Fiduciary shall be the Plan Administrator unless otherwise set forth in Appendix D.

1.9 **Claims Regulations** means the claims regulations issued by the U.S. Department of Labor under ERISA, as set forth at 29 CFR § 2560.503-1 and 29 CFR § 2590.715-2719, collectively, as may be amended from time to time. References herein to any section of the Claims Regulations will also refer to any successor provision thereof.

1.10 **COBRA Administrator** means the Plan Administrator, or the third party designated by the Plan Administrator to perform COBRA administration under the Plan on behalf of the Plan Administrator.

1.11 **Code** means the Internal Revenue Code of 1986, as amended, and the implementing regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code will also refer to any successor provision thereof.

1.12 **Dependent** means a dependent (including a Spouse) of an Employee who is covered under the Plan, as such term is defined under the respective Welfare Program, or otherwise provided in this SPD.

1.13 **Disclosure Administrator** means the individual or entity, as designated in Article XIV, to whom the Plan Administrator has delegated the authority, duty and discretion to furnish, on its behalf, the disclosures that are required by Section 104(b)(4) of ERISA and which are requested in accordance with Section 10.5 of this SPD.

1.14 **Effective Date** means the effective date of the amendment and restatement of the Plan, *i.e.*, January 1, 2019.

1.15 **Eligibility Date** means the date on which an Employee becomes eligible for coverage under the Plan, as specified in Section A of Appendix F.

1.16 **Employee** means any individual who is (1) considered to be in an employer-employee relationship with the Employer and (2) on the United States payroll records of the Employer for purposes of federal income tax withholding, unless otherwise specified in a Welfare Program. Except as may otherwise be expressly stated in a Welfare Program, the term "Employee" will not include any person during any period that such person was classified on the Employer's records as other than an Employee. For example, the term "Employee" will not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee or similar classification, regardless of any determination by a governmental agency that any such person is or was a common law employee of an Employer, even if such determination has a retroactive effect. For purposes of this definition, (a) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Section 414(n)(2) of the Code, whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party, and (b) an "independent contractor" means any person rendering service to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on IRS Form 1099 (or its successor), regardless of whether any agency (governmental or otherwise) or court concludes that the person is, or was, a common law employee of the Employer even if such determination has a retroactive effect.

Furthermore, employees who (i) are non-resident aliens and (ii) receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) will not be considered Employees who are eligible to participate in the Plan.

1.17 **Employer** means the Plan Sponsor or any Affiliate which is part of a controlled group of entities, as defined in Code Section 414(b) or (c), that includes the Plan Sponsor. In addition, any other Affiliate not described in the preceding sentence may adopt the Plan with the consent of the Plan Sponsor and, in such event, any such other adopting Employer of the Plan will be listed in Appendix A (attached hereto), as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Plan.

1.18 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

1.19 **Fully-Insured Program** means each of the following Welfare Programs that are fully-insured:

- Consolidated Communications, Inc. VSP Group Vision Care Insurance Program; and
- Kaiser Permanente Deductible HMO Plan for Consolidated Communications Holdings, Inc.

1.20 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

1.21 **Participant** means an Employee of the Employer who meets the requirements for eligibility as set forth in Article III and who properly enrolls for coverage under the Plan. The term "Participant" also includes any Dependent of a person specified in the previous sentence who is properly enrolled for coverage under the Plan. A person will cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan.

1.22 **Participant Contribution** means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" includes contributions used for the provision of benefits under a self-funded arrangement of the Plan Sponsor or an Employer as well as contributions used to purchase coverage under insurance contracts or policies.

1.23 **Plan** means the Consolidated Communications, Inc. Health Benefits Plan, which consists of (i) the Plan document, (ii) the Policy(ies) set forth in the Policy Appendix to the Plan document and incorporated therein by reference, (iii) this SPD (including any appendices attached hereto), and (iv) each Welfare Program Document incorporated hereunder by reference, as amended from time to time. The Plan document, Policy(ies), SPD and Welfare Program Documents each contain the terms of the Plan and together constitute the Plan.

1.24 **Plan Administrator** means the person or entity which has the authority and responsibility to manage and direct the operation of the Plan in its discretion. However, the Plan Administrator may assign or delegate duties to third parties, such as the Claims Administrator or the Claims Fiduciary, under the terms of either the Plan or any Welfare Program, or by means of a separate written agreement. The Plan Administrator is the "plan administrator" for purposes of Section 3(16)(A) of ERISA. The Plan Administrator will be Consolidated Communications, Inc.

1.25 **Plan Sponsor** means Consolidated Communications Holdings, Inc. or its successor in interest.

1.26 **Plan Year** means each twelve (12) consecutive month period commencing January 1st and ending on December 31st of each year.

1.27 **SPD** means this Summary Plan Description document, including any appendices attached hereto, and each Welfare Program Document incorporated hereunder by reference, as all such documents may be amended from time to time, and all of which are incorporated into the Plan by reference and contain the terms of the Plan.

1.28 **Spouse** means a person to whom an Employee is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable federal law (including, but not limited to, the Code, ERISA, and the Affordable Care Act) and any regulations promulgated under such federal law, but shall not include an individual divorced or legally separated from the Employee by court decree. The term "Spouse" will also include a common law spouse if the Employee and spouse were common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. The Employee must provide proof of marriage if requested by the Plan Administrator such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state.

1.29 **Welfare Program** means a program of benefits that is offered by the Plan Sponsor (and/or another Employer) under the Plan to provide certain employee group health benefits coverage to eligible Employees and their eligible Dependents, which would be an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately. The Welfare Programs are incorporated into this SPD, which is, in turn, incorporated into the Plan. Each Welfare Program under the Plan is identified in Appendix B of this SPD. The Plan Sponsor may add or delete a Welfare Program from the Plan by amending Appendix B of this SPD.

1.30 **Welfare Program Document** means a written arrangement, including (a) a benefits booklet, summary of coverage, plan document or summary plan description, including any amendments, riders or attachments thereto, (b) an insurance contract between an Employer and an insurance company, health maintenance organization (HMO), administrative service organization (ASO) or other similar organization to provide certain employee group health benefits, including any amendments, endorsements or riders thereto, or (c) a certificate of coverage, schedule of benefits, notice or other instrument under which a Welfare Program is established, operated or maintained. Each of the documents referenced in items (a), (b) and (c) (above) is attached to this SPD as part of Appendix C and incorporated, in its entirety, herein by reference. A Welfare Program Document (or any portion thereof) will not, in and of itself, constitute either the written "Plan document" or the "summary plan description" of the Plan, as required by ERISA, notwithstanding any references in any Welfare Program Document to the contrary; however, such Welfare Program Document does contain the terms of the Plan. Any reference to a Welfare Program Document also refers to any amendment, rider, exhibit or attachment thereto.

ARTICLE II
INTERPRETATION

Notwithstanding any reference in a Welfare Program Document that such Welfare Program Document, in and of itself (or any portion thereof), constitutes a "summary plan description" of the Plan, as required by ERISA, the official Summary Plan Description consists of this document (including any appendices attached hereto) and the Welfare Program Documents incorporated herein by reference. If a term or provision of the SPD conflicts with a term or provision of a Welfare Program Document, the term or provision of the relevant Welfare Program Document will control unless specifically stated otherwise herein. Further, if a term or provision of the SPD conflicts with any term or provision of the Plan document, then the term or provision of the SPD will control.

Notwithstanding the foregoing, if there is a conflict between a term or provision of the Plan document, a Welfare Program Document, a Policy or this SPD, and such conflict involves a term or provision required by ERISA, the Code or other controlling law, on the one hand, and a term or provision not so required on the other, the term or provision required by controlling law will control. This determination will be made by the Plan Administrator. The terms and provisions of this SPD will not enlarge the rights of a Participant, Dependent or Beneficiary to any benefits available under a Welfare Program.

The terms and provisions of the Plan include the terms and provisions of the Plan document, the Policy(ies) listed in the Policy Appendix to the Plan, the SPD, and the Welfare Program Documents.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.1 **Eligibility**.

An Employee and his Dependents will be eligible to participate in the Plan in accordance with the eligibility provisions of Appendix F.

3.2 **Enrollment**.

An Employee's or Dependent's enrollment in the Plan shall become effective as specified in Appendix F. The Plan Administrator may establish procedures in accordance with Appendix F and the Welfare Programs for the enrollment of Employees (and/or their Dependents) under the Plan. The Plan Administrator will provide enrollment forms, either paper or electronic, that must be completed by the prescribed deadline prior to commencement of coverage under the Plan.

3.3 **Termination of Participation**.

A Participant will cease being a Participant in the Plan, and coverage under the Plan for the Participant and his Dependents will terminate as specified in Appendix F.

ARTICLE IV
FUNDING

Notwithstanding anything to the contrary contained herein or in a Welfare Program Document, participation in the Plan by a Participant and the payment of Plan benefits will be conditioned on such Participant Contributions towards the cost of coverage under the Plan at such time and in such amounts as the Plan Administrator will establish from time to time. The Plan Administrator shall designate the applicable method by which the Participant must make any Participant Contributions, and the Participant must consent in writing to such payment method to remain covered under the Plan. To the extent the Plan provides for an electronic enrollment process, and as permitted by applicable law, completion of such process by an Eligible Employee will be deemed to provide the requisite written consent to the applicable payment method.

Nothing herein requires an Employer or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, Dependent or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Employee, Dependent or Beneficiary will have any right to, or interest in, the assets of any Employer as the result of coverage under the Plan until actually paid. The Plan shall not be "funded" for purposes of ERISA.

Benefits or premiums for the Plan will be provided through insurance contracts or through the general assets of the Employer in accordance with the terms of the relevant Welfare Program. An Employer will have no obligation, but will have the right, to insure or reinsure or to purchase stop loss coverage, where applicable, with respect to any Welfare Program under the Plan. To the extent that the Plan is provided through an Employer's purchase of insurance, payment of any benefits under such Welfare Program will be the sole responsibility of the insurer, and the Employer will have no responsibility for such payment.

ARTICLE V
BENEFITS

(a) Except as provided in Appendix F, and subject to subsection (b) below, the actual terms and conditions of eligibility, coverage, exclusions and limitations on coverage, and the additional rules pertaining to the benefits of Participants under the Plan, are set forth in the Welfare Program Documents. Subject to subsection (b), below, any maximum benefit amounts, deductibles, copayments, out-of-pocket maximum amounts, and the reimbursement percentages for eligible charges under the Plan, are contained in the Welfare Program Documents, as they may be amended from time to time. The Welfare Program Documents, as then currently in effect, are incorporated in their entirety by reference into this SPD which, in turn, is incorporated by reference into the Plan.

(b) In addition to any exclusions from coverage set out in the applicable Welfare Program Document, the Plan will exclude from coverage any charges incurred by a Participant with respect to which the Participant (i) is not obligated to pay, (ii) is not billed, or (iii) would not have been billed but for the coverage of such charges

under the terms of the Plan. Consequently, if the Claims Fiduciary determines that a health care provider is waiving, reducing or forgiving (or has waived, reduced, or forgiven) any portion of its charges for covered services or supplies provided to a Participant, or any portion of any copayment, deductible, or coinsurance amount that the Participant is required to pay for such provider's covered services or supplies under the applicable terms of the Plan, without the Claims Fiduciary's express written consent, then the Claims Fiduciary shall have the unilateral right and discretion to wholly or partially reduce the benefits paid under the terms of the Plan with respect to such services in order to offset, or in proportion to, the amount of such charges, copayments, deductibles, or coinsurance amounts waived, forgiven or reduced, regardless of whether such provider represents or affirms that the Participant remains financially responsible for such amount. Furthermore, the Claims Fiduciary reserves the unilateral right and discretion to require a Participant to provide satisfactory written proof that the Participant has paid the required copayment, deductible, or coinsurance amount attributable to any covered services or supplies received, whether prior to or subsequent to the payment by the Claims Fiduciary of any Plan benefits for such services or supplies; provided, however, that the Claims Fiduciary's failure to request any such proof in any one or more instance shall not constitute any waiver or limitation of this exclusion under the Plan.

For purposes of clarification, and not limitation, the exclusion set forth in this subsection would apply, for example, to an out-of-network provider's charges for services or supplies provided to a Participant based on such provider's agreement to set those charges at the in-network benefits level under the Plan or at another level not otherwise applicable to such services or supplies under the terms of the Plan.

The Claims Fiduciary shall have the sole discretion to (i) interpret, construe and apply the exclusion set out in this subsection and (ii) make any determinations and decisions deemed to be necessary or appropriate for such purpose, and (iii) otherwise effectuate the intent of such exclusion.

(c) To the extent that benefits under a Welfare Program are provided through a network provider organization, the Plan's reimbursement of charges by a participating network provider will be limited to the rates which have been negotiated between the Claims Administrator and the provider network. In addition, any amounts charged by network providers over the negotiated rate will not be covered and cannot be charged back to the Participant, that is, there will be no balance billing by network providers directly to Participants.

(d) Notwithstanding anything to the contrary contained herein, with respect to the Fully-Insured Programs, benefits will be paid solely in the form and amount specified in the relevant Welfare Program Document for each Fully-Insured Program, and pursuant to the terms and conditions of such Fully-Insured Program, except as otherwise required by ERISA, the Code or other applicable law, regulation, or other authority issued by a governmental entity.

(e) The Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This provision will not require that the Plan contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. Further, this provision will not prevent the Plan from establishing varying reimbursement rates based on quality or performance measures.

ARTICLE VI
CLAIMS PROCEDURES

6.1 **General**.

(a) Except as provided in subsection (b) (below), a claim for benefits under a Welfare Program will be submitted in accordance with, and to the party designated under, the terms of such Welfare Program. Notwithstanding the foregoing, unless a Welfare Program specifically provides otherwise, a claim for benefits must be submitted not later than twelve (12) months after the date that the claim arises (for example, the date a medical service is provided and the charge is incurred). If a Welfare Program does provide otherwise, then the limitation under the Welfare Program will control. In the event that a claim, as originally submitted, is not complete, the Claimant will be notified and the Claimant will then have the responsibility for providing the missing information within the timeframe stated in such notification.

A Participant or Beneficiary may designate an authorized representative to act as "claimant" on his or her behalf with respect to the Plan's claims procedures, as permitted by ERISA. The Claims Fiduciary for the applicable Welfare Program may require that any such designation be made in writing (including electronically) using a form prescribed by the Claims Fiduciary as consistent with ERISA and in accordance with the Claims Fiduciary's procedures for such purpose in a manner that is sufficiently clear and conspicuous to enable the Claims Fiduciary to reasonably verify the status of the authorized representative and the scope of such authorization. Whether any such designation of an authorized representation meets such requirements shall be determined by the Plan Administrator or Claims Fiduciary, as applicable, in its discretion. The Plan Administrator or the Claims Fiduciary, as applicable, may disregard any designation of an authorized representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, such entities reserve the right and discretion to refuse to honor a Participant's or Beneficiary's designation of an authorized representative if the Plan Administrator or Claims Fiduciary, as applicable, determines that such designation is fraudulent; such as, for example, when the Plan Administrator or Claims Fiduciary, as applicable, determines that the signature of approval on the designation does not belong to the Participant or Beneficiary.

(b) To the extent that a Welfare Program does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA and the regulations promulgated thereunder, as determined by the Plan Administrator, the claims procedures set out below in Sections 6.2 through 6.9 will apply to a claim for benefits under a Welfare Program. To the extent that a particular Welfare Program is not subject to the Affordable Care Act, then the provisions of this Article VI that apply only to plans subject to the Affordable Care Act shall not apply to such Welfare Program.

(c) The claims procedures applicable to claims made for benefits under the Plan do not include casual or general inquiries regarding eligibility or particular Welfare Program benefits that may be provided under the Plan. In order for an "inquiry" to constitute a claim for benefits or an appeal of an Adverse Benefit Determination, a Participant must follow the claim procedures under the applicable Welfare Program, or, if such procedures are not contained in such Welfare Program, then according to the claims procedures set forth in this Article VI.

(d) To the extent required by the Affordable Care Act with respect to a Health Care Claim or otherwise with respect to a Disability Claim filed after April 1, 2018, the Plan will ensure that any such claim and any appeal thereof are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters regarding any such person (such as a claims adjudicator or medical expert, or, with respect to a Disability Claim filed after April 1, 2018, a vocational expert) will not be made based upon the likelihood that such person will support the denial of benefits.

6.2 **Definitions**.

(a) *Adverse Benefit Determination* means any of the following: (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan; (ii) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit under the Plan, resulting from the application of precertification procedures or other utilization review procedures; (iii) a failure to cover an item or service for which benefits under the Plan are otherwise provided because it is determined to be experimental and/or investigational or not medically necessary or because another exclusion applies under the Plan; and (iv) with respect to a Health Care Claim under an ACA Program or a Disability Claim filed after April 1, 2018, a rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect (except to the extent that such cancellation or discontinuance of coverage is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage), whether or not, in

connection with the rescission, there is an adverse effect on any particular benefit at that time.

(b) *Adverse Benefit Determination on Review* means the upholding or affirmation of an appealed Adverse Benefit Determination.

(c) *Affordable Care Act Program* or *ACA Program* means each of the following (together, the "*ACA Programs*"), to the extent such program does not constitute an "excepted benefit" under the Affordable Care Act: (i) the Consolidated Communications, Inc. BlueCross BlueShield of Texas Health Benefits Program, and (ii) the Kaiser Permanente Deductible HMO Plan for Consolidated Communications Holdings, Inc.

(d) *Benefit Determination* means a determination by the Claims Administrator on a claim for benefits under the Plan, whether or not an Adverse Benefit Determination.

(e) *Benefit Determination on Review* means a determination by the Claims Fiduciary (or if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination on Review.

(f) *Claimant* means a Participant under the Plan, or his authorized representative or health care provider, who is designated by the Participant to act on his behalf. In the case of an Urgent Care Claim, a Health Care Professional with knowledge of the medical condition of the Participant to whom the Urgent Care Claim applies will be permitted to act as the authorized representative of such Participant.

(g) *Concurrent Care Decision* means, with respect to an ongoing course of treatment previously approved by the Plan which is to be provided over a period of time or number of treatments: (i) any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments; or (ii) any request by a Claimant to extend the ongoing course of treatment beyond the period of time or number of treatments. A Concurrent Care Decision described in clause (i) will constitute an Adverse Benefit Determination.

(h) *Disability Claim* means a claim for benefits that is conditioned upon a showing of "disability" by the Claimant.

(i) *External Review* means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the external review process described in Section 6.9.

