SUMMARY PLAN DESCRIPTION

OF THE

CONSOLIDATED COMMUNICATIONS, INC.
EMPLOYEE ASSISTANCE PROGRAM

(As Amended and Restated Effective as of January 1, 2020)

(UPDATED: EFFECTIVE AS OF JANUARY 1, 2020)

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CONSOLIDATED COMMUNICATIONS, INC.
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(As Amended and Restated Effective as of January 1, 2007)

Consolidated Communications Holdings, Inc. (the "**Plan Sponsor**") maintains the "Consolidated Communications, Inc. Employee Assistance Program" (the "**Plan**") for the benefit of the eligible Employees (and their eligible Dependents) of the Plan Sponsor and the other Employers which adopt the Plan. The Plan Sponsor has amended and restated the Plan, effective as of January 1, 2020.

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 personal counseling services and other employee assistance benefits to Participants in accordance with the terms, conditions and limitations of the Plan. Certain rules pertaining to coverage and limitations on coverage are set forth in the Schedules of Benefits, which are incorporated into this Summary Plan Description of the Plan ("**SPD**") in their entirety by reference and attached hereto as Appendix B.

Please review this Plan carefully, including the Schedules of Benefits, before you assume that any expense you incur for services will be eligible for coverage under the Plan. You should pay particular attention to the provisions in this Plan concerning exclusions and limitations on coverage.

The masculine gender of words used in this document include 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 Plan 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 Employer. 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 coverage limitations as set forth in the Schedules of Benefits 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 reserves the absolute right, authority and discretion to interpret, construe, construct and administer the terms and provisions of the Plan, in its 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. All decisions, interpretations and other determinations of the Plan Administrator will be final, binding 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 determines in its discretion that the Participant is entitled to them. 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 determination was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

ARTICLE I
DEFINITIONS

The following terms, where capitalized, shall have the meanings set forth below when used in this Plan, unless a different meaning is plainly required by the context:

1.1 Active Employment (Actively at Work) 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 Actively at Work if the Employee is absent from work due to a health factor. In no event will an Employee be considered Actively at Work 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 and the federal Health Care and Education Reconciliation Act of 2010, as amended, as well as related authoritative guidance under such statutes.

1.4 Beneficiary means an individual who is entitled to receive benefits under the Plan.

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 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.

1.8 Code means the Internal Revenue Code of 1986, as amended.

1.9 Covered Services means services or supplies which are eligible for payment or coverage under the Plan in accordance with its terms and conditions.

1.10 Dependent means an individual who meets the following criteria:

(a) The Spouse of an eligible Employee not employed by the Plan Sponsor or another Employer;

(b) A Child from birth to age 26;

(c) An unmarried Child, regardless of age, who is incapable of self-sustaining employment by reason of mental or physical disability and who qualifies as the eligible Employee's

dependent for federal income tax purposes under Section 152 of the Code, for so long as the disability persists, provided that the disability commenced before the Child reached age 26. The Plan Administrator reserves the right to require, at the Plan Sponsor's expense, an independent medical, psychiatric, or psychological evaluation in connection with any annual review of the Child's disabled status. In order to obtain or retain such coverage, the Dependent must submit to any such required evaluations; or

(d) A child who is the subject of a Qualified Medical Child Support Order (as defined in Section 11.1).

The term "Child" means the following:

(i) a natural child;

(ii) a step-child by legal marriage;

(iii) a child who has been placed for adoption with the Employee by a court of competent jurisdiction; or

(iv) a child for whom legal custody or guardianship has been awarded.

Grandchildren are not eligible Dependents unless they meet the foregoing definition of "Child".

A Dependent who is on active full-time military duty in the armed forces of any country is not eligible for coverage under the Plan, except as provided in Section 11.8.

No individual may be covered as the Dependent of more than one Employee. In addition, no individual may be covered twice under the Plan. If an Employee and his Spouse are both covered Employees, neither can be covered both as an eligible Employee and as an eligible Dependent. Only one of two married Participants may cover children as eligible Dependents. 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 will 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.

1.11 Disclosure Administrator means the individual or entity, as designated in Article XII, 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 8.4 of this SPD.

1.12 EAP means an employee assistance program that provides personal counseling services and other employee assistance benefits to individuals.

1.13 EAP Provider means the third party employee assistance program provider with whom the Plan Sponsor has entered into a contract to provide services to Participants under the Plan,

and to whom the Plan Administrator has delegated the determination of eligibility for benefits under the Plan.

1.14 Effective Date means January 1, 2020, *i.e.*, the effective date of the amendment and restatement of the Plan.

1.15 Employee means any individual who is considered to be in an employer-employee relationship with the Employer on the payroll records of the Employer for purposes of federal income tax withholding. The term "Employee" does not include any person during any period that such person was classified on the Employer's records as other than an Employee. For example, "Employee" shall not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, or similar classification, regardless of a determination by a governmental agency that any such person is or was an employee of the Employer whose wages were reportable on IRS form W-2. Furthermore, Employees who are non-resident aliens and who receive no earned income (within the meaning of Code Section 911(d)(2)) from the Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) shall not be considered Employees who are eligible to participate in the Plan.