(j) *Final Internal Adverse Benefit Determination* means an Adverse Benefit Determination on Review that has been upheld by the Plan at the completion of the internal appeals process described in Sections 6.5 and 6.6 (or an Adverse

Benefit Determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules of Section 6.10).

(k) *Final External Review Decision* means a determination by an Independent Review Organization at the conclusion of an External Review.

(l) *Health Care Claim* means a Pre-Service Claim, a Post-Service Claim, a Concurrent Care Decision or an Urgent Care Claim.

(m) *Health Care Professional* means a physician or other health care service provider who is licensed, accredited, or certified to perform the specified health services consistent with state law.

(n) *Independent Review Organization or IRO* means an entity that is accredited by URAC or by similar nationally-recognized accrediting organization (and that otherwise meets the applicable requirements of Section 2590.715-2719 of the Claims Regulations) and conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to Section 6.9.

(o) *Pre-Service Claim* means a claim for a benefit under a group health plan that, under the terms of the applicable plan, conditions the receipt of the benefit, in whole or in part, on pre-approval of the benefit in advance of obtaining medical care.

(p) *Post-Service Claim* means a claim for a benefit under a group health plan for reimbursement or consideration of payment for the cost of medical care that has already been rendered. A Post-Service Claim is a claim that is neither a Pre-Service Claim nor an Urgent Care Claim.

(q) *Urgent Care Claim* means a claim for medical care or treatment that, if not received, (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or (ii) in the opinion of a health care provider 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. If a health care provider with knowledge of the Claimant's medical condition deems the medical care or treatment urgent, then the claim is an Urgent Care Claim.

6.3 **Initial Claim Procedure and Time Limits**.

(a) Initial Claim Process.

A claim and all required documentation will be filed in writing with the applicable Claims Administrator and decided within the applicable timeframe under federal law, regardless of whether all information required to perfect the claim is included. The timeframe for decision begins upon receipt by the Claims Administrator of a claim submitted by the Claimant in accordance with the Plan's

claims procedures, and is contingent upon the type of claim that is submitted, whether the claim submitted is a complete claim or incomplete claim, whether additional information is required and whether an extension is required to make a decision on the claim.

(b) Urgent Care Claim:

(i) If an Urgent Care Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of such Benefit Determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Urgent Care Claim is received, subject to subsection (b)(ii).

(ii) If an Urgent Care Claim as submitted is incomplete, the Claims Administrator will notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receiving the incomplete claim. Such notice will request the additional information required to render a decision on the claim and explain why such information is necessary. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. Regardless of whether the Claimant provides the Claims Administrator with the requested information, the Claims Administrator will render a Benefit Determination on the claim and provide notice to the Claimant of such Benefit Determination as soon as possible, but not later than forty-eight (48) hours after the earlier of (A) receipt of the requested information or (B) the end of the period afforded the Claimant to provide the requested information.

(iii) In the event that the Claimant fails to follow the Plan's procedures for filing an Urgent Care Claim, the Claimant will be notified of such failure and of the proper procedures to be followed in filing such a Claim. The notification will be provided to the Claimant as soon as possible, but not later than twenty-four (24) hours following the failure. Notification may be oral, unless written notification is requested by the Claimant. For the purposes of this Section 6.3(b)(iii), a failure to follow the Plan's procedures for filing will mean only such a failure that is (A) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under the Plan; and (B) 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.

(iv) Notification of any Adverse Benefit Determination with respect to an Urgent Care Claim will be made in accordance with Section 6.4.

(c) Concurrent Care Decisions.

(i) As to a Concurrent Care Decision which is an Adverse Benefit Determination, the Claims Administrator will notify the Claimant, in accordance with Section 6.4, 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 Benefit Determination on Review of that Adverse Benefit Determination before the benefit is reduced or terminated.

(ii) In the event of a Concurrent Care Decision which is a request by a Claimant to extend the course of treatment beyond the period of time or number of treatments and is an Urgent Care Claim, such Concurrent Care Decision will be decided as soon as possible, taking into account the medical exigencies. The Claims Administrator will notify the Claimant of the Benefit Determination, whether or not adverse, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (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 or not involving an Urgent Care Claim, will be made in accordance with Section 6.4, and appeal of the same will be governed by Sections 6.6(a)(i), (ii) or (iii), as appropriate.

(d) *Other Health Care Claims.* In the case of a Health Care Claim that is neither an Urgent Care Claim nor a claim involving a Concurrent Care Decision as described in subsection (c), the Claims Administrator will notify the Claimant of the Plan's Benefit Determination, as follows:

(i) Pre-Service Claim:

(A) The Claims Administrator will render a Benefit Determination and provide notice to the Claimant of such Benefit Determination (whether or not adverse) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the Pre-Service Claim by the Plan. This period may be extended one time by the Plan for up to fifteen (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 fifteen (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 will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from the receipt of the notice within which to provide the specified information.

(B) In the event that the Claimant fails to follow the Plan's procedures for filing a Pre-Service Claim, the Claimant will be notified of such failure and of the proper procedures to be followed in filing such a claim. The notification will be provided to the Claimant as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Claimant. For the purposes of this Section 6.3(d)(i)(B), a failure to follow the Plan's procedures for filing will mean only such a failure that is (i) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under the Plan; and (ii) 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.

(C) Notification of an Adverse Benefit Determination made hereunder will be made in accordance with Section 6.4.

(ii) Post-Service Claim:

(A) The Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the Post-Service Claim. This period may be extended one time by the Plan for up to fifteen (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 thirty (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 the Claimant to submit the information necessary to decide the Post-Service Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

(B) Notification of an Adverse Benefit Determination made hereunder will be made in accordance with Section 6.4.

(e) *Disability Claims.*

(i) If a Disability Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the Disability Claim (the "**Initial Period**"). The Initial Period may be extended by the Plan for up to

thirty (30) days (the "**First Extension**"), provided that the Claims Administrator both (A) determines that such an extension is necessary due to matters beyond the control of the Plan, and (B) notifies the Claimant, prior to the expiration of the Initial Period, of the circumstances requiring the First Extension and the date by which the Plan expects to render a decision.

(ii) If, prior to the end of the First Extension, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the First Extension, the period for making the determination may be extended for up to an additional thirty (30) days (the "**Second Extension**"), provided that the Claims Administrator notifies the Claimant, prior to the expiration of the First Extension, of the circumstances requiring the Second Extension and the date as of which the Plan expects to render a decision.

(iii) In the case of any extension under this subsection (e), the notice of extension will specifically explain (A) the standards on which entitlement to a benefit is based, (B) the unresolved issues that prevent a decision on the claim, and (C) the additional information needed to resolve those issues, and the Claimant will be afforded at least forty-five (45) days within which to provide the specified information.

(iv) Notification of any Adverse Benefit Determination with respect to a Disability Claim will be made in accordance with Section 6.4.

6.4 **Notification of Benefit Determination.**

(a) Except as provided in Section 6.4(b), the Claims Administrator will provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification will set forth in a manner calculated to be understood by the Claimant:

(i) the specific reason or reasons for the Adverse Benefit Determination;

(ii) reference to the specific Plan provisions upon which the determination is based;

(iii) a description of additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) a description of the Plan's appeal procedures and time limits applicable to such procedures, including, in the case of an Urgent Care Claim, a description of the expedited review process applicable to such claims, along with a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review (or, if a Welfare Program requires two levels of appeal, following

an Adverse Benefit Determination on Review with respect to the second appeal);

(v) with respect to a Health Care Claim or a Disability Claim filed on or prior to April 1, 2018:

(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit 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

(B) if the Adverse Benefit Determination is based on a medical necessity or experimental and/or investigational 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 to the Claimant upon request;

(vi) with respect to a Health Care Claim under an ACA Program:

(A) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable));

(B) the reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the ACA Program's standard, if any, that was used in denying the claim;

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

(D) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes; and

(E) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (and, in the case of such request, the Claimant shall be provided with such information as soon as practicable, and such request shall not be considered a

request for internal appeal or External Review with respect to the claim); and

(vii) with respect to a Disability Claim filed after April 1, 2018:

(A) A discussion of the decision regarding the Disability Claim, including an explanation of the basis for disagreeing with (or not following):

(1) The views of any Health Care Professionals treating the Claimant and any vocational professionals who evaluated the Claimant, as presented to the Claims Administrator by the Claimant;

(2) The views of any 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 such advice was relied upon in making the Adverse Benefit Determination; and

(3) Any disability determination regarding the Claimant that was made by the Social Security Administration, as presented to the Claims Administrator by the Claimant;

(B) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for such 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 to the Claimant upon request;

(C) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for such 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 to the Claimant upon request; and

(D) 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 Disability Claim; whether a document, record, or other information is "relevant" to a Disability Claim will be determined by reference to Section 6.8.

(b) In the case of an Adverse Benefit Determination involving an Urgent Care Claim, the information described in Section 6.4(a) may be provided to the Claimant orally within the time frame prescribed in Section 6.3(b), provided that a written

or electronic notification is furnished to the Claimant not later than three (3) days after the oral notification.

(c) Any notification of an Adverse Benefit Determination with respect to either a Health Care Claim under an ACA Program or a Disability Claim filed after April 1, 2018, shall be provided in a culturally and linguistically appropriate manner, as described in Section 6.13.

6.5 **Appeal Procedures.**

(e) Each Claimant will have a reasonable opportunity to appeal an Adverse Benefit Determination to the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, to the Claims Administrator with respect to the first level appeal) as set forth hereafter. The Claimant must complete all of the administrative review steps available through the Claims Administrator before an appeal to the Claims Fiduciary, if any, is permitted under the Plan.

(f) Each Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim appealed. With respect to a claim under an ACA Program, a Claimant is allowed to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

(g) Each Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Plan. Whether a document, record, or other information is "relevant" to a claim for benefits under the Plan will be determined by reference to Section 6.8.

(h) The appeal will 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.

(i) The Claimant will have one-hundred eighty (180) days following receipt of notification of an Adverse Benefit Determination within which to appeal said Determination. If the applicable Welfare Program requires two levels of appeal, the Claimant will have sixty (60) days following receipt of notification of an Adverse Benefit Determination on review of the first appeal within which to file a second appeal of the Adverse Benefit Determination.

(j) The appeal will not afford deference to the initial Adverse Benefit Determination and will be conducted by a decision maker who is neither the individual who made the Adverse Benefit Determination that is on appeal, nor the subordinate of such decision maker.

(k) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, the decision maker will consult with a Health

Care Professional who has appropriate training and experience in the field of medicine involving the medical judgment.

(l) All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on appeal will be identified without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

(m) All Health Care Professionals engaged for purposes of consultation under Section 6.5(g) will be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is on appeal, nor the subordinate of such individual.

(n) In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's Benefit Determination on Review, will be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

(o) A Claimant will not be required to file more than two appeals of an Adverse Benefit Determination prior to bringing a civil action under Section 502(a) of ERISA. To the extent that the claims procedures set forth in any Welfare Program provide for more than two levels of appeal of an Adverse Benefit Determination, any level of appeal beyond the second level of appeal will be "voluntary".

(p) To the extent that any Welfare Program offers a voluntary level of appeal ("**Voluntary Appeal**") (except to the extent the Plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, and notwithstanding anything in such Welfare Program to the contrary:

(i) The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to submit a benefit dispute to a Voluntary Appeal;

(ii) Any statute of limitations or other defense based on timeliness is tolled during the time that a Voluntary Appeal is pending;

(iii) A Claimant may elect to submit a benefit dispute to a Voluntary Appeal only after exhaustion of the appeals permitted by the Welfare Program under which the benefit dispute arose, subject to Section 6.5(k);

(iv) A Claimant will be provided, upon request, sufficient information relating to the Voluntary Appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to Voluntary Appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to Voluntary Appeal will have no effect on the Claimant's rights to any other benefits under the Plan, and information

about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs will be imposed on the Claimant as part of the Voluntary Appeal.

(q) Notwithstanding anything in a Welfare Program to the contrary, a Claimant will not be subject to mandatory arbitration of an Adverse Benefit Determination, except to the extent that:

(i) The arbitration is counted as one of the two appeals described in Section 6.5(k) and is conducted in accordance with the requirements applicable to such appeals; and

(ii) The Claimant is not precluded from challenging the decision resulting from such arbitration under section 502(a) of ERISA or other applicable law.

(r) With respect to a Health Care Claim under an ACA Program:

(i) If the Claims Fiduciary has made a Final Internal Adverse Benefit Determination regarding such claim, the Claims Fiduciary shall, as soon as possible and sufficiently in advance of the required date for issuing the notice regarding its determination under Section 6.6(a), provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claims Fiduciary, or at the direction of the Claims Fiduciary, in connection with such claim, in order to give the Claimant a reasonable opportunity to respond prior to that date;

(ii) Before the Claims Fiduciary issues any Final Internal Adverse Benefit Determination with respect to such claim based on a new or additional rationale, the Claims Fiduciary will, as soon as possible and sufficiently in advance of the required date for issuing the notice regarding its determination under Section 6.6(a), provide the Claimant, free of charge, with the rationale, in order to give the Claimant a reasonable opportunity to respond prior to that date;

(iii) Notwithstanding the provisions of Section 6.6(a), if such new or additional evidence is received by the Claims Fiduciary so late that it would be impossible to provide it to the Claimant in time for the Claimant to have a reasonable opportunity to respond, the period for providing the notice of any Final Internal Adverse Benefit Determination is tolled until such time as the Claimant has a reasonable opportunity to respond; after the Claimant responds, or has a reasonable opportunity to respond but fails to do so, the Claims Fiduciary shall notify the Claimant of its final Benefit

Determination on Review as soon as the Claims Fiduciary, acting in a reasonable and prompt fashion, can provide the notice, taking into account the medical exigencies; and

(iv) The coverage which is the subject of the Adverse Benefit Determination on appeal will be continued pending the outcome of the appeal; for this purpose, the Plan will comply with the requirements of Section 2560.503-1(f)(2)(ii) of the Claims Regulations, which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

(s) With respect to a Disability Claim filed after April 1, 2018:

(i) Prior to the issuance of an Adverse Benefit Determination on Review regarding the Disability Claim, the Claimant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, by the Claims Administrator with respect to the first level appeal), or at the direction of such decision maker, in connection with such claim;

(ii) Prior to the issuance of an Adverse Benefit Determination on Review regarding the Disability Claim that is based on a new or additional rationale, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will provide the Claimant, free of charge, with such rationale; and

(iii) In the case of either subsection (i) or (ii), such evidence or rationale will be provided to the Claimant as soon as possible and sufficiently in advance of the date on which the notice of an Adverse Benefit Determination on Review is required to be provided under Section 6.6(a), in order to give the Claimant a reasonable opportunity to respond prior to that date.

6.6 **Benefit Determination on Review.**

(a) Timing of Notification.

(i) *Urgent Care Claim*. In the case of an Urgent Care Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant in accordance with Section 6.6(b) of the Plan's Benefit Determination on Review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claimant's appeal of an Adverse Benefit Determination by the Plan; provided that the Claims Fiduciary (or Claims Administrator) defers to the

attending health care provider with respect to the decision as to whether a claim constitutes "urgent care".

(ii) *Pre-service Claims*. In the case of a Pre-Service Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than thirty (30) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the applicable Welfare Program requires two appeals of an Adverse Benefit Determination, in which case such notification will be provided not later than fifteen (15) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

(iii) *Post-Service Claims*. In the case of a Post-Service Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the applicable Welfare Program requires two appeals of an Adverse Benefit Determination, in which case such notification will be provided not later than thirty (30) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

(iv) *Disability Claims*. In the case of a Disability Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than forty-five (45) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Claims Fiduciary determines that special circumstances require an extension of time for processing the claim. If the Claims Fiduciary determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial forty-five (45) day period. In no event will such extension exceed a period of forty-five (45) days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review.

(v) In the case of an Adverse Benefit Determination on Review, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of

appeal, the Claims Administrator with respect to the first level appeal) will provide access to, and copies of, documents, records, and other information described in Sections 6.6(b)(iii), (iv) and (vi) as appropriate.

(b) Manner and Content of Notification of Benefit Determination on Review.

The Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will provide a Claimant with written or electronic notification of the Plan's Benefit Determination on Review. In the case of an Adverse Benefit Determination on Review, the notification will set forth in a manner calculated to be understood by the Claimant:

(i) The specific reason or reasons for the Adverse Benefit Determination on Review;

(ii) Reference to the specific Plan provisions upon which the Adverse Benefit Determination on Review is based;

(iii) 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 under the Plan. Whether a document, record, or other information is relevant to a claim for benefits will be determined by reference to Section 6.8;

(iv) A statement describing any Voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures described in Section 6.5(1);

(v) A statement of the Claimant's right to bring an action under Section 502(a) of ERISA (or, if a Welfare Program requires two levels of appeal, the Claimant's right to bring an action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review with respect to the second appeal), and if the Adverse Benefit Determination on Review is regarding a Disability Claim which is filed after April 1, 2018, a description of any contractual limitations period under the applicable Welfare Program that applies to the Claimant's right to bring such an action, as described in Section 6.11, including the calendar date on which such contractual limitations period expires for such claim;

(vi) With respect to an appeal of either a Health Care Claim or a Disability Claim filed on or prior to April 1, 2018:

(A) 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";

(B) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review, either (1) the specific rule, guideline, protocol, or other similar criterion, or (2) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review and that a copy of the rule, guideline, protocol, or other similar criterion will be provided, free of charge, to the Claimant upon request; and

(C) if the Adverse Benefit Determination on Review is based on a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or (2) a statement that such explanation will be provided, free of charge, upon request;

(vii) With respect to a Health Care Claim under an ACA Program:

(A) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable));

(B) the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the ACA Program's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision;

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

(D) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes; and

(E) a statement describing availability upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and

(viii) With respect to an appeal of a Disability Claim that is filed after April 1, 2018:

(A) A discussion of the Adverse Benefit Determination on Review, including an explanation of the basis for disagreeing with (or not following):

(1) The views of any Health Care Professionals treating the Claimant and any vocational professionals who evaluated the Claimant, as presented to the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) by the Claimant;

(2) The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on Review, without regard to whether such advice was relied upon in making the Adverse Benefit Determination on Review; and

(3) Any disability determination regarding the Claimant that was made by the Social Security Administration, as presented to the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) by the Claimant;

(B) If the Adverse Benefit Determination on Review is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for such 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 to the Claimant upon request; and

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination on Review or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

(c) Any notification of an Adverse Benefit Determination on Review with respect to an appeal of either a Health Care Claim under an ACA Program or a Disability Claim that is filed after April 1, 2018 shall be provided in a culturally and linguistically appropriate manner, as described in Section 6.13.