1.16 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.

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

1.18 Full-Time means an Employee who is regularly scheduled to work at least 30 hours per week for an Employer. Notwithstanding the foregoing, Employees located in Illinois that are subject to a collective bargaining agreement shall not be considered Full-Time for purposes of eligibility for this Plan.

1.19 FMLA means the Family and Medical Leave Act of 1993, as amended from time to time, and the regulations and other authority issued thereunder by the appropriate governmental authority.

1.20 FMLA Leave means a leave of absence which the Employer is required to extend to an Employee under the provisions of the FMLA.

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

1.22 Participant means an Employee of an Employer who meets the requirements for eligibility as set forth in Article III and who is covered under the Plan. The term "Participant" also includes any Dependent of a person specified in the previous sentence who is covered under

the Plan. A person shall cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan.

1.23 Participant Contribution means the pre-tax or after-tax contribution required to be paid by a Participant, if any, for coverage under the Plan.

1.24 Plan means the Consolidated Communications, Inc. Employee Assistance Program, which consists of the Plan, this SPD (including any appendices attached hereto), and the Schedules of Benefits which are incorporated hereunder by reference, as amended from time to time.

1.25 Plan Administrator means Consolidated Communications, Inc., which has the authority and responsibility to manage and direct the operation of the Plan in its discretion. The Plan Administrator may assign or delegate duties to third parties, such as the EAP Provider, either under the terms of the Plan, or by means of a separate written agreement.

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

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

1.28 Privacy Regulations means regulations issued under HIPAA, at 45 CFR Part 160 and Part 164, Subparts A and E, which govern the privacy of individually identifiable health information.

1.29 Schedule of Benefits means a schedule prepared by the Plan Administrator from time to time which contains certain rules and limitations regarding coverage under the Plan. A Schedule of Benefits, as then effective, is an integral part of this SPD and the Plan. The Schedules of Benefits are incorporated into this SPD by reference. Participants shall, from time to time, receive copies of the Schedules of Benefits, as then in effect, from the Plan Administrator pursuant to the same requirements that apply to the distribution of this SPD and material modifications hereto.

1.30 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 applicable federal law, but shall not include an individual separated from the Employee under a legal separation or divorce decree. The term "Spouse" will also include a common law spouse if the Employee and spouse became common law married in a state which recognizes common law marriages and meet the requirements for common law marriage in that state. The Employee must provide proof of ceremonial or common law marriage acceptable to the Plan Administrator if requested, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state.

ARTICLE II
INTERPRETATION

The SPD, as required by ERISA, consists of this document and the Schedules of Benefits, as identified in Appendix B. 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 shall control.

Notwithstanding the foregoing, if there is a conflict between a term or provision of the Plan document or the 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 shall control. This determination shall be made by the Plan Administrator.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.1 Eligibility for Coverage.

Regular, Full-Time Employees (and their Dependents) of an Employer are eligible to participate in the Plan on the day the Employee begins Active Employment.

The Active Employment requirement shall not, however, prevent or delay coverage of an Employee who is on FMLA Leave or deprive such an Employee of any enhancement of benefits provided under the Plan while on FMLA Leave.

3.2 Enrollment for Coverage.

Enrollment in the Plan is automatic for an eligible Employee and his eligible Dependents. It is not necessary for the Employee to be enrolled in any other benefit plan or program of the Employer to participate in the Plan.

3.3 Effective Date of Coverage.

Except as provided in Section 11.9, an Employee's coverage and coverage for his eligible Dependents will become effective on the date the Employee meets the requirements for eligibility in Section 3.1.

3.4 Termination of Participation.

(a) *Participants who are **Employees**.*

Except as provided in Article IX, a covered Employee's coverage under the Plan will terminate at midnight on the earliest of the following:

(i) The last day of the month in which the covered Employee's employment with the Employer is terminated;

(ii) The date on which the covered Employee fails to meet the criteria for eligibility under the Plan;

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

(iv) The date on which the covered Employee dies;

(v) The date on which the covered Employee is absent from employment for more than 31 days for a period of duty in the uniformed services, except as provided under Section 11.8;

(vi) The date on which the covered Employee falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person, including enrolling a person as a Spouse or other Dependent who does not qualify as a Dependent under the terms of this Plan; or

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

(b) *Participants who are **Dependents**.*

Except as provided in Article IX, coverage under the Plan for a covered Dependent will terminate at midnight on the earliest of the following:

(i) The last day of the month in which the covered Employee's employment with the Employer is terminated;

(ii) The date on which the covered Employee fails to meet the criteria for eligibility under the Plan;

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

(iv) The date on which the covered Employee or covered Dependent dies;

(v) If the covered Dependent is a Spouse, the date on which the covered Employee becomes divorced or legally separated from the Spouse;

(vi) The last day of the month in which the covered Dependent ceases to qualify as a Dependent under the Plan;

(vii) The date on which the covered Dependent enters active full-time military duty in the armed forces of any country, except as provided under Section 11.8;

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

(ix) If the covered Dependent had qualified as a "Dependent" under Section 1.10(d):

(A) The date on which the Dependent ceases to be medically certified as disabled; or

(B) The last day of a thirty-one (31) calendar day period following the Employer's request to the covered Employee for required proof of the Dependent's continued incapacity, if the Employee fails to timely and properly provide the requested proof.

(x) Notwithstanding the foregoing, coverage may only be retroactively terminated (a) if the Dependent performs or omits an act, practice or omission that constitutes fraud, (b) if the Dependent makes an intentional misrepresentation of material fact, as determined by the Plan Administrator in its discretion, or (c) as permitted under the Affordable Care Act and the authoritative guidance issued thereunder.

(c) *Notification Regarding Events Causing Termination of Participation.*

A covered Employee is responsible for notifying the Plan Administrator as soon as possible (but in no event later than any applicable period prescribed by COBRA or as otherwise expressly provided herein) if one of the changes or events noted in subsections (a) or (b) (above) occurs which causes coverage under the Plan to terminate.

ARTICLE IV
FUNDING

Benefits or premiums for the Plan shall be funded through "risk shifting" insurance-type contracts purchased by the Plan Sponsor or Employer from an EAP Provider. To the extent that the Plan is funded through the Plan Sponsor's or the Employer's purchase of insurance, payment of any benefits under the Plan shall be the sole responsibility of the insurer, and the Plan Sponsor and/or the Employer shall have no responsibility for such payment.

ARTICLE V
EMPLOYEE ASSISTANCE BENEFITS

5.1 Employee Assistance Benefits.

The Plan's benefits are designed to assist Participants with many work-related and personal issues, from advice about a financial question to dealing with a stressful work situation to overcoming a serious emotional problem. The Plan provides access to confidential, in-person support through the EAP Provider for a wide range of personal issues.

Benefits for Covered Services under the Plan will be provided through the EAP Provider, in accordance with the Schedules of Benefits and this SPD.

To access Plan benefits, the Participant must contact the EAP Provider listed in Article XII. A representative of the EAP Provider will assist the Participant in determining which type(s) of services are needed. The Participant will then be connected to a counselor for assistance with the Participant's particular issue. The counselor may also refer the Participant to another resource or expert in the applicable field, as appropriate.

All EAP Providers are licensed in their areas of expertise and/ or accredited through the Council on Accreditation For Children and Family Services or another recognized accrediting agency.

The Participant's contact or interaction with the EAP Provider will be kept confidential. The EAP Provider will not inform the Employer of any appointments made by the Participant with the EAP Provider or any information shared between the Participant and the EAP Provider, except as may be provided in this SPD. In addition, all records, including medical information, referrals and evaluations, are kept confidential in accordance with applicable state and federal laws and regulations, including the HIPAA Privacy Regulations, if applicable. However, as permitted or required by applicable law, information received by the EAP Provider under the Plan may be disclosed in cases of an individual's imminent physical danger or of child abuse.

5.2 Exclusions From Coverage.

Notwithstanding anything to the contrary in this SPD or the Plan, the following services are not covered under this Article V and are not Covered Services under the Plan:

(a) Medical services, psychological testing or any other service that is covered under the Plan Sponsor's group health plan.

(b) Any service or supply not specifically identified as a Covered Service, unless determined otherwise by the Plan Administrator.

(c) Services or supplies received before coverage begins (including those received when coverage is delayed because the Participant has not started Active Employment or as related to the transition from prior medical coverage to this Plan as determined by the Plan Administrator).

(d) Services or supplies received after coverage has ended.

(e) Services which are covered by any workers' compensation or occupational disease law or insurance policy.

(f) Services that are unlawful where the person resides when the service is rendered.

ARTICLE VI
CLAIMS PROCEDURES

6.1 General.

(a) If the service(s) rendered to a Participant by the EAP Provider are Covered Services, the Participant is not required to file a claim for benefits under the Plan. However, in circumstances in which the Participant would be required to file a claim for benefits, as determined by the Plan Administrator or the EAP Provider, or in which the Participant would be entitled to appeal a benefits denial under the Plan, the procedures of this Article VI shall apply.

(b) An initial claim for benefits under the Plan shall be submitted in accordance with, and to the party designated under, the administrative procedures established by the Plan Administrator (or its delegate). A claim for benefits must be submitted not later than twelve (12) months after the date that the claim arises.

(c) In the event that a claim, as originally submitted, is not complete, the Claimant shall be notified and then have the responsibility for providing the missing information within the timeframe stated in such notification.