6.7 **Calculating Time Periods**.

For the purposes of Sections 6.3 and 6.6(a), the period of time within which a Benefit Determination or a Benefit Determination on Review is required to be made, will begin at the time a claim or appeal, as the case may be, is filed in accordance with the procedures of the Plan,

without regard to whether all information necessary to make a Benefit Determination or a Benefit Determination on Review, as the case may be, accompanies the filing. In the event that a period of time is extended as permitted under Section 6.3(d) or 6.6(a) due to a Claimant's failure to submit information necessary to decide a claim or the appeal, the period for making the Benefit Determination or the Benefit Determination on Review will 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.

6.8 **Relevance to Claim**.

For the purposes of Sections 6.4(a)(vii), 6.5(c) and 6.6(b)(iii), a document, record, or other information will be considered "relevant" to a Claimant's claim if such document, record, or other information:

(a) was relied upon in making the Benefit Determination;

(b) was submitted, considered, or generated in the course of making the Benefit Determination, without regard to whether such document, record, or other information was relied upon in making the Benefit Determination;

(c) demonstrates compliance with any administrative processes and safeguards in making the Benefit Determination; or

(d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Benefit Determination.

6.9 **External Review.**

External Review will only be available with respect to Health Care Claims that are incurred under an ACA Program. If an ACA Program is fully-insured, External Review thereunder will be provided in accordance with the State external review process or Federally-administered external review process that is applicable to the health insurance issuer of the ACA Program under the Affordable Care Act. If an ACA Program is self-funded, External Review thereunder will be provided in accordance with subsections (a) through (e) below, which subsections are intended to comply with the Federal external review process set forth in Section 2590.715-2719(d) of the Claims Regulations and shall be construed and applied accordingly.

(a) *Claims Eligible for External Review*. External Review applies only to the following under an ACA Program:

(i) An Adverse Benefit Determination, including a Final Internal Adverse Benefit Determination, that involves medical judgment (including, but not limited to, (A) a determination based medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, (B) a determination that a treatment is experimental or investigational, (C) a determination regarding whether the Claimant is entitled to a reasonable

alternative standard for a reward under a wellness program, or (D) a determination based on the Plan's compliance with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations), as determined by the external reviewer; and

(ii) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that the Claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for External Review.

(b) *Request for External Review*. A Claimant may file a written request for External Review with the Claims Fiduciary if such request is filed by the date that is four months after the date of receipt a notice of the Adverse Benefit Determination or Final Internal Adverse Benefit Determination ("**Last Filing Date**") or, if there is no such date in the fourth month following receipt of the notice, then the Last Filing Date will be the first day of the fifth month following receipt of the notice. If the Last Filing Date would fall on a Saturday, Sunday, or Federal holiday, the Last Filing Date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(c) *Preliminary Review and Notice*. Within five business days following receipt of a request for an External Review, the Claims Fiduciary shall complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered by the ACA Program at the time the health care item or service in question was requested, or, in the case of a retrospective review, whether the Claimant was covered by the ACA Program at the time the health care item or service was provided;

(ii) The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the eligibility requirements of the ACA Program;

(iii) The Claimant has exhausted the Plan's internal appeal process applicable to the ACA Program, unless the Claimant is not required to exhaust the internal appeals process as provided in Section 6.10; and

(iv) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Claims Fiduciary will issue a written notice to the Claimant. If the Claimant's request for External Review is complete, but not eligible for External Review, the notice will include the reasons for the request's ineligibility and current contact information, including telephone number, for the Employee Benefit Security Administration.

If the request is not complete, the notice will include a description of the information or materials necessary to complete the request, and the Claimant shall be permitted to perfect the request for External Review by the later of (A) 48 hours after the Claimant receives the notice, or (B) the Last Filing Date.

(d) *Referral to Independent Review Organization*. If a Claimant's request is eligible for External Review, the Claims Fiduciary will assign the request to an Independent Review Organization to conduct the External Review in accordance with an independent and unbiased process that meets the requirements of Section 2590.713-2719(d)(2)(iii) of the Claims Regulations. No costs, including filing fees, will be imposed on a Claimant who requests External Review.

The assigned IRO will provide timely written notice to the Claimant, confirming whether the request is eligible for External Review and including a statement that the Claimant may, within ten business days following the date of receipt of the notice, submit additional information to the IRO in writing. Any such additional information will be considered by the IRO when conducting the External Review. The IRO is not required to, but may in its discretion, accept and consider additional information submitted in writing after ten business days.

Within five business days after the date that a request for External Review is assigned to the IRO, the Claims Fiduciary will provide the IRO with the documents and information that were considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, provided however, any failure by the Claims Fiduciary to timely provide such documents and information will not delay the conduct of the External Review. If the Claims Fiduciary fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, in which case the IRO will notify the Claimant and the Claims Fiduciary of its decision within one business day after such decision is made.

Upon receipt of any information submitted by the Claimant, the IRO will, within one business day thereafter, forward such information to the Claims Fiduciary. Upon its receipt of any such information, the Claims Fiduciary may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Claims Fiduciary will not delay the External Review. The External Review may be terminated as a result of the Claims Fiduciary's reconsideration only if the Claims Fiduciary decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment with respect to the claim. In that case, within one business day after making such a decision, the Claims Fiduciary will provide written notice of its decision to the Claimant and the IRO. The IRO will terminate the External Review upon receipt of such notice from the Claims Fiduciary.

If the External Review is not terminated based on the Claims Fiduciary's reconsideration, the IRO will review and consider all of the information and documents timely provided to the IRO, as well as the following, to the extent such information or documents are available and the IRO considers them appropriate:

(i) The Claimant's medical records;

(ii) The attending Health Care Professional's recommendation;

(iii) Reports from appropriate Health Care Professionals and other documents submitted by the Claims Fiduciary, Claimant, or the Claimant's treating provider;

(iv) The terms of the Plan, as applicable to the claim;

(v) Appropriate practice guidelines;

(vi) Any applicable clinical review criteria developed and used by Claims Fiduciary, unless the criteria are inconsistent with the applicable terms of the Plan or with applicable law; and

(vii) To the extent the final IRO decision maker is different from the IRO's clinical reviewer, the opinion of such clinical reviewer, after considering information described in this notice, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

In reaching its Final External Review Decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process applicable to the claim. The IRO will provide written notice of its Final External Review Decision to both the Claimant and the Claims Fiduciary within 45 days after its receipt of the request for the External Review. Such notice will contain a general description of the reason for the request for External Review (including information sufficient to identify the claim), references to the evidence or documentation considered by the IRO in reaching its decision, and the other information required by the Claims Regulations.

After a Final External Review Decision, the IRO will maintain records of all claims and notices associated with the External Review process for six years and will make such records available for examination as required by the Claims Regulations or other applicable law.

The IRO's Final External Review Decision will be binding except to the extent that (i) other remedies are available under State or Federal law to either the Plan or to the Claimant or (ii) the Plan voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a Final External Review

Decision that denies the claim or otherwise fails to require such payment or benefits.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Adverse Benefit determination, the Plan will immediately provide coverage or payment for the claim.

(e) *Expedited External Review*. An expedited External Review shall be provided:

(i) If the Claimant received an Adverse Benefit Determination that involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal;

(ii) If the Claimant received a Final Internal Adverse Benefit Determination and the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function; or

(iii) If the Claimant received a Final Internal Adverse Benefit Determination which concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from the facility.

Immediately upon receipt of a request for an expedited External Review, the Claims Fiduciary will determine if the request meets the eligibility requirements set forth in Section 6.9(c). The Claims Fiduciary will immediately send a notice to the Claimant that meets the requirements described in Section 6.9(c) to communicate its eligibility determination.

If the Claimant's request is eligible for expedited External Review, the Claims Fiduciary will assign the request to an IRO pursuant to the requirements in Section 6.9(d). The Claims Fiduciary will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent such information or documents are available and the IRO considers them appropriate, will consider such information or documents as described in Section 6.9(d). In reaching its decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO will provide the Claimant and the Plan with a notice of its Final External Review Decision, in accordance with the requirements set forth in Section 6.9(d), as expeditiously as the Claimant's medical condition or circumstances require, but

in no event more than 72 hours after the IRO receives the request for an expedited External Review. If such notice is not in writing, then within 48 hours after the date such notice is provided, the IRO will provide a written confirmation of its decision to the Claimant and the Claims Fiduciary.

6.10 **Exhaustion of Administrative Remedies**.

(a) *Exhaustion Required Prior to Action for Recovery*. Notwithstanding anything to the contrary in a Welfare Program, no action at law or in equity may be brought to recover under the Plan until all administrative remedies have been exhausted (including two internal appeals of an Adverse Benefit Determination if required by the applicable Welfare Program). If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the Plan's claim procedures outlined herein, such Claimant will have no right of review and will have no right to bring any action in any court. The denial of the claim will become final and binding on all persons for all purposes.

(b) *Deemed Exhaustion – Health Care Claim under an ACA Program*. If the Plan fails to strictly adhere to all of the applicable requirements of Sections 6.3 through 6.8 with respect to a Health Care Claim under an ACA Program, the Claimant is deemed to have exhausted the internal claims and appeals process of the Plan (except as provided in subsection (d), below) with respect to such claim. In such case, the Claimant may initiate an External Review under Section 6.9, as applicable, and is also entitled to pursue any available remedies under Section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If the Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(c) *Deemed Exhaustion – Disability Claim Filed After April 1, 2018*. If the Plan fails to strictly adhere to all of the applicable requirements of Sections 6.3 through 6.8 with respect to a Disability Claim filed after April 1, 2018, the Claimant is deemed to have exhausted the administrative remedies available under the Plan (except as provided in subsection (d), below) with respect to such claim. Accordingly, the Claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If the Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(d) *De Minimis Violations*. Notwithstanding subsections (b) and (c), above, the internal claims and appeals process with respect to a Health Care Claim under an ACA Program and the administrative remedies under the Plan with respect to a Disability Claim filed after April 1, 2018, will not be deemed exhausted based on

de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant, so long as the Plan demonstrates that the violation (i) was for good cause or due to matters beyond the control of the Plan and (ii) occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant (provided, however, this exception shall not be applicable if the violation is part of a pattern or practice of violations by the Plan). The Claimant may request a written explanation of the *de minimis* violation from the Plan, and the Plan will provide such explanation within 10 days, including a specific description of the Plan's basis, if any, for asserting that the violation should not cause the internal claims and appeals process of the Plan with respect to a Health Care Claim under an ACA Program or the administrative remedies of the Plan with respect to a Disability Claim filed after April 1, 2018, to be deemed exhausted. If a court (or, with respect to a Health Care Claim under an ACA Program, an external reviewer) rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception, then:

(i) with respect to a Health Care Claim under an ACA Program, the Claimant has the right to resubmit and pursue the internal appeal of the Claim, in which case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim, and time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice; and

(ii) with respect to a Disability Claim filed after April 1, 2018, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court, and, within a reasonable time after such receipt, the Plan shall provide the Claimant with notice of the resubmission.

6.11 **Action for Recovery**.

Unless otherwise expressly stated in a Welfare Program, and subject to Section 6.10, any action at law or in equity with respect to any and all claims relating to the Plan must be brought for recovery within one year from the earlier of (1) the date of a Final Internal Adverse Benefit Determination, if applicable, or (2) the accrual of any claim under or relating to the Plan that does not result in a Final Internal Adverse Benefit Determination. If the particular Welfare Program expressly states a limitations period for bringing an action thereunder, then the Welfare Program will control.

6.12 **Participant's Responsibilities**.

Each Participant will be responsible for providing the Claims Fiduciary, the Plan Administrator and/or the Employer with the Participant's and each Beneficiary's current U.S. mailing address and electronic address, as specified in the Welfare Programs. Any notices required or permitted to be given hereunder will be deemed given if directed to such address furnished by the Participant and mailed by regular United States mail, delivered by messenger or other professional delivery service, or by electronic means as specified in Section 2520.104b-l(c)

of ERISA. The Claims Fiduciary, Plan Administrator and the Employer will not have any obligation or duty to locate a Participant, Dependent or Beneficiary.

In the event that a Participant, Dependent or Beneficiary becomes entitled to a payment under the Plan and such payment is delayed or cannot be made:

(a) because the current address according to the Claims Fiduciary's records is incorrect;

(b) because the Participant, Dependent or Beneficiary fails to respond to the notice sent to the current address according to the Claims Fiduciary's records;

(c) because of conflicting claims to such payments; or

(d) for any other reason;

the amount of such payment, if and when made, will be determined under the provisions of the Plan without payment of any interest or earnings.

To the extent that the entitlement of a Participant, Dependent, Beneficiary or other individual to a benefit under the Plan is the subject of an interpleader action in a court of competent jurisdiction, the Plan Administrator, Plan Sponsor and any other Plan fiduciary may act in reliance upon any order issued by such court regarding any individual's entitlement to benefits under the Plan, which action shall satisfy its fiduciary and other duties under the Plan.

6.13 Standards for Culturally and Linguistically Appropriate Notifications.

The notifications described in Sections 6.4(c) and 6.6(c) with respect to Health Care Claims under an ACA Program and Disability Claims filed after April 1, 2018 (for purposes of this Section 6.13, each a "**Determination Notice**", and, collectively, "**Determination Notices**"), shall be administered in accordance with the requirements set forth in subsection (a), below, for the applicable non-English languages described in subsection (b), below.

(a) *Requirements.*

(i) The Plan shall provide oral language services to a Claimant that include (A) answering questions in any applicable non-English language and (B) providing assistance with filing claims and appeals of any Adverse Benefit Determinations (including, with respect to a Health Care Claim under an ACA Program, External Review) in any applicable non-English language;

(ii) The Plan shall provide, upon request by a Claimant, a Determination Notice in any applicable non-English language; and

(iii) The Plan shall include in the English versions of all Determination Notices a statement, prominently displayed in any applicable non-English language, which clearly indicates the Plan's procedures by which a Claimant may access the language services provided by the Plan.

(b) *Applicable Non-English Language.* With respect to an address in any United States county to which a Determination Notice is sent, a non-English language is an "applicable non-English language" if ten percent or more of the population residing in such county is literate only in the same non-English language, as determined in guidance published by the U.S. Department of Labor.

6.14 **Unclaimed Benefits**.

If, within twelve (12) months after any amount becomes payable hereunder to a Participant or Beneficiary, and the same will not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care will have been exercised in attempting to make such payments, the amount thereof will be forfeited and will cease to be a liability of the Plan.

ARTICLE VII
COORDINATION OF BENEFITS

7.1 **Coordinating Benefits with Coverage from Another Source**.

If a Participant has coverage under the Plan as well as coverage from another source (or sources), benefits that are received through the Plan will be coordinated with the benefits available under the plan(s) containing the Participant's other source of benefits. The coordination of benefits ("**COB**") provisions in this Article VII will apply to all health benefits provided under the Plan, but only to the extent that the applicable Welfare Program does not contain its own COB provisions. In the event that the Welfare Program contains COB provisions, such provisions will govern and control the coordination of benefits under that Welfare Program.

7.2 **Coverage from Another Source**.

For purposes of this Article VII, "coverage from another source" will mean any other plan, policy or contract (individually and collectively, a "plan") providing benefits or services for medical, prescription drug, dental, vision care, or employee assistance treatment, including but not limited to, one of the following:

(a) group insurance, or any other arrangement of coverage for individuals in a group health maintenance organization (HMO) or other group on an insured, self-insured or uninsured basis, or state or federal programs providing health coverage other than a state plan under Medicaid or TRICARE;

(b) group coverage sponsored through a school or other educational institution, for a student;

(c) coverage under a service plan contract or prepayment plan or program;

(d) group coverage under franchise organizations; or

(e) no-fault insurance required under any law of a government and provided on other than a group basis, but only to the extent the benefits are required under such no-fault law.

7.3 **Construction**.

Coverage from another source will be construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

7.4 **Allowable Charge**.

For a charge to be allowable it must be a usual and reasonable charge and at least part of it must be covered under the Plan.

When benefits are reduced under a primary plan because a Participant does not comply with the other plan's provisions, the amount of such reduction will not be considered an allowable charge. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred or direct provider arrangements.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: the Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Participant does not use an HMO or network provider, the Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Participant used the services of an HMO or network provider.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will, for purposes of this Article VII, be considered to be the allowable charge.

7.5 **Automobile Limitations**.

When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. Except as required by law, the Plan will always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

7.6 **Ordering of Benefits**.

When coverage is provided by two or more sources for the same allowable charge as stated above, whether the Plan or the other plan (either, a "plan") is primary is established in the following order:

(a) The plan that has no COB provision will be considered primary to a plan that has COB provisions;

(b) The plan covering the person as an Employee will be primary to the plan covering the person as a Dependent;

(c) The plan covering a person in his own capacity will be primary to the plan covering a person as a Dependent; however, if the person is a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a Dependent and primary to the plan covering the person as a non-Dependent, then the plan covering the person as a Dependent is primary, Medicare is secondary and the plan covering the person as a non-Dependent is the tertiary plan (that is, in this specific situation, the plan covering the person as a non-Dependent pays only after the plan covering the person as a Dependent and after Medicare);

(d) The plan covering a person as an active Employee will be primary to the plan covering the person as a retired, terminated, inactive, suspended or laid-off Employee, except that if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply;

(e) The plan covering a person as an Employee will be primary to the plan covering the person as a COBRA Participant or a beneficiary under any other federal or state continuation coverage, except that if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply;

(f) The plan covering a Dependent as a Dependent of an active Employee is primary to the plan covering the Dependent as the Dependent of a former employee or as a COBRA Participant or a beneficiary under any other federal or state continuation coverage;

(g) For the purposes of a Dependent covered under the plans of both of his non-divorced parents (or parents who never married, but who live together) the plan covering the parent whose birthday falls first in the year will be primary to the plan covering the parent whose birthday falls later in the year. If both parents have the same birthday, then the plan covering the parent for the longest period of time will be primary, except that if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply;

(h) For a Dependent whose parents are divorced or legally separated (or if the parents never married and do not live together), and the Dependent is covered by the plans of both parents, the plan covering the parent who is responsible for the Dependent's health care under the terms of a court decree or state agency order will be the primary payor for any period after the plan has actual knowledge of those terms. If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not divorced. In the absence of such court decree or state agency order, payment will be made in the order as follows:

(i) the plan of the natural parent with custody;

(ii) the plan of the step-parent with custody; and

(iii) the plan of the natural parent without custody; and

(i) If (a), (b), (c), (d), (e), (f), (g) or (h) do not apply, then the plan covering the person for the longest period of time will be primary.