(d) The claims procedures applicable to claims made for benefits under the Plan do not include casual or general inquiries regarding eligibility or particular benefits that may be provided under the Plan. Requests for eligibility or coverage determinations which are not associated with a claim for benefits under the Plan shall not constitute a claim for benefits under ERISA or the Plan. In order for such an "inquiry" or request to constitute a claim for benefits or an appeal of an Adverse Benefit Determination, it must be associated with a claim for benefits that is made by a Claimant in accordance with the claim procedures set forth in this Article VI.

(e) 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 Adverse Benefit Determination.

(c) *Affordable Care Act Program* or *ACA Program* means this Consolidated Communications, Inc. Employee Assistance Program, to the extent such program does not constitute an "excepted benefit" under the Affordable Care Act.

(d) *Benefit Determination* means a determination by the EAP Provider 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 EAP Provider or Plan Administrator 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 shall 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) shall constitute an Adverse Benefit Determination.

(h) *Disability Claim* means a claim for benefits under the Plan 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 in Section 6.9.

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

(k) *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).

(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 professional licensed, accredited, or certified to perform 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 2590.714-2719 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) *Other Claim* means a claim other than (i) a Disability Claim or (ii) a Health Care Claim.

(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) *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.

(r) *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 shall be filed in writing with the applicable EAP Provider 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 EAP Provider of a claim submitted by the Claimant in accordance with the Plan's claims procedures, and is contingent upon the type of health care 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 EAP Provider 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 EAP Provider 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 EAP Provider with the requested information, the EAP Provider 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 shall be notified of such failure and of the proper procedures to be followed in filing such a Claim. The notification shall 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 shall 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 shall be made in accordance with Section 6.4 (below).

(c) *Concurrent Care Decisions*.

(i) As to a Concurrent Care Decision which is an Adverse Benefit Determination, the EAP Provider shall notify the Claimant, in accordance with Section 6.4 (below), 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 shall be decided as soon as possible, taking into account the medical exigencies. The EAP Provider shall 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, shall be made in accordance with Section 6.4 (below), and appeal of the same shall be governed by Sections 6.6(a)(i), (ii) or (iii) (below), 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 EAP Provider shall notify the Claimant of the Plan's Benefit Determination, as follows:

(i) Pre-Service Claim:

(A) The EAP Provider 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 EAP Provider 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 shall specifically describe the required information, and the Claimant shall 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 shall be notified of such failure and of the proper procedures to be followed in filing such a Claim. The notification shall 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 shall 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 shall be made in accordance with Section 6.4 (below).

(ii) Post-Service Claim:

(A) The EAP Provider shall render a Benefit Determination and provide notice 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 EAP Provider 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 Claim, the notice of extension shall specifically describe the required information, and the Claimant shall 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 shall be made in accordance with Section 6.4 (below).

(e) *Disability Claims*.

(i) If a Disability Claim is submitted, the EAP Provider 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 EAP Provider 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 EAP Provider 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 EAP Provider 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 shall 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 shall 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 shall be made in accordance with Section 6.4 (below).

(f) *Other Claims.*

(i) If an Other Claim is submitted, the EAP Provider will render a Benefit Determination and provide notice to the Claimant of any denial, in whole or in part, of such Other Claim within a reasonable period of time, but not later than ninety (90) days after receipt of the Other Claim, unless the EAP Provider determines that special circumstances require an extension of time for processing the Other Claim. If the EAP Provider 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 ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such 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.

(ii) Notification of any Adverse Benefit Determination with respect to an Other Claim shall be made in accordance with Section 6.4 (below).

6.4 Notification of Benefit Determination.

(a) Except as provided in Section 6.4(b) (below), the EAP Provider shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall 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;

(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 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 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).

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

(A) a statement that the Claimant has the right 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) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

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

(D) a discussion of the decision, including an explanation of the basis for disagreeing with or not following one or more of the following: (I) the views of any Health Care Professional treating the Claimant and any vocational professionals who evaluated the Claimant, as presented to the EAP Provider by the Claimant, (II) 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 the advice was relied upon in making the Adverse Benefit Determination, and (III) any disability determination regarding the Claimant that was made by the Social Security Administration, as presented to the EAP Provider by the Claimant.

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

(a) *General Appeal Procedures*.

(i) Each Claimant shall have a reasonable opportunity to appeal an Adverse Benefit Determination to the Plan Administrator as set forth hereafter. The Claimant must complete all of the administrative review steps available through the EAP Provider before any appeal to the Plan Administrator is permitted under the Plan.

(ii) Each Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim appealed. With respect to Health Care Claims 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.

(iii) 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 (below).

(iv) 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.

(v) The Claimant shall have one-hundred eighty (180) days (sixty (60) days in the case of an Other Claim) following receipt of notification of an Adverse Benefit Determination within which to file an appeal of said Determination.

(b) *Disability Claims and Health Care Claims Appeal Procedures.* The following appeal procedures, in addition to those set forth in subsection (a), shall apply to Disability Claims and Health Care Claims:

(i) 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.

(ii) 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.

(iii) 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.

(iv) All Health Care Professionals engaged for purposes of consultation under Section 6.5(b)(ii) (above) 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.

(v) 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.

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

(A) If the Plan Administrator has made a Final Internal Adverse Benefit Determination regarding such claim, the Plan Administrator 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 Plan Administrator, or at the direction of the Plan Administrator, in connection with such claim, in order to give the Claimant a reasonable opportunity to respond prior to that date;

(B) Before the Plan Administrator issues any Final Internal Adverse Benefit Determination with respect to such claim based on a new or additional rationale, the Plan Administrator 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;

(C) Notwithstanding the provisions of Section 6.6(a), if such new or additional evidence is received by the Plan Administrator 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 Plan Administrator shall notify the Claimant of its final Benefit Determination on Review as soon as the Plan Administrator, acting in a reasonable and prompt fashion, can provide the notice, taking into account the medical exigencies; and

(D) 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.

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

(A) 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 Plan Administrator, or at the direction of the Plan Administrator, in connection with such claim;

(B) 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 Plan Administrator will provide the Claimant, free of charge, with such rationale; and

(C) In the case of either subparagraph (A) or (B), 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 Plan Administrator shall notify the Claimant in accordance with Section 6.6(b) (below) 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 Plan 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 Plan Administrator shall notify the Claimant, in accordance with Section 6.6(b) (below), of the Plan's Benefit Determination on Review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than thirty (30) 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 Plan Administrator shall notify the Claimant in accordance with Section 6.6(b) (below), 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.

(iv) *Disability Claims.* In the case of a Disability Claim, the Plan Administrator shall notify the Claimant in accordance with Section 6.6(b) (below) 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 Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the

Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial forty-five (45) day period. In no event shall the extension exceed a period of forty-five (45) days from the end of the initial period. The extension notice shall 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) *Other Claims.* In the case of an Other Claim, the Plan Administrator shall 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 60 days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial sixty (60) day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review

(vi) In the case of an Adverse Benefit Determination on Review, the Plan Administrator shall provide access to, and copies of, documents, records, and other information described in Sections 6.6(b)(iii) and (v) (below) as appropriate.

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

The Plan Administrator shall 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 shall 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 shall be determined by reference to Section 6.8 (below));

(iv) A statement of the Claimant's right to bring an action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review;

(v) If the Adverse Benefit Determination on Review is regarding a Disability Claim which is filed after April 1, 2018, a description of a contractual limitations period 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) if the Adverse Benefit Determination on Review is based upon an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse 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;

(B) if the Adverse Benefit Determination on Review is based upon 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, upon request; and

(C) 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."

(vii) With respect to an appeal of Health Care Claims 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 or Final Internal Adverse Benefit Determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final 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, 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).

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

(A) 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;

(B) If the Adverse Benefit Determination on Review is based upon 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 upon request; and

(C) A discussion of the Adverse Benefit Determination on Review, including an explanation of the basis for disagreeing with or not following one or more of the following: (I) the views of any Health Care Professional treating the Claimant and any vocational professionals who evaluated the Claimant, as presented to the Plan Administrator by the Claimant, (II) 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 on Review, without regard to whether the advice was relied upon in making the Adverse Benefit Determination on Review, and (III) any disability determination regarding the Claimant that was made by the Social Security Administration, as presented to the Plan Administrator by the Claimant.

(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) (above), the period of time within which a Benefit Determination or a Benefit Determination on Review is required to be made, shall 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 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 shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. The period for making a Benefit Determination on Review under Section 6.6(a) will also be tolled under the circumstances described, and as provided in Section 6.5(b)(vi)(C).

6.8 Relevance.

For the purposes of Sections 6.5(b)(ii) and 6.6(b)(iii) (above), a document, record, or other information shall 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.

6.10 Exhaustion of Administrative Remedies.

(a) *Exhaustion Required Prior to Action for Recovery.* No action at law or in equity may be brought to recover under the Plan until all administrative remedies, including the appeal procedures, have been exhausted. 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 shall have no right of review and shall have no right to bring any action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

(b) *Deemed Exhaustion – Medical 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 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 Section 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 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 must 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 Medical 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.

(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.

No action at law or in equity may be brought for recovery under the Plan sooner than sixty (60) days or later than one (1) year from the time written proof of a claim is required to be furnished.

6.12 Participant's Responsibilities.

Each Participant shall be responsible for providing the Plan Administrator and/or the Employer with the Participant's, Dependent's and each Beneficiary's current U.S. mailing address and electronic address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address furnished by the Participant and mailed by regular United States mail or by electronic means as specified in Section 2520.104b-l(c) of ERISA. The Plan Administrator, the Plan Sponsor and the Employer shall 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 Plan Administrator'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 Plan Administrator'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, shall be determined under the provisions of the Plan without payment of any interest or earnings.

To the extent that the entitlement of a Participant or Dependent 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 an 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.

ARTICLE VII
AMENDMENT OR TERMINATION

7.1 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 Chief Legal Officer 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. 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.