(j) Notwithstanding any provision to the contrary, to the extent required by applicable law, the Plan shall be primary with respect to items or services for which a State provides child health assistance under the State's child health plan. This provision will be interpreted in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, and the authoritative guidance thereunder.

7.7 **Reduction of Benefits Payable by the Plan**.

Whenever the Plan is considered secondary to another plan, benefits will be payable by the primary plan to the extent that the expense is an incurred charge, and the Plan will be liable for the remainder of the eligible expenses that would be payable in the absence of dual coverage up to the amount that would otherwise be payable to the extent payable in total under the Plan.

7.8 **Coordination of Benefits for Persons Eligible for Medicare**.

The above provisions of this Article VII will apply to all Participants eligible for Medicare, subject to the following provisions.

(a) The Plan is a primary plan with regard to the following Participants eligible for Medicare:

(i) any Participant (or Participant's Spouse) who is covered under the Plan by reason of current employment status with an Employer and who is also entitled to Medicare benefits, for as long as such employment status continues; provided that this rule will not apply if the Employer has fewer than twenty (20) Employees in current employment status for each working day in each of twenty (20) or more calendar weeks in the current calendar year and the preceding calendar year;

(ii) any Participant who is entitled to Medicare benefits solely on the basis of having end-stage renal disease ("ESRD"); provided that Medicare will be considered to be the primary payer of benefits on behalf of an insured individual with ESRD after expiration of the period that begins on the date the individual first becomes entitled to Medicare Part A benefits under Social Security Act Section 226A and ends 30 months later; and

(iii) any disabled Participant who is entitled to Medicare but still participates in the Plan on the basis of current employment status, for as long as such employment status continues; provided that this rule will not apply unless

the Employer had at least one hundred (100) individuals in current employment status on a typical business day during the previous calendar year.

(b) The Plan is a secondary plan with regard to all other Participants eligible for Medicare to the full extent permitted by Medicare or other applicable federal law.

(c) When a Participant is eligible for, or would have been eligible for with proper request enrollment in Parts A and B of Medicare, but is not enrolled in Parts A and B of Medicare, benefits payable under the Plan will be reduced by benefits that would have been payable had the Participant been properly enrolled in Parts A and B of Medicare.

7.9 **Claims Determination Period**.

Benefits will be coordinated on a calendar year basis. This is called the "claims determination period." However, the claims determination period does not include any part of a year during which a person has no coverage under the Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

7.10 **Reduced Benefits when the Plan Pays Second**.

When the Plan pays first, the benefits of the Plan are determined before those of another plan and without considering the benefits of the other plan. When the Plan pays second, the benefits of the Plan may be reduced or denied as herein described. The benefits of the Plan will be reduced when the sum of:

(a) The benefits that would be payable for the allowable charges under the Plan in the absence of this COB provision, and

(b) The benefits that would be payable for the allowable charges under the other benefit plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable charges in a claims determination period. In that case, the benefits of the Plan will be reduced so that the Plan's benefits and the benefits payable under the other benefit plans do not total more than those allowable charges that would be available under the Plan in the absence of this COB provision.

When the benefits of the Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Plan.

7.11 **Right to Receive or Release Necessary Information**.

To make this provision work, the Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person; provided however, any disclosure of "protected health information", as that term is defined in Section 12.1, by the Plan will be made in accordance with Article XII herein and the requirements of HIPAA. A Participant must

provide the Plan with the information it requests about other plans and their payment of allowable charges in order to be eligible for benefits (or continued benefits) under the Plan.

7.12 **Facility of Payment to Other Plan**.

The Plan may repay other plans for benefits paid that the Plan Administrator determines, in its discretion, should have been paid under the Plan. Any such repayment by the Plan will count as a valid payment under the Plan.

7.13 **Right of Recovery**.

The Plan may pay benefits that should be paid by another benefit plan. In this case the Plan may recover the amount paid from the other benefit plan or the Participant. That repayment will count as a valid payment under the other benefit plan. Further, the Plan may pay benefits that are later found to be greater than the allowable charge. In this case, the Plan may recover the amount of the overpayment from the source to which it was paid.

ARTICLE VIII
RIGHT OF SUBROGATION AND REIMBURSEMENT

The provisions of this Article VIII will govern and control the Plan's rights to subrogation and reimbursement, and will supersede any subrogation and reimbursement provisions set forth in any Welfare Program Document (other than a Welfare Program Document for a Fully-Insured Program) to the extent that such other provisions are more restrictive or limited regarding the rights of the Plan than are these provisions. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law as determined by the Plan Administrator.

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this Article VIII on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this Article VIII on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

8.1 **Benefits Subject to this Provision**.

This Article VIII will apply to all benefits provided under the Plan, except for those provided under a Fully-Insured Program. For purposes of this Article, certain terms are defined as follows:

(a) "**Recovery**" means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant's attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate

for any losses or damages caused by, resulting from, or in connection with, the injury or illness.

(b) "**Reimbursement**" means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.

(c) "**Subrogation**" means the Plan's right to pursue the Participant's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.

(d) "**Third Party**" means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Participant's injury or illness.

The term "Third Party" will include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

8.2 **When this Provision Applies**.

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this Article VIII.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Participant agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this Article VIII, and Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

(a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this Article VIII apply;

(b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

(c) Must cooperate fully with the Plan in its exercise of its rights under this Article VIII, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to Section 8.5, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this Article VIII ("**S&R Agreement**").

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injury or illness. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may

notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Participant's claim for benefits for the injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made-whole" and "common-fund" doctrines. A Participant who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this Article VIII. A Participant who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this Article VIII and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this Article VIII and to make changes in its interpretation as it deems necessary or appropriate.

8.3 **Amount Subject to Subrogation or Reimbursement**.

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs,

comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

8.4 **When Recovery Includes the Cost of Past or Future Expenses**.

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this Article VIII.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to an illness or injury for which a Recovery has been made. Acceptance of benefits under the Plan for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

8.5 **When a Participant Retains an Attorney**.

If the Participant retains an attorney, the Plan will not pay any portion of the Participant's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Participant's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Participant's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this Article VIII. A Participant's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

8.6 **When the Participant is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent**.

The provisions of this Article VIII will apply to the parents, trustee, guardian or other representatives of a minor Participant and to the heirs or personal representatives of the estate of a deceased Participant, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this Article VIII, the term "Participant" will also include a COBRA Qualified Beneficiary (as defined in Section 11.11) who has elected COBRA Continuation Coverage under the Plan. If a covered Dependent is the Participant whose benefits under the Plan are subject to the Plan's Subrogation and Reimbursement rights, the covered Employee who enrolled such Dependent under the Plan will also be required to execute the S&R Agreement, upon request, even if the Dependent is not a minor (*e.g.*, a full time post secondary student) and, in such event, the Employee will be liable for any breach of this Article VIII by the Employee or such Dependent.

8.7 **When a Participant Does Not Comply**.

When a Participant does not comply with the provisions of this Article VIII, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this Article VIII, the Participant will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

ARTICLE IX
AMENDMENT OR TERMINATION

The provisions of this Article IX will govern and control amendment and termination of the Plan, and will supersede any conflicting or inconsistent provisions set forth in a Welfare Program Document.

9.1 **Right to Amend**.

The Board of Directors (or a committee of the Board of Directors), the CEO, and any other officer of the Plan Sponsor who is duly authorized by the Board of Directors (or such committee) or the CEO for this purpose, will each have the right, authority and power to make, at any time, and from time to time, any amendment to the Plan. The Vice President - Compensation & Benefits and the Vice President – Human Resources of the Plan Sponsor each have the right, authority and power to make, at any time, any amendment to the Plan as he or she may deem necessary or desirable to ensure the Plan's continued compliance with applicable law and authoritative guidance thereunder. Notwithstanding the foregoing, no amendment will prejudice any claim under the Plan that was incurred but not paid prior to the effective date of the amendment, unless the person or entity responsible for the amendment, as applicable, determines

that such amendment is necessary or desirable to comply with applicable law or is required under the terms of a particular Welfare Program. Moreover, if the Plan is amended, a Participant's right to receive coverage for expenses incurred for supplies or services that were actually received or actually rendered on his behalf before the effective date of such amendment will not be reduced or eliminated. However, an amendment may reduce or eliminate a Participant's right to receive coverage for expenses that are or will be incurred for supplies or services that are received or rendered on or after the effective date of the amendment, even if such supplies or services were approved or are part of a series of treatments or services that began prior to such effective date.

9.2 **Right to Terminate**.

The Board of Directors (or a committee of the Board of Directors), the CEO, and any other officer of the Plan Sponsor who is duly authorized by the Board of Directors (or such committee) or the CEO for this purpose, will each have the right, authority, power and discretion to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its or his discretion; provided, however, such termination will not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Board of Directors (or such committee) or CEO, as applicable, determines it is necessary or desirable to comply with applicable law. An Employer, by action of its board of directors (or equivalent governing body) or chief executive officer, may terminate the Plan with respect to its Employees only, at any time with at least thirty (30) days prior notice to the Plan Administrator; provided, however, the Plan Administrator, in its discretion, may limit such termination to the end of a Plan Year.

ARTICLE X
ADMINISTRATION

10.1 **Controlling Provisions**.

The provisions of this Article X shall supersede any provisions of a Welfare Program Document for a Welfare Program that is not a Fully-Insured Program regarding the subject matter hereof and shall govern and control.

With respect to a Fully-Insured Program, to the extent a provision of this Article X conflicts with, or is inconsistent with, a provision of the Welfare Program Document regarding the same subject matter, the provision of the Welfare Program Document will control, unless such conflict involves a term or provision required by ERISA, the Code or other controlling law, in which case the term or provision required by controlling law will control. This determination will be made by the Plan Administrator.

10.2 **Allocation of Authority**.

The Plan Administrator will control and manage the operation and administration of the Plan, except to the extent such duties have been delegated to other persons or entities as provided in this SPD. Any decisions made by the Plan Administrator or Claims Fiduciary (or any other person or entity delegated authority by the Plan Administrator or Claims Fiduciary, as applicable, to determine benefits in accordance with the Plan) will be final and conclusive on all

Participants, and all other persons and entities, subject only to the claims appeal provisions of the Plan. Neither the Plan Administrator nor any Employee will receive any compensation from the Plan with respect to services provided under the Plan, except as an Employee may be entitled to benefits hereunder.

10.3 **Powers and Duties of Plan Administrator**.

The Plan Administrator (and the Claims Fiduciary, but only with respect to reviewing and making decisions regarding claims under a Welfare Program) will each have such powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to have final discretionary authority to (i) administer, enforce, construe, and construct the Plan, including the Welfare Program Documents, (ii) make decisions relating to all questions of eligibility to participate and (iii) make a determination of benefits including, without limitation, reconciling any inconsistency, correcting any defect, supplying any omission and making all findings of fact;

(b) to prescribe procedures to be followed by Participants filing application for benefits;

(c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, any information that explains the Plan and benefits thereunder;

(d) to receive from the Employer and from Participants such information as necessary for the proper administration of the Plan;

(e) to furnish the Employer and the Participants such annual reports with respect to the administration of the Plan as necessary;

(f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses;

(g) to exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of Participants, including an examination at the Employer's expense of the records of the Plan to be made by such attorneys, accountants, auditors or other agents as it may select, in its discretion, for that purpose; and

(h) to appoint persons or entities to assist in the administration as it deems advisable; and the Plan Administrator may delegate thereto any power or duty imposed upon or granted to it under the Plan.

All decisions, interpretations, determinations and actions in the exercise of the powers and duties described in this Section will be final and conclusive on all persons and entities subject only to the claims appeal provisions of the Plan. Benefits under the Plan will be paid only if the Plan Administrator (or Claims Fiduciary) determines in its discretion that the Participant is entitled to them. There will be no *de novo* review of any such decision,

interpretation, determination or action by any court. Any review of any such decision, interpretation, determination or action will be limited to determining whether the decision, interpretation, determination or action in question was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

The Plan Administrator (or Claims Fiduciary) may rely upon the direction or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under the Plan, and will not be responsible for any act or failure to act. Neither the Plan Administrator nor the Employer makes any guarantee to any Employee in any manner for any loss that may result because of the Employee's participation in the Plan.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted by the Plan Administrator (or the Claims Fiduciary) in a fashion consistent with its intent, as determined by the Plan Administrator (or the Claims Fiduciary). The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

10.4 **Delegation by the Plan Administrator**.

The Plan Administrator may delegate to other persons or entities any of the administrative functions relating to the Plan, together with all powers necessary to enable its designee(s) to properly carry out such duties hereunder, including, without limitation, delegation to the Claims Administrator and the Claims Fiduciary. The Plan Administrator may employ such counsel, accountants, Claims Administrators, Claims Fiduciaries, consultants, actuaries and such other persons or entities as it deems advisable in its discretion. The Plan Administrator, as well as any person to whom any duty or power in connection with the operation of the Plan is delegated, may rely upon all valuations, reports, and opinions furnished by any accountant, consultant, third-party administration service provider, legal counsel, or other specialist. Moreover, the Plan Administrator or such delegate who is also an Employee will be fully protected in respect to any action taken or permitted in good faith in reliance on such information.

10.5 **Disclosure Responsibility.**

(a) *General*. The Disclosure Administrator shall, in response to a written request by a Participant or Beneficiary, furnish a copy of the documents and instruments specified in Section 104(b)(4) of ERISA ("Plan Disclosures") as required by ERISA. A Participant's or Beneficiary's request for Plan Disclosures must be submitted to the Disclosure Administrator in writing, at the address listed in Article XIV of this SPD, and must identify the particular Plan Disclosures that are being requested. The Disclosure Administrator may, in its discretion, impose a reasonable charge to cover the cost of copying and furnishing the requested Plan Disclosures to the extent permitted by ERISA.

(b) *Requests by an Authorized Representative*. A request for Plan Disclosures may be submitted to the Disclosure Administrator by an authorized representative of the Participant or Beneficiary, provided that (i) the authorization of such representative is designated in writing by the Participant or Beneficiary in a manner that is sufficiently clear and conspicuous, as determined by the Disclosure Administrator in its discretion, to enable the Disclosure Administrator to reasonably verify the status of the authorized representative and the scope of such authorization, and (ii) a copy of the signed authorization is submitted to the Disclosure Administrator with the request for Plan Disclosures. The Disclosure Administrator will not make any Plan Disclosures to a person or entity claiming to be an authorized representative prior to receipt of an authorization that meets the criteria in clauses (i) and (ii), as determined by the Disclosure Administrator. The Disclosure Administrator may disregard any designation of an authorized representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, the Disclosure Administrator reserves the right and discretion to refuse to honor a Participant's or Beneficiary's designation of an authorized representative if the Disclosure Administrator determines that such designation is fraudulent; such as, for example, when the Disclosure Administrator determines that the signature of approval on the designation does not belong to the Participant or Beneficiary.

(c) *Examination of Records*. Participants and Beneficiaries shall have the right to examine such records, documents and other data as required by ERISA at reasonable times during regular business hours. Nothing contained in the Plan shall give any Participant the right to examine any data or records with respect to any other Participant except as required by applicable law which cannot be waived.

10.6 **Rules and Decisions**.

The Plan Administrator may adopt such rules and procedures, as it deems necessary or appropriate for the proper administration of the Plan. The Plan Administrator will be entitled to rely upon information furnished to it which appears proper without the necessity of any independent verification or investigation.

10.7 **Facility of Payment for Incapacitated Participant**.

Whenever, in the Claims Fiduciary's opinion, a Participant is entitled to receive any payment of a benefit hereunder and is under a legal disability or is incapacitated in any way so as to be unable to manage his own financial affairs (including physical and mental incompetence or status as a minor), the Claims Fiduciary may direct payments to such person or to the person's legal representative (such as a guardian or conservator, upon proper proof of appointment furnished to the Claims Fiduciary), Dependent, or relative of such person for such person's benefit, or the Claims Fiduciary may direct payment for the benefit of such person in such manner as the Claims Fiduciary considers advisable in its discretion. Any payment of a benefit, to the full extent thereof, in accordance with the provisions of this Section 10.7 will be a complete discharge of any liability for the making of such payment under the Plan.

10.8 **Assignment and Payment of Benefits**.

The provisions of this Section 10.8 shall supersede any provisions of a Welfare Program Document (other than the Welfare Program Document(s) of a Fully-Insured Program) regarding the subject matter hereof and shall govern and control.

Except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Fiduciary, or other delegate of the Plan Administrator is a named party (a "**Plan Agreement**"), no rights, causes of action and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, an out-of-network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to or on behalf of a Participant. For purposes of clarification and not limitation, such rights and causes of action shall include any administrative, statutory, or legal right or cause of action that a Participant or other individual may have under ERISA, including, but not limited to, any right to (a) make a claim for Plan benefits, (b) request the Plan or other documents related to the Plan or a claim for benefits, (c) file an appeal of a denied claim for Plan benefits, or (d) file a lawsuit under ERISA or other applicable law.

In the absence of a Plan Agreement which specifically provides for assignment of the Participant's benefits and/or rights under the Plan (*i.e.*, is not merely an agreement between the Participant and the provider or its representative or agent), the Plan Administrator and Claims Fiduciary, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the provider, the Participant, or to another designated person or entity, with or without the Participant's authorization, with each such payment being made on behalf of the Participant, and not to such payment recipient in its, his or her own right. Moreover, if the Plan Administrator or Claims Fiduciary, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator or Claims Fiduciary of the anti-assignment provisions of this Section 10.8. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the Participant for benefits under the Plan to the full extent of such payment.

Disclosures of information about the Participant can only be made to a Participant or a Participant's authorized representative in accordance with applicable law and the terms of the Plan.

10.9 **Overpayments**.

If, for any reason, any benefit, premium or fee under the Plan is erroneously paid or reimbursed by the Plan Administrator, Claims Fiduciary or other person or entity to a Participant or to an insurance company, a healthcare or other services provider (including an assignee of the Participant as described in Section 10.8), or other person or entity for the benefit of a Participant (collectively, a "**Third-Party Payee**"), such erroneously-paid amount shall constitute an "**Overpayment**" under the Plan, with respect to which the Plan shall have a right of first and primary reimbursement from such Participant or Third-Party Payee that is enforceable by an equitable lien equal to 100% of the Overpayment amount ("**Overpayment Reimbursement**").

Without limitation, the Plan's right to Overpayment Reimbursement is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA and shall be construed accordingly.