7.2 Right to Terminate.

The CEO and any other officer of the Plan Sponsor who is duly authorized by 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 shall not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the CEO determines it is necessary or desirable to comply with applicable law. An Employer, by action of its board of directors, 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 VIII
ADMINISTRATION

8.1 Allocation of Authority.

The Plan Administrator shall 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 any other person or entity delegated authority by the Plan Administrator to act in accordance with the Plan) shall be final and conclusive on all Employees, their Spouses and Dependents, and all other persons and entities, subject only to the claims appeal provisions of the Plan. Neither the Plan Administrator or any Employee shall receive any compensation from the Plan with respect to services provided under the Plan, except as an Employee may be entitled to benefits hereunder.

8.2 Powers and Duties of Plan Administrator.

The Plan Administrator shall have such duties and 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 administer, enforce, construe, and construct the Plan and decisions relating to all questions of eligibility to participate and determination of benefits. All decisions, interpretations and other determinations described in this subsection (a) shall be final and conclusive on all persons and entities subject only to the claims appeal provisions of the Plan, and there shall be no *de novo* review of any such determination by any court. Any review of such determination shall be limited to determining whether the determination was so arbitrary and capricious as to be an abuse of discretion under ERISA standards;

(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, information explaining the Plan;

(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.

The Plan Administrator 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 shall 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 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 shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

All decisions, interpretations, determinations and actions in the exercise of the powers and duties described in this Section 8.2 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 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.

8.3 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. The Plan Administrator may employ such counsel, accountants, EAP Providers, consultants, actuaries and such other persons or entities as it deems advisable in its discretion. The Plan Administrator and the Plan Sponsor, 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 tables, valuations, certificates, reports, and opinions furnished by any actuary, accountant (including any Employees who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist. Moreover, the Plan

Administrator, Plan Sponsor, or such delegate shall be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

8.4 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 XII 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.

8.5 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. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it which appears proper without the necessity of any independent verification or investigation.

8.6 Facility of Payment for Incapacitated Participant.

Whenever, in the Plan Administrator's opinion, a person 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 Plan Administrator may direct the Employer to make 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 Plan Administrator), Dependent, or relative of such person for such person's benefit, or the Plan Administrator may direct the Employer to apply the payment for the benefit of such person in such manner as the Plan Administrator considers advisable in its discretion. Any payment of a benefit, to the full extent thereof, in accordance with the provisions of this Section 8.5 shall be a complete discharge of any liability for the making of such payment under the Plan.

8.7 Assignment and Payment of Benefits.

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 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 reserves 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 elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator of the anti-assignment provisions of this Section 8.7. 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. Accordingly, if a provider is overpaid as the result of accepting a payment for the same covered service from the Participant and from the Plan, the provider, and not the Plan, shall be responsible for reimbursing the Participant for such overpayment.

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

8.8 Overpayments.

If, for any reason, any benefit, premium or fee under the Plan is erroneously paid or reimbursed by the Plan Administrator 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 8.7), 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. By accepting a benefit, premium or fee under the Plan, each Participant and Third-Party Payee automatically acknowledges and agrees that the Plan has the right to pursue Overpayment Reimbursement from the general assets of the Participant or Third-Party Payee to whom the Overpayment was made, to the full extent permitted by ERISA.

If such Overpayment is not refunded to the Plan within a reasonable time period as determined by the Plan Administrator, 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 by the Plan on behalf of the Participant, or (b) recouped by any other method which the Plan Administrator, as applicable, deems to be appropriate in its discretion, to the extent permitted by applicable law. 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 deductions 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, as permitted by applicable law (in which case, such payment offset to a Third-Party Payee shall not constitute an adverse benefit determination that is subject to 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 8.8, the offset of the Overpayment hereunder is simply an adjustment to the amount payable 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 IX
COBRA CONTINUATION COVERAGE

9.1 Continuation of Benefits under COBRA.

Qualified Beneficiaries shall have all continuation rights required by COBRA for health benefits offered under the Plan. The Plan Administrator shall adopt such policies and provide such forms, as it deems advisable, to implement the rights contemplated by this Section 9.1.

9.2 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 9.5, 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 IX. 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 shall 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 shall 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 9.12.

9.3 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 9.3 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 9.4;

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

(d) the date the Qualified Beneficiary, after the date he 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 9.6, 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.

9.4 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 shall 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 shall not apply to the forty-five (45) day period for payment of COBRA premiums as applicable to initial elections.

Except as provided in Section 9.6, the Continuation Coverage Contribution shall 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 9.4, an amount not significantly less than the amount the Plan requires to be paid shall be defined as the lesser of fifty dollars ($50) or ten percent (10%) of the required payment amount.

9.5 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 9.12, 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 9.5 and the Plan's procedures for providing such notice. Failure to make timely notification shall result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Article IX.

A Qualified Beneficiary must notify the Plan Administrator, as described in Section 9.12, 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.