If such Overpayment is not refunded to the Plan within a reasonable time period as determined by the Plan Administrator or Claims Fiduciary, the Overpayment shall be (a) charged directly to the Participant (including, without limitation, to a covered Employee on behalf of any of his or her Dependents or Beneficiaries) or to a Third-Party Payee as a reduction of the amount of future benefits otherwise payable on behalf of the Participant, or (b) recouped by any other method which the Plan Administrator or Claims Fiduciary, as applicable, deems to be appropriate in its discretion. For example, the selected repayment method may include, without limitation, (i) payroll deduction in the case of an Employee or his Dependent or Beneficiary (in which case the Employee must execute such forms authorizing payroll deduction as the Plan Administrator shall require as a mandatory condition of his participation, or continued participation, in the Plan) or (ii) offsetting other payments made by the Plan to the Participant, or to the same Third-Party Payee on the Participant's behalf (in which case, such payment offset to a Third-Party Payee shall not constitute an adverse benefit determination that is subject the ERISA claims and appeals procedures of the Plan). For purposes of clarity and not limitation, in the event of the application of any Overpayment Reimbursement to a Third-Party Payee pursuant to the foregoing provisions of this Section 10.9, the offset of the overpayment hereunder is simply an adjustment to the amount owed to the Third-Party Payee to reflect the Overpayment and shall not be considered to be the denial or partial denial of any benefit claim under the Plan.

ARTICLE XI
COBRA CONTINUATION COVERAGE

11.1 **Continuation of Benefits under COBRA**.

Qualified Beneficiaries will have all continuation rights required by COBRA for group health plan benefits offered under the Welfare Programs within the Plan. To the extent a Welfare Program offering health benefits does not specify COBRA rights in accordance with Code Section 4980B, the Plan will be administered in accordance with Code Section 4980B and as set forth in this Article XI. In addition, the Plan Administrator will adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section 11.1.

11.2 **Election of COBRA Coverage**.

(a) COBRA Continuation Coverage for Terminated Employees.

A Qualified Beneficiary who is a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of either of the following Qualifying Events: termination of employment (other than for gross misconduct) or reduction of hours of employment with the Employer.

(b) COBRA Continuation Coverage for Qualifying Dependent.

Subject to Section 11.5, a Qualified Beneficiary who is a Qualifying Dependent of a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if:

(i) his participation under the Plan would terminate as a result of a Qualifying Event; or

(ii) the Qualifying Dependent is a child born to, adopted or placed for adoption with the Covered Employee during the Covered Employee's period of COBRA Continuation Coverage.

(c) Enrollment for COBRA Continuation Coverage.

A Qualified Beneficiary (or a third party on behalf of the Qualified Beneficiary) must complete and return the required enrollment materials within a maximum of sixty (60) days from the later of:

(i) loss of coverage; or

(ii) the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage.

Failure to enroll for COBRA Continuation Coverage during this maximum sixty (60) day period will terminate all rights to COBRA Continuation Coverage under this Article XI. A separate election as to what health coverage, if any, is desired may be made by or on behalf of each Qualified Beneficiary. However, an affirmative election of COBRA Continuation Coverage by a Covered Employee or his Spouse will be deemed to be an election for that Covered Employee's Qualifying Dependents who would otherwise lose coverage under the Plan, unless the election specifically provides to the contrary. Elections for COBRA Continuation Coverage may be made by the Qualified Beneficiary or on his behalf by a third party (including a third party that is not a Qualified Beneficiary).

COBRA Continuation Coverage for a Qualified Beneficiary that is a child who is born to, adopted by or placed for adoption with a Covered Employee begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment.

If, during the election period, a Qualified Beneficiary waives COBRA Continuation Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA Continuation Coverage. However, if a waiver is later revoked, coverage will not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan's "COBRA Administrator", at the address listed in Section 11.12.

11.3 **Period of COBRA Coverage**.

A Qualified Beneficiary who qualifies for COBRA Continuation Coverage as a result of termination of employment (other than for gross misconduct) or reduction in hours of employment, may elect COBRA Continuation Coverage for up to eighteen (18) months measured from the date of the Qualifying Event. With respect to all other Qualifying Events, a Qualified Beneficiary who is a Qualifying Dependent may continue COBRA Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event.

Coverage under this Section 11.3 may not continue beyond:

(a) the date on which the Employer ceases to maintain a group health plan within its controlled group;

(b) the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 11.4;

(c) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes enrolled in Medicare;

(d) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes covered under another group health plan and is no longer subjected, due to changes in the law or otherwise, to a pre-existing condition exclusion or limitation under the Qualified Beneficiary's other coverage or new employer plan; or

(e) in the case of a disabled Qualified Beneficiary (and his disabled or non-disabled family members) receiving COBRA Continuation Coverage under the eleven (11) month extended coverage described in Section 11.6, and with respect to such extended coverage, the first day of the month that begins more than thirty (30) days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of Similarly Situated Beneficiaries, for example, for the submission of a fraudulent claim.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a Covered Employee during a period of COBRA Continuation Coverage, the maximum period of COBRA Continuation Coverage is the maximum period applicable to the Qualifying Event giving rise to the period of COBRA Continuation Coverage during which the child was born or placed for adoption.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA Continuation Coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11.4 **Contribution Requirements for COBRA Coverage**.

Qualified Beneficiaries who elect COBRA Continuation Coverage as a result of a Qualifying Event (or third parties on behalf of a Qualified Beneficiary) will be required to pay Continuation Coverage Contributions. Qualified Beneficiaries (or third parties on behalf of a Qualified Beneficiary) must make the Continuation Coverage Contributions monthly on or prior to the first day of the month of such coverage. However, a Qualified Beneficiary has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage

Contributions for the first month plus the cost for the period between the date health coverage would otherwise have terminated due to the Qualifying Event and the date the Qualified Beneficiary actually elects COBRA Continuation Coverage. If the Qualified Beneficiary fails to make the Continuation Coverage Contribution for the first month's premium, coverage will either terminate or will be retroactively cancelled.

The Qualified Beneficiary will have a thirty (30) day grace period from the due date (the first of each month) to make the Continuation Coverage Contributions due for such month. Continuation Coverage Contributions must be postmarked on or before the end of the thirty (30) day grace period.

If Continuation Coverage Contributions are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made on a timely basis. The thirty (30) day grace period will not apply to the forty-five (45) day period for payment of COBRA premiums as applicable to initial elections.

Except as provided in Section 11.6, the Continuation Coverage Contribution will be one hundred percent (100%) of the cost of coverage plus a two percent (2%) administrative fee for a total contribution of one hundred two percent (102%) of the cost of coverage.

If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not significantly less than the amount due for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (thirty (30) days) for payment of the deficiency to be made. For purposes of this Section 11.4, an amount not significantly less than the amount the Plan requires to be paid will be defined as the lesser of fifty dollars ($50) or ten percent (10%) of the required payment amount.

11.5 **Limitation on Qualified Beneficiary's Rights to COBRA Coverage**.

If a Qualified Beneficiary loses, or will lose, health coverage under the Plan as a result of a Qualifying Event that is a divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary or the Covered Employee (or a representative of either) must notify the Plan Administrator, as described in Section 11.12, within a maximum of sixty (60) days after the latest of (a) the Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of his responsibility to provide a Qualifying Event notice as described in this Section 11.5 and the Plan's procedures for providing such notice. Failure to make timely notification will result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Article XI.

A Qualified Beneficiary must notify the Plan Administrator, as described in Section 11.12, of the birth to, adoption by or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage.

For all other Qualifying Events (including when the Qualifying Event is the end of employment, the death of a Covered Employee, commencement of a proceeding in bankruptcy

with respect to the Employer, a Covered Employee's entitlement to Medicare (Part A, Part B, or both)), the Employer must notify the Plan Administrator of the Qualifying Event. The notice must be provided within a maximum of thirty (30) days after the Qualifying Event.

11.6 **Extension of COBRA Coverage Period**.

A Qualified Beneficiary or the Covered Employee (or a representative of either) must notify the Plan Administrator, as described in Section 11.12, if a second Qualifying Event occurs while the Qualified Beneficiary is receiving COBRA Continuation Coverage. The Qualified Beneficiary must notify the Plan Administrator within a maximum of sixty (60) days after the latest of (a) the second Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the second Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of his responsibility to provide a notice of a second Qualifying Event and the Plan's procedures for providing such notice.

If a second Qualifying Event that is not a termination of employment or reduction in hours occurs during an eighteen (18) month period of COBRA Continuation Coverage explained in Section 11.3 (or twenty-nine (29) month period, if extended due to disability), coverage may be extended to a maximum of thirty-six (36) months from the date of the first Qualifying Event for the affected Qualifying Dependent. Coverage will be extended, however, only if the second Qualifying Event would have caused the Qualifying Dependent to lose coverage under the Plan in the absence of the first Qualifying Event. Any such extension of COBRA Continuation Coverage applies only to Qualifying Dependents. Therefore, such extension would apply to a child adopted or placed for adoption with a Qualified Beneficiary, but would not apply to a spouse who was added to a Qualified Beneficiary's COBRA Continuation Coverage as a result of the Qualified Beneficiary's becoming married after commencement of the initial eighteen (18) month continuation period.

The maximum COBRA Continuation Coverage Period is extended up to eleven (11) months for Qualified Beneficiaries (and their disabled or non-disabled family members receiving COBRA Continuation Coverage due to the same Qualifying Event) for up to twenty-nine (29) months in total (measured from the date of the Qualifying Event), provided the following requirements are met:

(a) the Social Security Administration ("**SSA**") determines that the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or within the first sixty (60) days of COBRA Continuation Coverage following the Qualifying Event, and

(b) the Qualified Beneficiary or the Covered Employee (or a representative of either) provides notice to the Plan Administrator, as described in Section 11.12, of such SSA determination:

(i) within sixty (60) days after the latest of (A) the date of the SSA determination, (B) the date on which the Qualifying Event occurred, (C) the date on which the Qualified Beneficiary loses coverage due to the Qualifying Event, or (D) the date on which the Qualified Beneficiary is

informed, including through this SPD or a COBRA general notice, of the obligation to provide the disability notice and the Plan's procedures for providing such notice; but

(ii) not later than the last day of the initial eighteen (18) month period of COBRA Continuation Coverage.

In such event, the Continuation Coverage Contribution will be one hundred fifty percent (150%) of the cost of coverage for the nineteenth (19^{th}) through twenty-ninth (29^{th}) months of COBRA Continuation Coverage.

However, if a Qualified Beneficiary who meets the above requirements receives a final determination from the SSA that he is no longer disabled, said beneficiary or the Covered Employee (or a representative of either) must notify the Plan Administrator, as described in Section 11.12, within thirty (30) days after the later of (a) the date of that determination or (b) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of the obligation to provide the end-of-disability notice and the Plan's procedures for providing such notice. Such a final determination by the SSA will end the disability extension of COBRA Continuation Coverage for all Qualified Beneficiaries as of the later of either: (i) the first day of the month following thirty days (30) from the final determination date; or (ii) the end of the COBRA Continuation Coverage period without regard to the disability extension.

11.7 **Responses to Inquiry Regarding Qualified Beneficiary's Right to Coverage**.

If a provider of health care (such as a physician, hospital, or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary during the election period, the Plan will give a complete response to the health care provider about the Qualified Beneficiary's COBRA Continuation Coverage rights during the election period, and his right to retroactive coverage if COBRA is elected. If a provider of health care (such as a physician, a hospital or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary with respect to whom the required payment has not been made for the current period, but for whom any applicable grace period has not expired, the Plan will inform the health care provider of all of the details of the Qualified Beneficiary's right to pay for such coverage during the applicable grace period.

11.8 **Coordination of Benefits - Medicare and COBRA**.

For purposes of this Article XI, "Medicare Entitlement" means being entitled to Medicare due to either (a) enrollment (automatically or otherwise) in Medicare Parts A or B, or (b) being medically determined to have end-stage renal disease ("**ESRD**") and (i) having applied for Medicare Part A, (ii) having satisfied any waiting period requirement and (iii) being either (A) insured under Social Security, (B) entitled to retirement benefits under Social Security or (C) a spouse or dependent of a person satisfying either (A) or (B). Such Medicare Entitlement is a COBRA terminating event.

If a Covered Employee has a Qualifying Event due to his termination of employment or reduction in work hours, and such Qualifying Event occurs less than eighteen (18) months after the date the Covered Employee became entitled to Medicare, the maximum period of COBRA

Continuation Coverage for the Covered Employee's Qualifying Dependents will be extended to the last day of the thirty-six (36) month period measured from the date the Covered Employee became entitled to Medicare, while the maximum period of COBRA Continuation Coverage for the Covered Employee is eighteen (18) months from the Qualifying Event.

If a Covered Employee has a Qualifying Event due to his termination of employment or reduction in work hours and, after the Covered Employee has elected COBRA Continuation Coverage and during the first eighteen (18) months of COBRA Continuation Coverage (or twenty-nine (29) months if extended due to disability), the Covered Employee first becomes entitled to Medicare, the Covered Employee's COBRA Continuation Coverage will end, and the maximum period of COBRA Continuation Coverage for his Qualifying Dependents who were Qualified Beneficiaries and elected COBRA Continuation Coverage will be extended to the last day of the thirty-six (36) month period measured from the date of the Qualifying Event. Coverage will be extended, however, only if the Covered Employee's Medicare entitlement would have caused such Qualifying Dependents to lose coverage under the Plan in the absence of the Qualifying Event. The Covered Employee or Qualifying Dependent (or a representative of either) must provide notice to the Plan Administrator, as described in Section 11.12, of the Covered Employee's Medicare entitlement within a maximum of sixty (60) days after the latest of (a) the date of Medicare entitlement, (b) the date the Qualified Beneficiary would lose coverage on account of the Medicare Entitlement, or (c) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of the responsibility to provide a notice of Medicare entitlement and the Plan's procedures for providing such notice.

11.9 **Relocation and COBRA Coverage**.

If a Qualified Beneficiary moves outside the service area of a region-specific benefit package, alternative coverage, if available to active employees, will be made available to the Qualified Beneficiary no sooner than the date of the Qualified Beneficiary's relocation, or if later, the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage.

11.10 **COBRA Coverage and HIPAA Special Enrollment Rules**.

Once a Qualified Beneficiary is receiving COBRA Continuation Coverage, the Qualified Beneficiary has the same right to enroll family members under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules as if the Qualified Beneficiary were an Employee or Participant in the Plan, provided that such family members do not become Qualified Beneficiaries, pursuant to Section 11.2, and are therefore not eligible to elect COBRA Continuation Coverage in their own right.

Election of COBRA Continuation Coverage by a Qualified Beneficiary may serve to bridge coverage between the Plan and any future coverage under another plan.

11.11 **Definitions**.

For purposes of this Article XI only, the following definitions will apply:

(a) *COBRA* means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(b) *Continuation Coverage* means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage will be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of the Plan are modified for Similarly Situated Beneficiaries, such coverage will also be modified in the same manner for all Qualified Beneficiaries as of the same date. Open enrollment rights extended to active Employees will also be extended to similarly situated Qualified Beneficiaries.

(c) *Continuation Coverage Contribution* means the amount of premium contribution required to be paid by or on behalf of a Qualified Beneficiary for Continuation Coverage.

(d) *Continuation Coverage Period* means the applicable time period for which Continuation Coverage may be elected.

(e) *Covered Employee* means an individual who was covered under the Plan on the day prior to the Qualifying Event and who is or was provided such coverage by virtue of the individual's performance of services for one or more entities maintaining the Plan. If an individual who otherwise would be a Covered Employee is denied coverage under the Plan in violation of applicable law, including HIPAA, the individual is considered a Covered Employee.

(f) *Open Enrollment Period* means a period during which an Employee covered under the Plan can choose to be covered under another plan or under another benefit option within the same plan, or add or eliminate coverage of family members.

(g) *Qualified Beneficiary* means a Covered Employee or Qualifying Dependent.

(h) Qualifying Dependent means:

(i) a Dependent covered under the Plan on the day prior to the Qualifying Event; or

(ii) a Dependent child who is born to, adopted or placed for adoption with a Covered Employee during the Covered Employee's period of COBRA Continuation Coverage; or

(iii) a child who is covered under the Plan on the day prior to the Qualifying Event pursuant to the terms of a qualified medical child support order.

(i) *Qualifying Event* means any of the following events which would otherwise result in a Covered Employee's or a Qualifying Dependent's loss of health coverage under the Plan in the absence of this provision:

(i) a Covered Employee's termination of employment, for any reason other than gross misconduct;

(ii) a Covered Employee's reduction in work hours resulting in a change of status such that the Covered Employee is no longer eligible to be a Covered Employee;

(iii) a Covered Employee's divorce or legal separation;

(iv) a Qualifying Dependent ceasing to qualify as a Dependent under the provisions of the Plan;

(v) a Covered Employee's entitlement to benefits under Medicare;

(vi) the death of a Covered Employee;

(vii) the failure of a Covered Employee to return from FMLA leave (Note: the Covered Employee and family members will be entitled to COBRA Continuation Coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave); or

(viii) a proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a Covered Employee retired at any time.

Note: A loss of health coverage under the Plan includes any increase in the premium or contribution that must be paid by the Covered Employee (or Spouse or Dependent) for coverage under the Plan that results from the occurrence of one of the events listed above in Subsections (i)(i) – (i)(viii). The loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage Period. If coverage is reduced or eliminated in anticipation of an event, such reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

(j) *Similarly Situated Beneficiaries* means Employees or their Dependents, as applicable, who are Participants in the Plan.

11.12 **Qualified Beneficiary Notice Procedures**.

Any notice that a Qualified Beneficiary is required to provide under this Article XI must be in writing. The Plan Administrator may contract with a third-party administrator to perform services as the Plan's COBRA Administrator.

A Qualified Beneficiary must provide its applicable notice ("**Notice**") to the COBRA Administrator at the following address:

UnifyHR
105 Decker Ct., Suite 310
Irving, Texas 75062

(800) 519-8366

The Notice must be postmarked no later than the last day of the applicable required notice period. The information that must be provided in the Notice is based on the purpose of the Notice, as follows:

(a) Qualifying Event Notice.

The Notice to inform the Plan Administrator of a Qualifying Event (including a Covered Employee's entitlement to Medicare) must contain (1) the name of the Qualified Beneficiary; (2) the name of the Plan to which the Notice applies; (3) a description of the Qualifying Event; and (4) the date on which the Qualifying Event occurred.

(b) Disability Determination Notice.