9.6 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 9.12, 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 9.3 (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 9.12, 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 of the obligation to provide the disability 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 shall 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 9.12, 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 of the obligation to provide the end-of-disability notice. Such a final determination by the SSA shall end the disability extension of COBRA Continuation Coverage for all Qualified Beneficiaries as of the later of either: (a) the first day of the month following thirty days (30) from the final determination date; or (b) the end of the COBRA Continuation Coverage period without regard to the disability extension.

9.7 Responses to Inquiries 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.

9.8 Coordination of Benefits - Medicare and COBRA.

For purposes of this Article IX, "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 shall 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 shall end, and the maximum period of COBRA Continuation Coverage for his Qualified Dependents who were Qualified Beneficiaries and elected COBRA Continuation Coverage shall be extended to the last day of the thirty-six (36) month period measured from the date of the Qualifying Event. Coverage shall 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 9.12, 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.

9.9 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.

9.10 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 9.2, 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.

9.11 Definitions.

For purposes of this Article IX only, the following definitions shall 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 shall 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 shall 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.

(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 Qualified 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.

9.12 Qualified Beneficiary Notice Procedures.

Any notice that a Qualified Beneficiary is required to provide under this Article IX must be in writing. The Plan Administrator may perform services as the Plan's COBRA

Administrator, or the Plan Administrator may contract with a third party administrator to perform services as the "**COBRA Administrator**" on behalf of the Plan Administrator.

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

UnifyHR, LLC
105 Decker Court, Suite 310
Irving, TX 75062

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

(a) *Qualifying Event Notice* - The Event Notice to inform the Plan Administrator of a Qualifying Event (including a Covered Employee's entitlement to Medicare) must contain (i) the name, address, date of birth and Social Security number of the Qualified Beneficiary; (ii) the name of the Plan to which the Event Notice applies; (iii) a description of the Qualifying Event; and (iv) the date on which the Qualifying Event occurred.

(b) *Disability Determination Notice* - The Event Notice to inform the Plan Administrator of a Qualified Beneficiary's disability determination by the SSA must contain (i) the name of the Qualified Beneficiary, (ii) the name of the Plan to which the Event Notice applies, and (iii) a copy of the SSA's disability determination letter.

(c) *Determination of End of Disability Notice* - The Event Notice to inform the Plan Administrator of the SSA's determination that a disabled Qualified Beneficiary is no longer disabled must contain (i) the name of the Qualified Beneficiary, (ii) the name of the Plan to which the Event Notice applies, and (iii) a copy of the SSA's determination letter that a disability no longer exists.

(d) *Birth, Adoption or Placement Notice* - The Event 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 (i) the name of the Covered Employee, (ii) the name of the Plan to which the Event Notice applies, (iii) the reason for the Event Notice (*i.e.*, the birth, adoption or placement for adoption of a child, as applicable), and (iv) the date of such child's birth, adoption or placement for adoption.

9.13 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 XII for additional information.

9.14 Questions and Other Information Regarding COBRA Coverage.

The Employee Participant shall 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 9.12.

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 XII.

ARTICLE X
HIPAA PRIVACY

10.1 HIPAA Privacy in General.

This Article X 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 X, "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.

10.2 Designation of Health Care Components and Safeguards.

The Plan is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy Regulations), and as such, the provisions of this Article X will only apply to the health care components of the Plan (collectively referred to as the "**Health Care Components**"). All references to PHI in this Article X refer to PHI 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 Regulations 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 Regulations.

Note: For purposes of this Section 10.2, the portions of the Plan which provide employee assistance program benefits constitutes the Health Care Components.

10.3 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 Regulations, as permitted and/or required by, and consistent with, the Privacy Regulations. 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 Components 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.

10.4 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 X.

10.5 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 ePHI, the Plan Sponsor agrees, on behalf of the Plan, to:

(a) 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;

(b) 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;

(c) 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

(d) 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.

10.6 Adequate Separation Between the Plan and the Plan Sponsor.

In accordance with the Privacy Regulations, only the following Employees or classes of Employees may be given access to PHI:

- HIPAA Privacy Official;
- HIPAA Complaint Official;
- Benefits Analyst;
- Sr. Benefits Analyst;

- Manager, Employee Benefits;
- Vice President – Compensation & Benefits;
- Chief Legal Officer;
- Senior Vice President;
- 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; and
- Software Engineers and HR Systems Analyst.

10.7 Limitations of PHI Access and Disclosure.

The persons described in Section 10.6 may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

10.8 Noncompliance Issues.

If the persons described in Section 10.6 do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

10.9 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 Regulations), 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.

10.10 Other Medical Privacy Laws.

The Plan shall comply with the Privacy Regulations 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.

10.11 Additional Requirements Imposed by the Health Information Technology for Economic and Clinical Health Act ("HITECH").

The provisions of this Section 10.11 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.

10.12 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).

10.13 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.