The Notice to inform the Plan Administrator of a Qualified Beneficiary's disability determination by the SSA must contain (1) the name of the Qualified Beneficiary, (2) the name of the Plan to which the Notice applies, and (3) a copy of the SSA's disability determination letter.

(c) Determination of End of Disability Notice.

The Notice to inform the Plan Administrator of the SSA's determination that a disabled Qualified Beneficiary is no longer disabled must contain (1) the name of the Qualified Beneficiary, (2) the name of the Plan to which the Notice applies, and (3) a copy of the SSA's determination letter that a disability no longer exists.

(d) Birth, Adoption or Placement Notice.

The Notice to inform the Plan Administrator of the birth, adoption or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage must contain (1) the name of the Covered Employee, (2) the name of the Plan to which the Notice applies, (3) the reason for the Notice (i.e., the birth, adoption or placement for adoption of a child, as applicable), and (4) the date of such child's birth, adoption or placement for adoption.

11.13 **Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Continuation Coverage**.

Special COBRA rights may apply to certain Covered Employees who are eligible for trade adjustment assistance under the Trade Act of 2002 ("**TAA Employees**"). These TAA Employees may be entitled to a second opportunity to elect COBRA Continuation Coverage for themselves and certain family members (if they did not already elect COBRA Continuation Coverage) during a special second election period. This special second election period lasts for sixty (60) days or less. It is the 60-day period beginning on the first day of the month in which the TAA Employee becomes eligible for certain benefits under the Trade Act of 2002 and during the six (6) month period immediately after the TAA Employee's coverage under the Plan ends.

A Covered Employee who qualifies or may qualify for this special election period should contact the Plan Administrator's Benefits Department at the address and telephone number listed in Article XIV for additional information.

11.14 **Questions and Other Information Regarding COBRA Coverage**.

The Covered Employee will be responsible for keeping the Plan Administrator informed of any changes in his address and the addresses of his Spouse and his Dependents. Questions concerning a Participant's COBRA coverage rights should be directed to the COBRA Administrator at the address and/or telephone number listed in Section 11.12.

In the event that the Plan Administrator changes COBRA Administrators or the Participant is unable to reach the above-referenced COBRA Administrator, the Participant should direct questions to the Plan Administrator's Benefits Department at the address and telephone number listed in Article XIV.

ARTICLE XII
HIPAA PRIVACY AND SECURITY

12.1 **HIPAA Privacy and Security in General**.

This Article XII is intended to comply with the requirements under the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**"); the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E, as promulgated under HIPAA ("**Privacy Standards**"); the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 160 and part 164, subpart C, as promulgated under HIPAA ("**Security Standards**"); and, effective as of September 23, 2013, the regulations issued on January 25, 2013 ("**HIPAA Omnibus Rules**"), which amended the Privacy Standards, the Security Standards, the HIPAA Enforcement Rule at 45 CFR part 160, subparts C through E ("**Enforcement Rules**") and the "**Breach Notification Rules**" issued under the Health Information Technology for Economic and Clinical Health Act ("**HITECH**"). References to any section of the Privacy Standards, the Security Standards, the Enforcement Rules or the Breach Notification Rules shall include any amendments or successor provisions thereto, including the HIPAA Omnibus Rules.

For purposes of this Article XII, "Protected Health Information" ("**PHI**") means information, including genetic information, that is created or received by the Plan which (i) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (ii) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (iii) is transmitted or maintained in any form or medium. "Electronic Protected Health Information" ("**ePHI**") means individually identifiable health information that is created or received by the Plan and transmitted by or maintained in electronic media.

12.2 **Designation of Health Care Components and Safeguards**.

To the extent the Plan is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy Standards), the provisions of this Article XII will only apply to the health care components of the Plan (collectively referred to as the "**Health Care Components**"). All references to Protected Health Information (PHI) or Electronic Protected Health Information (ePHI) in this Article XII refer to PHI or ePHI that is created or received by or on behalf of the Health Care Components. The Health Care Components will thus comply with the following requirements:

(a) The Health Care Components of the Plan will not disclose PHI to another component of the Plan in circumstances in which the Privacy Standards would prohibit such disclosure if the Health Care Components and the other component were separate and distinct legal entities; and

(b) If an employee of the Plan Sponsor performs duties for both the Health Care Components of the Plan and for another component of the Plan, such employee will not use or disclose PHI created or received in the course of, or incident to, the employee's work for the Health Care Component in a way prohibited by the Privacy Standards.

Note: For purposes of this Section 12.2, the portions of the Plan which provide medical benefits, prescription drug benefits, dental benefits, vision care benefits and employee assistance program benefits constitute the Health Care Components.

12.3 **Use and Disclosure of Protected Health Information**.

The Plan Sponsor may only use and disclose PHI that it receives from a Health Care Component of the Plan, which is considered a "group health plan" as defined by the Privacy Standards, as permitted and/or required by, and consistent with, the Privacy Standards. This includes, but is not limited to, the right to use and disclose a Participant's PHI in connection with payment, treatment, and health care operations, or as otherwise permitted or required by law. The Plan shall not use or disclose PHI that is genetic information for underwriting purposes.

Payment includes activities undertaken by the Health Care Component of the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(a) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);

(b) Coordination of benefits or non-duplication of benefits;

(c) Adjudication of health benefit claims (including appeals and other payment disputes);

(d) Subrogation of health benefit claims;

(e) Establishing employee contributions;

(f) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) Billing, collection activities and related health care data processing;

(h) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

(i) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(k) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(l) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(m)Obtaining reimbursements due to the Plan.

Health Care Operations include, but are not limited to, the following activities:

(a) Quality assessment;

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(d) Enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

(e) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(f) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including

formulary development and administration, development or improvement of payment methods or coverage policies; and

(g) Business management and general administrative activities of the Plan, including, but not limited to:

(i) Management activities relating to the implementation of, and compliance with, HIPAA's administrative simplification requirements;

(ii) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(iii) Resolution of internal grievances; and

(iv) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

1.10 **Certification of Amendment of Plan Documents by Plan Sponsor**.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in this Article XII.

12.5 **Plan Sponsor Agrees to Certain Conditions for PHI**.

The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(e) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to an individual in accordance with HIPAA's access requirements;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor 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

(k) Establish separation between the Plan and the Plan Sponsor in accordance with 45 CFR § 164.504(f)(2)(iii).

With respect to ePHI, the Plan Sponsor agrees, on behalf of the Plan, to:

(i) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(ii) Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) under the Privacy Standards is supported by reasonable and appropriate security measures;

(iii) Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the Plan agrees to implement reasonable and appropriate security measures to protect the information; and

(iv) Report to the Plan any security incident of which it becomes aware, in accordance with the administrative procedures adopted by the Plan for compliance with the Security Standards.

12.6 **Adequate Separation Between the Plan and the Plan Sponsor**.

In accordance with the Privacy Standards, only the employees or classes of employees designated in Appendix E may be given access to PHI.

12.7 **Limitations of PHI Access and Disclosure**.

The persons described in Appendix E may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

12.8 **Noncompliance Issues**.

If the persons described in Appendix E do not comply with the Plan document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

12.9 **Members of Organized Health Care Arrangement**.

To the extent that any Health Care Component is fully-insured, the Plan and the health insurance issuer or HMO with respect to such Health Care Component are an organized health care arrangement (as defined in § 160.103 of the Privacy Standards), but only with respect to PHI created or received by the health insurance issuer or HMO that relates to the individuals who are Participants or Beneficiaries in such Health Care Component.

12.10 **Additional Requirements Imposed by HITECH**.

The provisions of this Section 12.10 will apply to the Plan to the extent the Plan is a "covered entity" as defined in 45 CFR § 160.103. In accordance with, and to the extent required by, HITECH and the regulations and other authority promulgated thereunder by the appropriate governmental authority, the Plan will (a) comply with notification requirements when unsecured PHI has been accessed, acquired, or disclosed as a result of a breach, (b) comply with an individual's request to restrict disclosure of PHI, (c) limit disclosures of PHI to a limited data set or the minimum necessary, (d) provide an accounting of disclosures, and (e) provide access to PHI in electronic format.

12.11 **Limitation on the Use and Disclosure of Genetic Information**.

Notwithstanding anything herein to the contrary, no "genetic information" (as defined by Section 105 of the Genetic Information Nondiscrimination Act of 2008) shall be used or disclosed for underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, or ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance).

12.12 **Notification in Case of a Breach of Unsecured PHI**.

In the event of the acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Standards that constitutes a "Breach," as such term is defined in 45 CFR 164.402, the Plan, or its designee, shall notify each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, used or disclosed as a result of the Breach no later than sixty (60) days after the Plan, or its designee, discovers the Breach, unless notification may be delayed as permitted by 45 CFR 164.412 because such notice would impede a criminal investigation or damage national security. The Plan, or its designee, will mail individual notifications by first-class mail to the individual's last known address or by electronic mail, provided that electronic disclosure is permitted by the applicable regulations. The individual notification will include the following information:

- A brief description of what happened, including the date of the Breach and the date of its discovery, if known;

- A description of the type of PHI involved, such as name, social security number, date of birth, address, account number, diagnosis, disability code, or other type of information involved;

- Any steps the individual should take to protect himself from potential harm resulting from the Breach;

- A brief description of what the Plan or its business associate is doing to investigate the Breach, mitigate harm to individuals, and to protect against further Breaches; and

- Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, e-mail address, web site, or postal address.

If the Breach involves more than 500 residents of a state or jurisdiction, the Plan, or its designee, will also notify prominent media outlets that service the state or jurisdiction of the Breach. Additionally, the Plan will notify the Secretary of the Department of Health and Human Services of the Breach as required by 45 CFR 164.408.

12.13 **Other Medical Privacy Laws.**

The Plan will comply with the Privacy Standards and the Security Standards as well as with any applicable federal, state and local laws governing confidentiality of health care information, to the extent such laws are not preempted by HIPAA or ERISA.

ARTICLE XIII
MISCELLANEOUS LAW PROVISIONS

13.1 **Qualified Medical Child Support Orders.**

Rules relating to Qualified Medical Child Support Orders ("**QMCSO**") – Any health plan offered under the Plan will provide benefits in accordance with the applicable requirements of any QMCSO.

(a) Definitions.

For purposes of Section 13.1, 13.2, 13.3 and 13.4, the following definitions apply:

(i) The term "Qualified Medical Child Support Order" will be defined for purposes of Sections 13.1, 13.2, 13.3 and 13.4 as follows: A Medical Child Support Order:

(A) which 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 a Participant or Beneficiary is eligible under a group health plan; and

(B) with respect to which the requirements of this Section 13.1 under "Information to be Included in a QMCSO" and "Restriction on New Types or Forms of Benefits" are met.

(ii) The term "Medical Child Support Order" will be defined in Sections 13.1, 13.2 and 13.3 as follows: Any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

(A) provides for child support with respect to a child of a Participant under a health plan offered under the Plan or provides for health benefit coverage to such a child pursuant to a state domestic relations law (including a community property law), and relates to benefits under the health plan offered under the Plan; or

(B) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a health plan offered under the Plan.

(iii) For purposes of Sections 13.1, 13.2, 13.3 and 13.4, the term "Alternate Recipient" will be defined as follows: Any child of a Participant who is recognized under a Medical Child Support Order as having the right to enrollment under a health plan provided within the Plan with respect to such Participant.

(b) Information to be Included in a QMCSO.

A Medical Child Support Order meets the requirements of this paragraph only if such order clearly specifies:

(i) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient;

(ii) 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; and

(iii) the time period to which such order applies.

(c) Restriction on New Types or Forms of Benefits.

A Medical Child Support Order meets the requirements of this paragraph only if such order does not require a health plan to provide any type or form of benefit, or any option,

not otherwise provided under the health plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).

(d) QMCSO Coverage Ends.

A child who is covered pursuant to a QMCSO will have coverage end on the date the QMCSO expires.

13.2 **Procedural Requirements.**

(a) Timely Notifications and Determinations.

In the case of any Medical Child Support Order received by the Plan Administrator for a health plan offered under the Plan -

(i) the Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the Plan's procedures for determining whether a Medical Child Support Order is a QMCSO, and

(ii) within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a QMCSO and notify the Participant and each Alternate Recipient of such determination.

(b) Establishment of Reasonable Procedures.

The Plan Administrator will establish reasonable procedures to determine whether a Medical Child Support Order is a QMCSO and to administer the provisions of benefits under such QMCSO. Such procedures:

(i) will be in writing;

(ii) will provide for the notification of each person specified in a Medical Child Support Order who is named as eligible to receive benefits under the Plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and

(iii) will permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a QMCSO.

A Participant may obtain a copy of the QMCSO procedures, without charge, upon request to the Benefits Department of the Plan Administrator at the address and/or telephone number listed in Article XIV.

13.3 **Actions Taken by Fiduciaries.**

(a) General Requirement.

If the Plan Administrator acts in accordance with Sections 13.1, 13.2 and 13.3 in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Plan's obligation to the Participant and each Alternate Recipient will be discharged.

(b) Treatment of Alternate Recipients.

(i) An individual who is an Alternate Recipient under a QMCSO will be considered a Beneficiary under the Plan for purposes of any provision of ERISA.

(ii) An individual who is an Alternate Recipient under any Medical Child Support Order will be considered a Participant under the specific health plan for purposes of the reporting and disclosure requirements of Title I of ERISA.

(c) Direct Provision of Benefits Provided to an Alternate Recipient.

Any payment for reimbursement of expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian will be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

(d) Payment to State Official Treated as Satisfaction of Plan's Obligation to Make Payment to Alternate Recipient.

Payment of benefits by the Plan to an official of a state or a political subdivision thereof, whose name and address have been substituted for the name and address of an Alternate Recipient in a QMCSO, will be treated as payment of benefits to the Alternate Recipient.

13.4 **National Medical Support as Qualified Medical Child Support Order.**

(a) An appropriately completed National Medical Support Notice ("**Notice**") promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998 will be deemed to be a QMCSO if the Notice does not require the Plan to provide any type of form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993), and the Notice clearly specifies the following:

(i) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient (an official of a state or political subdivision may be substituted for the mailing address of any Alternate Recipient, if provided for in the Notice);

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

(iii) the period to which the Notice applies.

(b) If a Notice which satisfies Section 13.4(a) is issued for a child of a Participant under the Plan who is a noncustodial parent of the child, the Plan Administrator, within forty (40) business days after the date of the Notice, will:

(i) notify the state agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the Plan and, if so, whether such child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a state or political subdivision thereof substituted for the name of such child pursuant to Section 13.4(a)(i)) to effectuate the coverage; and

(ii) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

(c) Nothing in this Section 13.4 will be construed as requiring the Plan, upon receipt of Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before the receipt of such Notice.

13.5 **Rights of States for Group Health Plans where Participants are Eligible for Medical Benefits.**

(a) Compliance by Plans with Assignment of Rights.

A Welfare Program offered under the Plan that provides health benefits will comply with any assignment of rights made by or on behalf of such Participant or a Beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(l)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

(b) Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility.

In determining or making any payments for benefits of an individual as a Participant or Beneficiary, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

(c) Acquisition by States of Rights of Third Parties.

If payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act offered under the Plan in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant to such payment for such items or services; provided, however that in no event will such a state law be applied to the extent it attempts to create rights for the state plan which are greater than those of the Participant under the Plan, specifically including any state law which provides that a state plan can make a claim for benefits or recover benefits beyond the period permitted under the Plan.

13.6 **Health Program Coverage of Dependent Children in Adoption Cases.**

(a) Coverage Effective Upon Placement For Adoption.

Notwithstanding anything in the Welfare Program Documents to the contrary, if a Welfare Program offered under the Plan provides health coverage for Dependent children of Participants or Beneficiaries, such Welfare Program will provide benefits to Dependent children Placed For Adoption with Participants or Beneficiaries under the same terms and conditions as apply in case of Dependent children who are natural children of Participants or Beneficiaries under the Plan, irrespective of whether the adoption has become final.

(b) Definitions.

For purposes of this Section 13.6, the following definitions apply:

(i) Child means, in connection with any adoption or Placement For Adoption of the Child, an individual who has not attained age eighteen (18) as of the date of such adoption or Placement For Adoption.

(ii) Placement, Placement For Adoption, or being Placed For Adoption, in connection with any Placement For Adoption of a Child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child. The Child's Placement with such person terminates upon the termination of such legal obligation.

13.7 **Continued Coverage of Pediatric Vaccine under Group Health Plans.**

A Welfare Program offered under the Plan that is a health plan may not reduce its coverage of the costs of pediatric vaccines (as defined under Section 1928(h)(6) of the Social Security Act as amended by Section 13830 of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993.

13.8 **Family and Medical Leave Act.**

(a) General.

If an Employee Participant takes a leave pursuant to the federal Family and Medical Leave Act ("**FMLA**"), health benefits coverage for such Participant may continue, subject to the Participant's continued participation in the Plan, on the same basis as for active Participants for the first day on which such approved leave began until the end of the FMLA leave, pursuant to the requirements of the FMLA. The Employee may continue his coverage for the period of the leave of absence, but not to exceed the period prescribed by the FMLA, provided that he pays any required Participant Contributions under the Plan. If the Employee fails to return to work on expiration of the leave period or notifies the Employer during the leave that he will not be returning to work due to reasons within his control, his coverage under the Plan will be terminated at the end of the month in which he fails to return to work or the end of the month in which he gives such notice to the Employer.

(b) Re-enrollment.

An Employee Participant who elects to revoke coverage under the Section 125 cafeteria plan sponsored by the Plan Sponsor ("**Flex Plan**") or whose coverage terminates during a leave granted pursuant to FMLA for failure to make any required Participant Contribution, will be eligible to re-enroll in the Plan immediately upon returning from the FMLA leave subject to payment of applicable Participant Contributions. Coverage will commence on the day of his return to employment to Active Service subject to administrative policies for election of coverage established by the Plan Administrator and payment of any required Participant Contributions. However, coverage will be reinstated only if the person(s) had coverage under the Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated, subject to any changes that affect the work force as a whole.

(c) COBRA.

An approved leave of absence, which may include a leave pursuant to FMLA, does not constitute a Qualifying Event under COBRA within the meaning of Section 11.11. The failure of the Employee Participant to return to work following the FMLA leave is a COBRA Qualifying Event. Notification by the Participant of the Participant's intent not to return from FMLA leave is a COBRA Qualifying Event if such failure to return results in a termination of employment. The last day of such leave will be deemed the date the Qualifying Event occurred.

(d) Contributions.

An Employee Participant in the Plan who takes an FMLA leave is entitled to continue to participate in the Welfare Programs provided under the Plan during such leave. However, if the Participant is also a participant in the Flex Plan, the Participant may revoke his election to participate in the Flex Plan. If the Participant does not revoke his Flex Plan election, or if he does not participate in the Flex Plan, he must continue to make Participant Contributions to the Plan on a pay-as-you-go basis, unless the Participant makes advance payments or, if permitted under administrative policies adopted by the Plan Administrator, subsequent payments following the Participant's

return from leave, provided that such administration has been previously approved by the Plan Administrator. Deductions for coverage or participation while on a *paid* leave will be withheld from the Participant's paychecks during the leave.

(e) Termination of Benefits while on FMLA Leave.

If a Participant's coverage under the Plan has been terminated while on FMLA leave, such coverage will be reinstated upon timely return from FMLA leave. A Participant who elected to cease participation in the Flex Plan while on FMLA leave may elect to commence participation upon timely return from FMLA leave.

13.9 **Uniformed Services Employment and Reemployment Rights Act.**

The Plan will comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("**USERRA**") with regard to continuation rights during an approved military leave of absence and reenrollment rights on return from such military leave of absence.

(a) An Employee who is not at work because of a period of duty in the Uniformed Services (as defined in USERRA), may, at the Employee's election, continue coverage in any or all Welfare Programs under the Plan during the period of absence, so long as the Employee satisfies the necessary provisions and makes any required Participant Contribution as provided under USERRA.

(b) The maximum period of coverage for an Employee, an Employee's Spouse and/or Dependents, if any, under a Welfare Program during a period of duty in the Uniformed Services will be governed by the applicable limitations and provisions contained in USERRA unless more generous limitations are provided under the Employer's leave of absence policy.

(c) An Employee who elects to continue coverage in one or more Welfare Programs under the Plan will pay:

(i) the Employee's share, if any, for coverage under the Plan if the Employee performs service in the Uniformed Services for up to thirty-one (31) days; or

(ii) one hundred two percent (102%) of the full premium or cost under the Plan (determined in the same manner as the applicable COBRA Continuation Coverage premium under Section 4980B(f)(4) of the Code) if the Employee performs service in the Uniformed Services for thirty-one (31) days or more.

(d) During the period of service in the Uniformed Services, the Employee may pay the necessary costs associated with coverage under the Plan, if any, by:

(i) remitting payment to the Employer on or before each pay period for which the Participant Contributions would have been deducted from the Employee's paycheck had the Employee not been absent serving in the

Uniformed Services, provided that any delinquent payments must be made within thirty (30) days after their due date;

(ii) at the Employee's request, prepaying the amounts that will become due during the period of service in the Uniformed Services out of one or more of the Employee's paychecks preceding such period of service in the Uniformed Services; or

(iii) pre-approved arrangement with the Plan Administrator and in accordance with administrative policies adopted by the Plan Administrator wherein the Employer pays the Employee's Participant Contributions during the Employee's period of service in the Uniformed Services. Upon return from such service, the Employee will reimburse the Employer for such previous payments.

Any Employee who is a Participant, who is not at work because of service in the Uniformed Services and who returns to active employment within the relevant time period determined under USERRA, will be eligible to return to work and immediately participate in the same Welfare Programs which the Participant had elected to participate in prior to serving in the Uniformed Services, subject to any changes in the Welfare Programs that affect the workforce as a whole, provided that the Participant returns to employment with the same benefit eligibility status that he held prior to serving in the Uniformed Services, and provided further, that the Participant makes all required elections to participate in the Plan on a timely basis. Except to the extent provided in administrative policies adopted by the Plan Administrator (or the Employer, if applicable), the maximum period of health care coverage available to a Participant (and his Dependents) while on a USERRA leave of absence will end on the earlier of (i) the last day of the maximum coverage period prescribed under USERRA (or if required by USERRA's discrimination rules, the last day of the longest period that the Employer's leave of absence policy permits Welfare Program coverage to continue) or (ii) the day after the date upon which the person fails to apply for a return to a position of employment within the time required under Section 4312(a) of USERRA. For purposes of determining eligibility for health benefits (and only if the Participant pays the full amount which the Employer is permitted to charge the Participant for health coverage under USERRA), a Participant who experiences a reduction in hours or termination of employment solely due to a USERRA leave will continue to be considered qualified as a Participant under the Plan until the earliest date that the termination of his health benefits is permitted under USERRA.

13.10 **Health Insurance Portability and Accountability Act.**

The Plan will comply with HIPAA with respect to a Welfare Program offered under the Plan that provides health benefits, except to the extent that such health benefits are "excepted benefits" which are not subject to HIPAA's portability provisions.

(a) Eligibility.

The Plan will not base eligibility rules or waiting periods on any of the following: health status, mental or physical medical condition, genetic information or evidence of

insurability or disability. However, the Plan may continue to provide for the exclusion of specified health conditions or lifetime maximums on certain specific benefits provided under the Plan. These restrictions do not preclude the Plan from applying differing benefit levels, benefit schedules or premium rates in certain situations as provided under HIPAA.

(b) Enrollment.

(i) Loss of coverage. Special enrollment periods will generally be provided for eligible Employees and their eligible Dependents (including their eligible Spouses) whose other health coverage terminates due to (A) exhaustion of COBRA continuation coverage, or (B) if the other coverage is not COBRA continuation coverage, "loss of eligibility" for the other health coverage (for reasons other than the individual's failure to pay premiums or for cause) or termination of employer contributions toward the cost of the other coverage, if the Employee had previously declined coverage under the Plan or a particular Welfare Program for himself and/or his Dependents, because he or they had other coverage under a group health plan or health insurance. For this purpose, "loss of eligibility" includes, but is not limited to:

(A) A loss of eligibility for the other coverage resulting from legal separation, divorce, cessation of dependent status (such as attaining the maximum age for eligibility as a dependent child under the other coverage), death of the Employee, termination of employment, a reduction in the number of hours of employment, or any loss of eligibility for coverage after a period that is measured based on any of those events;

(B) In the case of other coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of other coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim under the other coverage that would meet or exceed a lifetime maximum benefit limit on all benefits; and

(E) A situation in which the other coverage no longer offers any benefits to the class of similarly situated individuals that includes the individual.

If the other coverage is COBRA Continuation Coverage, the coverage must be exhausted. A loss of COBRA Coverage resulting from the individual's failure to pay premiums is not considered exhaustion of COBRA Coverage for purposes of permitting special enrollment.

To be eligible for special enrollment, the Employee must request enrollment no more than thirty-one (31) days after the termination of the other coverage (or after the employer stops contributing toward the other coverage), or for purposes of subsection (D) above, after a claim is denied under the other coverage due to the operation of the lifetime maximum benefit limit on all benefits. The Employee must also have met any requirements under the Plan for stating in writing that coverage was previously declined due to other health coverage.

(ii) Acquisition of New Dependent. Special enrollment periods will be available for the following individuals, in the event the eligible Employee acquires a new Spouse or Dependent as a result of marriage, birth, adoption or placement for adoption, if enrollment is requested no more than thirty-one (31) days following the applicable event:

(A) The eligible Employee, if the Employee acquires a new Dependent as described in this subsection (b)(ii);

(B) The eligible Spouse of the Participant, if either (1) the Spouse becomes the Participant's newly-acquired Dependent through marriage, or (2) the Participant acquires a new Dependent child as described in this subsection (b)(ii);

(C) The eligible Employee and his eligible Spouse, if either (1) the Spouse becomes the Employee's newly-acquired Dependent through marriage, or (2) the Employee acquires a new Dependent child as described in this subsection (b)(ii);

(D) The eligible Dependents of the Participant, if the Participant acquires a new Dependent as described in this subsection (b)(ii);

(E) The eligible Employee and his eligible Dependents, if the Employee acquires a new Dependent as described in this subsection (b)(ii) above; and

(F) The eligible Employee, his eligible Spouse and his eligible Dependents, if the Employee acquires a new Dependent as described in this subsection (b)(ii) above.

In the event of an acquisition of a new Dependent due to birth, adoption or placement for adoption, coverage may be effective retroactively to the date of such birth, adoption or placement for adoption. All other enrollments pursuant to a HIPAA special enrollment right will be effective no sooner than the date the Plan Administrator receives the completed enrollment form and no later than the first day of the month following the date the Plan Administrator receives the completed enrollment form.

(iii) Medicaid/CHIP Special Enrollment Period. Notwithstanding any provision of the Plan to the contrary, the Plan shall permit an eligible Employee or an eligible Employee's Dependent who is eligible for, but not enrolled in, coverage under the Plan to elect to enroll in the Plan if either of the following conditions is met:

(A) *Termination of Medicaid or CHIP coverage*. The eligible Employee or the eligible Employee's Dependent is (i) covered under a Medicaid plan under Title XIX of the Social Security Act ("**Medicaid**") or under a State child health plan under Title XXI of such Act ("**CHIP**"), and (ii) coverage of the eligible Employee or the eligible Employee's Dependent under such a plan is terminated as a result of loss of eligibility for such coverage; or

(B) *Eligibility for Employment Assistance under Medicaid or CHIP*. The eligible Employee or the eligible Employee's Dependent becomes eligible for assistance under Medicaid or CHIP.

In order to enroll in the Plan due to an event described in clause (A) or (B) above, the eligible Employee must request coverage under the Plan not later than sixty (60) days after the date: (a) of termination of coverage under Medicaid or CHIP or (b) the eligible Employee or his eligible Dependent is determined to be eligible for assistance under Medicaid or CHIP. The request for coverage must be made in writing to the Plan Administrator.

With respect to an eligible Employee or eligible Employee's Dependent who elects coverage in accordance with this Section 13.10(b)(iii), coverage under the Plan shall be effective as of the first day of the month following the date the completed request for enrollment is received and accepted by the Plan Administrator.

(c) HIPAA and COBRA Continuation Coverage.

COBRA Continuation Coverage, as amended by HIPAA, will be provided in accordance with Article XI herein.

13.11 **Mental Health Parity and Addiction Equity Act.**

The Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 ("**MHPAEA**") with respect to health benefits provided under a Welfare Program, except to the

extent that such health benefits are "excepted benefits" that are not subject to the MHPAEA provisions in Part 7 of ERISA. If a Welfare Program offered under the Plan provides medical and surgical benefits and mental health benefits or substance use disorder benefits, then the Welfare Program shall be construed and administered in accordance with Section 712 of ERISA and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

13.12 **Newborns' and Mothers' Health Protection Act.**

The Plan will comply with the Newborns' and Mothers' Health Protection Act ("**NMHPA**") with respect to health benefits provided under a Welfare Program, except to the extent that such health benefits are "excepted benefits" which are not subject to the NMHPA provisions in Part 7 of ERISA. Under NMHPA, the Plan and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section delivery. However, the Plan or the issuer may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier. The Plan and the insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six (96) hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. The Plan or insurers may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours, as applicable.

13.13 **Women's Health and Cancer Rights Act.**

The Plan will comply with the Women's Health and Cancer Rights Act ("**WHCRA**") with respect to health benefits provided under a Welfare Program, except to the extent that such health benefits are "excepted benefits" which are not subject to the WHCRA provisions in Part 7 of ERISA. A Welfare Program offered under the Plan that provides health coverage will provide coverage for the following medical and surgical benefits for an individual who is receiving health plan benefits in connection with a mastectomy and who has elected breast reconstruction:

(a) reconstruction of the breast on which the mastectomy has been performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage will be determined in consultation with the attending physician or other health care provider and patient. Coverage for breast reconstruction and related services associated with a mastectomy will be subject to deductibles, co-payments, coinsurance amounts, pre-certification and utilization review requirements that are consistent with those that apply to other benefits under the Welfare Program.

13.14 Genetic Information Nondiscrimination Act.

The Plan will comply with the Genetic Information Nondiscrimination Act of 2008 as provided in Section 702 of ERISA and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

13.15 Patient Protection and Affordable Care Act.

The Plan will comply with the Affordable Care Act, and the regulations and other authority promulgated thereunder by the appropriate governmental authority, with respect to health benefits provided under a Welfare Program, except to the extent that such health benefits are not subject to the Affordable Care Act.

13.16 Other Laws.

The Plan will comply with all other laws applicable to a Welfare Program to the extent not preempted by ERISA or other controlling federal law. Such laws will include, but not be limited to the Americans with Disabilities Act ("**ADA**"), the Pregnancy Discrimination Act ("**PDA**") and the Small Business Job Protection Act ("**SBJPA**").

13.17 Governing Law.

Except as otherwise required for a Fully-Insured Program, all matters or issues relating to the interpretation, construction, validity, and enforcement of the Plan shall be governed by the laws of the State of Texas, without giving effect to any choice-of-law principle that would cause the application of the laws of any jurisdiction other than Texas, except to the extent such laws are preempted by ERISA or other controlling federal law.

ARTICLE XIV
IMPORTANT ERISA INFORMATION

Name of Plan: Consolidated Communications, Inc. Health Benefits Plan

Plan Sponsor: Consolidated Communications Holdings, Inc., Attn: Human Resources, 2116 S. 17th Street, Mattoon, Illinois 61938.

Plan Administrator: Consolidated Communications, Inc., Attn: Human Resources, 508 Old Magnolia Road, Conroe, Texas 77304.

Plan Sponsor and Plan Administrator's Telephone Number: (833) 224-1300.

Plan Sponsor's Employer Identification Number: 02-0636095.

Plan Number: 501.

Type of Plan: The Plan is an "employee welfare benefit plan" subject to ERISA which provides (1) self-funded medical benefits, (2) self-funded prescription drug benefits, (3) self-funded dental benefits, (4) fully-insured vision care benefits, (5) fully-insured medical and prescription drug

benefits, and (6) self-insured digital physical therapy program benefits. No trust is maintained in connection with the Plan.

Type of Administration: The Plan is administered by the Plan Administrator, with benefits being provided in accordance with the terms, limits and conditions of the Plan. The Plan Administrator has engaged the Claims Administrator(s), as set forth in Appendix D, to process claims and perform other administrative duties under the Plan.

Agent for Service of Legal Process: The Plan Administrator at the address listed above.

Disclosure Administrator: Vice President - Compensation & Benefits, Consolidated Communications, Inc., 508 Old Magnolia Road, Conroe, Texas 77304.

Plan Year: The Plan and its records are kept on a Plan Year basis. The Plan Year is the 12-month period beginning each January1st and ending on December 31st.

Sources of Contributions: The adopting Employers and Participants pay the costs for coverage. The Plan Sponsor determines the portion of costs to be paid by the adopting Employers and the Participants.

Collective Bargaining: The Plan provides coverage to (i) eligible Employees who are not members of a collective bargaining unit, and (ii) eligible Employees who are members of a collective bargaining unit and whose coverage is provided pursuant to the terms of one or more collective bargaining agreements. A copy of each such agreement, and a complete list of the Employers and bargaining units covered under the Plan, may be obtained by Participants (and their Beneficiaries in the event of death) upon written request to the Plan Administrator. They are available for examination by Participants and Beneficiaries at (i) the principal office of each bargaining unit that is a party to a covered collective bargaining agreement and (ii) each worksite of the Employer in which at least 50 Participants covered by the Plan are customarily employed. The Plan Administrator may impose a reasonable charge to cover the cost of furnishing any such collective bargaining agreement or list.

ARTICLE XV
STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue healthcare coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan Participants and Beneficiaries.

No one, including the Employer, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, and you disagree with that denial, you must file an appeal of that denial in accordance with the Claims Procedures described in this SPD. If your appeal is denied in accordance with the Claims Procedures herein, and you have exhausted the administrative remedies provided to you under the Plan, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person who was sued to pay these costs and fees. If you are not successful, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact a representative of the Plan Administrator at (833) 224-1300.

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

SUMMARY PLAN DESCRIPTION OF THE CONSOLIDATED COMMUNICATIONS, INC. HEALTH BENEFITS PLAN

APPENDIX A

As of January 1, 2022, other than as specified in the definition of "Employer" in the Plan, there are no additional adopting Employers of the Plan.

A complete listing of the Employers that have adopted the Plan may be obtained by a Participant or Beneficiary upon written request to the Plan Administrator at the address listed in Article XIV. Such listing is also available for examination by a Participant or Beneficiary by contacting the Plan Administrator at the address or telephone number listed in Article XIV.

SUMMARY PLAN DESCRIPTION OF THE CONSOLIDATED COMMUNICATIONS, INC. HEALTH BENEFITS PLAN

APPENDIX B

The following Welfare Programs are incorporated, in their entirety, by reference into this SPD:

1. Consolidated Communications, Inc. BlueCross BlueShield of Texas Health Benefits Program, which includes the:

    - Consolidated Communications, Inc. BlueCross BlueShield of Texas PPO Program and Prime Therapeutics Prescription Drug Program;

    - Consolidated Communications, Inc. BlueCross BlueShield of Texas High Deductible Program and Prime Therapeutics Prescription Drug Program; and

    - Consolidated Communications, Inc. BlueCross BlueShield of Texas Low Premium High Deductible Program and Prime Therapeutics Prescription Drug Program;

2. Consolidated Communications, Inc. CIGNA Dental Preferred Provider Benefits Program;

3. Consolidated Communications, Inc. VSP Group Vision Care Insurance Program;

4. Kaiser Permanente Deductible HMO Plan for Consolidated Communications Holdings, Inc. (California Employees only);

5. Consolidated Communications, Inc. Wellness Program; and

6. Consolidated Communications, Inc. Digital Physical Therapy Program.

SUMMARY PLAN DESCRIPTION OF THE CONSOLIDATED COMMUNICATIONS, INC. HEALTH BENEFITS PLAN

APPENDIX C

The Welfare Program Documents are attached hereto and incorporated, in their entirety, into this SPD by reference.

SUMMARY PLAN DESCRIPTION OF THE CONSOLIDATED COMMUNICATIONS, INC. HEALTH BENEFITS PLAN

APPENDIX D

As of January 1, 2022, the following third party entities serve as Claims Administrators and Claims Fiduciaries (unless indicated otherwise) under the Plan with respect to the following Welfare Programs:

Welfare Program	Claims Administrator/Claims Fiduciary
• Consolidated Communications, Inc. BlueCross BlueShield of Texas Health Benefits Program	**Medical:** BlueCross BlueShield of Texas Claims Division P.O. Box 660044 Dallas, TX 75266-0044 **Prescription Drug:** Prime Therapeutics P.O. Box 660044 Dallas, TX 75266-0044 *Mail Service Prescription Drug claims:* Prime Therapeutics P.O. Box 660044 Dallas, TX 75266-0044
• Consolidated Communications, Inc. CIGNA Dental Preferred Provider Benefits Program	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 1-800-244-6224
• Consolidated Communications, Inc. VSP Group Vision Care Insurance Program	Vision Service Plan Attention: Claims Services P.O. Box 385018 Birmingham, AL 35238-5018 1-800-877-7195 www.vsp.com

Welfare Program	Claims Administrator/Claims Fiduciary
• Kaiser Permanente Deductible HMO Plan for Consolidated Communications Holdings, Inc.	Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923
• Consolidated Communications, Inc. Wellness Program	Navigate Wellness, LLC dba Navigate Wellbeing Solutions 140 S. 68th St, Suite 2200 Des Moines, IA 50266
• Consolidated Communications, Inc. Digital Physical Therapy Program	SWORD Health Technologies, Inc. 65 East Wadsworth Park Drive, Suite 230 Draper, UT 84020 help@swordhealth.com

SUMMARY PLAN DESCRIPTION OF THE
CONSOLIDATED COMMUNICATIONS, INC.
HEALTH BENEFITS PLAN

APPENDIX E

The following job classifications of employees (or classes of employees) are hereby designated as being entitled to receive Protected Health Information subject to HIPAA from the Plan:

- HIPAA Privacy Official;
- HIPAA Complaint Official;
- Benefits Analyst;
- Sr. Benefits Analyst;
- Manager, Employee Benefits;
- Vice President – Compensation & Benefits;
- Chief Legal Officer;
- Director, Labor;
- Senior Director, Employee Relations and HR Business Partners;
- HR Generalists and Staff Specialist, to the extent these persons have access to PHI when working with the Benefits Staff with respect to the Plan;
- Software Engineers, HR Systems Analyst and Business Analysts;
- Sr. Labor Relations Specialist; and
- Labor Relations Specialist.

SUMMARY PLAN DESCRIPTION OF THE CONSOLIDATED COMMUNICATIONS, INC. HEALTH BENEFITS PLAN

APPENDIX F

This Appendix sets forth certain terms and conditions of eligibility and participation in the Plan, effective as of January 1, 2022. Terms and conditions of eligibility specified in the Welfare Program Documents that are not contrary to, or inconsistent with, the terms and conditions in this Appendix F shall also apply.

Notwithstanding Article II of the SPD, the terms and conditions of this Appendix F shall supersede any conflicting or inconsistent term or condition of a Welfare Program, and shall govern and control (except as otherwise noted herein). However, if such conflict or inconsistency involves a term or condition required by ERISA, the Code or other controlling law, on the one hand, and a term or condition not so required on the other, the term or condition required by controlling law shall control. Further, the following terms and conditions shall be subject to all other provisions of this document (without regard to any Welfare Program Document incorporated herein, except as otherwise noted) which govern eligibility for participation in the Plan.

A. Employee Eligibility.

1. General.

An Employee (1) who (i) is not represented by a labor union under a collective bargaining agreement with an Employer, (ii) is represented by either the Communications Workers of America, AFL-CIO, Local 13000 Unit 104, CLEC labor union or the Communications Workers of America, AFL-CIO, Local 13000 Unit 104, ILEC labor union, (iii) is represented by the International Brotherhood of Electrical Workers Local Union 949 labor union, or (iv) is represented by International Brotherhood of Electrical Workers Local 89, Communications Workers of America Local 6312, International Brotherhood of Electrical Workers Local 986, Communications Workers of America Local 3171, International Brotherhood of Electrical Workers Local 124, or International Brotherhood of Electrical Workers Local 2327 (each, a "**FairPoint Telecom Union**") and (2) who as of his or her start date, is reasonably expected to work an average of thirty (30) Hours of Service or more per week, shall be eligible to participate in the Plan as of his or her "Eligibility Date", which is the first day of the month following the date on which such Employee satisfies the requirements of (1) and (2).

An Employee (1) who (i) is not represented by a labor union under a collective bargaining agreement with an Employer, (ii) is represented by either the Communications Workers of America, AFL-CIO, Local 13000 Unit 104, CLEC labor union or the Communications Workers of America, AFL-CIO, Local 13000 Unit 104, ILEC labor union, (iii) is represented by the International Brotherhood of Electrical Workers Local Union 949 labor union, or (iv) is represented by a FairPoint Telecom Union and (2) who as of his or her start date, either (i) is *not* reasonably expected to work an average of thirty (30) Hours of Service or more

per week or (ii) is a "seasonal employee", shall be eligible to participate in the Plan only if such Employee averages thirty (30) or more Hours of Service per week during the initial measurement period established by the Employer in accordance with the look-back measurement method described in the Treasury Regulations promulgated under Code Section 4980H (the "**Look-Back Measurement Method**"), in which case the Employee's "Eligibility Date" will be the first day of the month following a two-month administrative period after the end of the initial measurement period.

An Employee's ongoing eligibility for the Plan will be determined based on the Employee's status as a "full-time employee" (*i.e.*, an Employee who is employed an average of at least thirty (30) Hours of Service per week with an Employer), as determined in accordance with Employer's elections under the Look-Back Measurement Method, including the applicable measurement periods, administrative periods, stability periods and other rules governing an Employee's status as a "full-time employee"; provided, however, that an Employee who changes from a position of employment with the Employer in which his status is not a "full-time employee" to a position in which he is reasonably expected to average 30 or more Hours of Service per week will be eligible for coverage that is effective on the first day of the month after the change in job position (*i.e.*, his "**Eligibility Date**").

For purposes of this Section A, an "**Hour of Service**" means any hour for which an Employee is paid, or entitled to be paid, for (i) the performance of duties for the Employer or (ii) a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

Notwithstanding the foregoing provisions of this Section A, (1) an Employee who is classified in the Employer's records as a "temporary employee" shall not be eligible to participate in the Plan, and (2) an Employee who is represented by a FairPoint Telecom Union shall be eligible to participate in a particular Welfare Program under the Plan only if, and to the extent, that the relevant collective bargaining agreement specifically provides for coverage under such Welfare Program.

The Plan Administrator (or its designee) determines, in its sole discretion, whether any Employee satisfies these requirements and is eligible for coverage under the Plan.

2. Chairman Eligibility.

The Consolidated Communications, Inc. Chairman of the Board, who was enrolled in the Plan as of December 31, 2017 (the "**Chairman**"), shall also be eligible to participate in the Plan. Except with respect to Sections D.1(b) and (c) of this Appendix F and the other provisions of this Section A of this Appendix F, references herein to "Employee" shall be deemed to include the Chairman.

B. Dependent Eligibility.

An eligible Employee may enroll an individual in the Plan in accordance with the Plan's enrollment procedures if such individual satisfies the following definition of "**Dependent**":

(a) An eligible Employee's Spouse;

(b) A Child under the age of 26; and

(c) An eligible Employee's unmarried Child with a mental or physical disability who is unable to hold a self-sustaining job due to the disability. Such a child may stay eligible for Dependent benefits past the age limit described in subsection b above as long as the Child (a) became totally disabled before he or she reached such age limit, (b) was covered as a Dependent under the Plan before reaching such age limit, and stayed continuously covered until reaching such limit, (c) depends on the Employee for most of the child's support and maintenance, and (d) remains unmarried. The eligible Employee must submit proof that the child is totally disabled within 31 days after the day coverage for such child would normally end under the terms of the Plan.

The term "Child", for purposes of subsections b and c in the definition of "Dependent", above, means:

(a) An eligible Employee's natural child;

(b) An eligible Employee's legally adopted child, including a child for whom the participant is a party in a suit in which the adoption of the child is sought;

(c) An eligible Employee's grandchild, provided the Employee has a court appointed guardianship or conservatorship, or the Employee has legally adopted the grandchild;

(d) An eligible Employee's stepchild; or

(e) An eligible Employee's foster child, provided the Employee has a court appointed guardianship or conservatorship.

Notwithstanding the foregoing provisions of this Section B, (a) the Plan shall treat any person as a Dependent who is required to be treated as a Dependent under the terms of any valid Qualified Medical Child Support Order (*i.e.*, a QMCSO), and (b) if the applicable Welfare Program Document for a Fully-Insured Program provides a definition of "Dependent" or "Child" that is more restrictive than the corresponding definition in this Section B, the definition in such Welfare Program Document will control for purposes of that Fully-Insured Program.

At any time, the Plan Administrator may require acceptable proof that a Spouse or a Child qualifies or continues to qualify as a Dependent under the Plan. An Employee may be required to reimburse the Plan for any benefits or reimbursements provided to an individual as a Dependent at a time when such individual did not satisfy the Dependent eligibility requirements specified above, to the extent permitted by applicable law, including the Affordable Care Act.

Notwithstanding the foregoing, Dependents are not eligible for the Consolidated Communications, Inc. Wellness Program.

C. Enrollment.

An Employee who wishes to enroll himself and his eligible Dependents for coverage under the Plan when he first becomes eligible must perform the following requirements:

1. Complete any benefits enrollment as may be required by the Plan Administrator or other human resources employee designated by the Plan Administrator to name himself and each of his Dependents, if any, to be covered;

2. Submit the completed benefits enrollment as directed by the Plan Administrator; and

3. Agree to make any required Participant Contributions as indicated in the Plan enrollment documents.

For each person to be covered by the Plan, the required benefits enrollment must be completed by the Employee, and received and accepted by the Plan Administrator, no later than 31 consecutive days following the Employee's Eligibility Date (as specified in Section A of this Appendix F). All required documentation must be submitted and all eligibility requirements must have been met.

If the benefits enrollment is completed and accepted within 31 days following the Employee's Eligibility Date, coverage for the Employee and his Dependents will be effective on the Employee's Eligibility Date.

If an Employee does not enroll for coverage within 31 days following his Eligibility Date, the Employee may only enroll himself and his eligible Dependents during any "special enrollment" period under HIPAA (but only if the eligibility requirements for "special enrollment", as specified herein, are met) or any late or annual enrollment period, as provided in this document or a Welfare Program Document.

D. Termination of Coverage.

1. Employees.

An Employee's coverage shall terminate on the earliest to occur of the following:

(a) The date on which the Welfare Program or Plan is terminated or amended, resulting in the Employee's loss of coverage;

(b) The last day of the month in which he ceases to be an Employee;

(c) The last day of the month in which he ceases to be an eligible Employee under the Plan, except as provided in Section E of this Appendix F;

(d) The last day of the period for which any required Participant Contribution for his coverage was made; or

(e) The date on which the Employee falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person including, without limitation, enrolling a person as a Spouse or other Dependent who does not qualify as a Dependent under the terms of the Plan.

Notwithstanding the foregoing, coverage may only be retroactively terminated (a) if an Employee performs or omits an act, practice or omission that constitutes fraud, (b) if an Employee makes an intentional misrepresentation of material fact, as determined by the Plan Administrator in the exercise of its discretion, (c) as permitted under the Affordable Care Act and the authoritative guidance issued thereunder, or (d) for failure to pay a Participant Contribution when due.

Certain Employees may be eligible for retiree health plan coverage. Please contact the Plan Administrator or refer to the Summary Plan Description for the Consolidated Communications, Inc. Retiree Health Benefits Plan for more information.

2. Dependents of Employees.

Coverage for a Dependent of an Employee shall terminate on the earliest to occur of the following:

(a) The date on which the Welfare Program or Plan is terminated or amended, resulting in the Employee's or Dependent's loss of coverage;

(b) The last day of the month on which the Dependent ceases to be an eligible Dependent under the Plan, except as provided in Section E of this Appendix F;

(c) The last day of the period for which any required Participant Contribution for the Dependent's coverage was made;

(d) The date on which the Employee's coverage terminates;

(e) The date the Dependent's coverage ceases to be available to the Employee; or

(f) The date on which the Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person.

Notwithstanding the foregoing: (a) coverage may only be retroactively terminated (i) if an Employee or Dependent performs or omits an act, practice or omission that constitutes fraud, (ii) if an Employee or Dependent makes an intentional misrepresentation of material fact, as determined by the Plan Administrator in the exercise of its discretion, (iii) as permitted under the Affordable Care Act and the authoritative guidance issued thereunder, or (iv) for failure to pay a Participant Contribution when due; and (b) if an Employee dies while the Employee and his Dependents are covered under the Plan, coverage under the Plan will terminate for such Dependents on the last day of the month in which the Employee died.

E. Continuation of Coverage During Leave of Absence.

An Employee who is not in Active Service due to a leave of absence as designated by the Employer (a "**LOA Employee**") may be eligible to continue participation in the Plan for all or some portion of the leave of absence for himself and for any of his Dependents who were Participants at the time the Employee ceased to be in Active Service, subject to the following:

(a) A LOA Employee's right to elect to continue participation in the Plan, the duration of any such continued participation, and the Participant Contribution that may be charged during such leave of absence (which Participant Contribution may be higher than the rate charged to Employees in Active Service) will be determined in accordance with the Employer's employee leave of absence policy as then in effect and which may be amended from time to time (which policy is hereby incorporated by reference to the extent necessary to determine a LOA Employee's right to elect continued participation, the duration of continued participation, the method for determining applicable Participant Contributions during such continued participation, and other terms and conditions of continued participation in the Plan during an approved leave of absence);

(b) In no event will the duration of such continued coverage exceed 18 months; and

(c) The provisions of this Section E shall be subject to, and construed in accordance with, the requirements of the FMLA and USERRA when applicable.

SUMMARY PLAN DESCRIPTION OF THE CONSOLIDATED COMMUNICATIONS, INC. HEALTH BENEFITS PLAN

APPENDIX G

This Appendix sets forth certain terms and conditions for coverage under the Consolidated Communications, Inc. Wellness Program (the "**Wellness Program**"). The terms and conditions in this Appendix G shall be subject to all other provisions of this Summary Plan Description document which otherwise govern participation and coverage in the Plan.

Wellness Program Discounts

An Employee will be eligible for a discounted Participant Contribution (the "**Wellness Discount**") under the Consolidated Communications, Inc. BlueCross BlueShield of Texas and Kaiser Permanente Deductible HMO Plan for Consolidated Communications Holdings, Inc. with respect to the coverage option in which he or she is enrolled only if he or she (1) completes a health screening with a physician of his or her choice (and timely submits the applicable results to the Claims Administrator for the Wellness Program) and (2) timely completes a health questionnaire prepared by the Claims Administrator for the Wellness Program. To be eligible for the Wellness Discount with respect to a particular Plan Year, the health screening and health questionnaire must be completed and submitted during the 12-month period from October 1 through September 30 which precedes such Plan Year (*e.g.*, the health screening and health questionnaire must be completed and submitted between October 1, 2017 and September 30, 2018 in order to qualify for the Wellness Discount for the 2019 Plan Year).

Effective as of October 1, 2022, an Employee will be eligible for the Wellness Discount under the Consolidated Communications, Inc. BlueCross BlueShield of Texas Health Benefits Program and Kaiser Permanente Deductible HMO Plan for Consolidated Communications Holdings, Inc. with respect to the coverage option in which he or she is enrolled only if he or she (1) completes a health screening with a physician of his or her choice (and timely submits the applicable results to the Claims Administrator for the Wellness Program), (2) timely completes a health questionnaire prepared by the Claims Administrator for the Wellness Program, and (3) completes one variable criteria established annually by the Claims Administrator for the Wellness Program. To be eligible for the Wellness Discount with respect to a particular Plan Year, the health screening, health questionnaire, and variable criteria must be completed and submitted during the 12-month period from October 1 through September 30 which precedes such Plan Year (*e.g.*, the health screening, health questionnaire, and variable criteria must be completed and submitted between October 1, 2022 and September 30, 2023 in order to qualify for the Wellness Discount for the 2024 Plan Year).

The amount of the Wellness Discount for a particular Plan Year will be communicated to Employees prior to the beginning of such Plan Year, and will comply with the requirements of applicable law and regulation (including, but not limited to, the ADA and the non-discrimination regulations under HIPAA, to the extent each is applicable). In addition, the eligibility requirements for the Wellness Discount are subject to change each Plan Year and will be communicated to Employees prior to the beginning of such Plan Year.

SUMMARY PLAN DESCRIPTION OF THE
CONSOLIDATED COMMUNICATIONS, INC.
HEALTH BENEFITS PLAN

APPENDIX H

As of January 1, 2022, the Plan covers Employees who are covered by the contract between the Mankato Citizens Telephone Company Mid-Communications, Inc. and the International Brotherhood of Electrical Workers Local Union 949.

As of January 1, 2022, the Plan also covers Employees who are subject to a collective bargaining agreement between the Employer and the following unions, which agreement provides for coverage under the Plan:

- Communications Workers of America, AFL-CIO, Local 13000 Unit 104, ILEC;
- Communications Workers of America, AFL-CIO, Local 13000 Unit 104, CLEC;
- International Brotherhood of Electrical Workers Local 89;
- Communications Workers of America Local 6312;
- International Brotherhood of Electrical Workers Local 986;
- Communications Workers of America Local 3171;
- International Brotherhood of Electrical Workers Local 124; and
- International Brotherhood of Electrical Workers Local 2327.

SUMMARY PLAN DESCRIPTION OF THE CONSOLIDATED COMMUNICATIONS, INC. HEALTH BENEFITS PLAN

APPENDIX I

PROVISIONS RELATED TO THE COVID-19 NATIONAL EMERGENCY

Please read the following provisions which affect other parts of this SPD.

Suspension of Special Enrollment, COBRA, and Claims Deadlines

In connection with the national emergency resulting from the COVID-19 outbreak, several deadlines have been suspended under the Plan. If any of the following deadlines ends on or after March 1, 2020, it will be suspended for up to one year, or until sixty (60) days after the announced end of the national emergency, if earlier:

- The 30-day period (or 60-day period, if applicable) to request special enrollment;
- The 60-day election period for COBRA continuation coverage;
- The 45-day (initial premium) and 30-day (monthly premium) deadlines for making COBRA premium payments;
- The deadline for individuals to notify the Plan of a qualifying event or determination of disability for COBRA purposes;
- The deadline for filing a benefit claim or appealing an adverse benefit determination under the Plan's claims review procedures;
- The deadline for filing a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination pursuant to the Plan's claims review procedures; and
- The deadline for submitting information to perfect a request for external review upon a finding that the request was not complete pursuant to the Plan's claims review procedures.

Good Faith Relief for Provision of Notices to Employees

Federal relief also provides an extension of deadlines for furnishing required notices or disclosures to Participants, Beneficiaries, and other persons, as long as the Plan and responsible Plan fiduciary act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances. Good faith acts include use of electronic alternative means of communicating with Participants and Beneficiaries who the Plan fiduciary reasonably believes have effective access to electronic means of communication, including email, text messages, and continuous access websites.