ARTICLE XI
MISCELLANEOUS LAW PROVISIONS

11.1 Qualified Medical Child Support Orders.

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

(a) *Definitions.*

For purposes of Section 11.1, 11.2, 11.3 and 11.4, the following definitions apply:

(i) The term "Qualified Medical Child Support Order" shall be defined for purposes of Sections 11.1, 11.2, 11.3 and 11.4 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 11.1 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" shall be defined in Sections 11.1, 11.2 and 11.3 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 11.1, 11.2, 11.3 and 11.4, the term "Alternate Recipient" shall 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 shall have coverage end on the date the QMCSO expires.

11.2 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 shall 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 shall 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 shall 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) shall be in writing;

(ii) shall 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) shall 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 XII.

11.3 Actions Taken By Fiduciaries.

(a) *General Requirement.*

If the Plan Administrator acts in accordance with Sections 11.1, 11.2 and 11.3 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 shall be discharged.

(b) *Treatment of Alternate Recipients.*

(i) An individual who is an Alternate Recipient under a QMCSO shall 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 shall 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 shall 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, shall be treated as payment of benefits to the Alternate Recipient.

11.4 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 shall 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 11.4(a) (above), 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, shall:

(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 11.4(a)(i) (above)) 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 11.4 shall 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.

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

(a) *Compliance by Plans with Assignment of Rights.*

The Plan shall 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 shall 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.

11.6 Health Program Coverage of Dependent Children in Adoption Cases.

(a) *Coverage Effective Upon Placement For Adoption.*

The Plan shall 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 11.6, 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.

11.7 Family and Medical Leave Act.

(a) *General.*

If an Employee Participant takes an FMLA Leave, health 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 a period of twelve (12) weeks (or twenty-six (26) weeks, in the case of Participants who take servicemember family leave, reduced by any other FMLA leave taken within the same twelve (12) month period), 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 on the date he fails to return to work or the date following the date he gives such notice to the Employer.

(b) *Re-enrollment.*

An Employee Participant who elects to revoke coverage under the Section 125 plan sponsored by the Plan Sponsor ("**Flex Plan**") or whose coverage terminates during an FMLA Leave for failure to make any required Participant Contribution, shall be eligible to re-enroll in the Plan immediately upon returning from the leave subject to payment of applicable Participant Contributions. Coverage shall 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 an FMLA Leave, does not constitute a Qualifying Event under COBRA within the meaning of Section 9.11. 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 shall be deemed the date the Qualifying Event occurred.

(d) *Contributions.*

An employee Participant who takes a FMLA Leave is entitled to continue to participate in 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 any required 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.

If the Participant revokes his election to participate in the Flex Plan, then the Participant may, upon timely return from FMLA Leave, elect to reinstate his election to participate in the Flex Plan. Such benefits provided under the Flex Plan will be reinstated upon the Participant's re-election.

(e) *Termination of Benefits while on FMLA Leave.*

If a Participant's benefits have terminated while on FMLA Leave, such benefits will be reinstated upon timely return from FMLA Leave. Benefits coverage that was canceled during the Participant's FMLA Leave may be reinstated within thirty (30) days after the Participant's return to active employment with the Employer.

11.8 Uniformed Services Employment and Reemployment Rights Act.

The Plan shall 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, may, at the Employee's election, continue coverage under the Plan during the period of absence, so long as the Employee satisfies the necessary provisions and makes any required Participant Contributions as provided under USERRA.

(b) The maximum period of coverage for an Employee, an Employee's Spouse and/or Dependents, if any, under the Plan during a period of duty in the Uniformed Services shall 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 the Plan shall 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 of 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, shall be eligible to return to work and immediately participate in the Plan, subject to any changes in the Plan 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 shall 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 Plan 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 shall 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.

11.9 Health Insurance Portability and Accountability Act.

The Plan shall comply with HIPAA.

(a) *Eligibility.*

The Plan shall 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 either specific benefits or all 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 shall generally be provided for eligible Employees and their eligible Dependents whose other health coverage terminates due to (A) exhaustion of COBRA continuation coverage, or (B) 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 requests enrollment no more than thirty (30) days after the termination of the other coverage and if he had previously declined coverage under the Plan for himself and/or his Dependents.

(ii) Acquisition of New Dependent. Special enrollment periods shall be available for the following individuals, in the event the eligible Employee (or Participant) acquires a new Dependent as a result of marriage, birth, adoption or placement for adoption, if enrollment is requested no more than thirty (30) days following the applicable event:

(A) The eligible Employee, if he had previously declined coverage under the Plan for himself;

(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) above;

(C) The eligible Employee, who previously declined coverage under the Plan for himself, 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) above;

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

(E) The eligible Employee, if he had previously declined coverage under the Plan for himself, and his eligible Dependents, if the Employee acquires a new Dependent child 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 shall 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 provisions 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 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 11.9(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, shall be provided in accordance with Article IX herein.

11.10 Other Laws.

The Plan shall comply with all other laws to the extent not preempted by ERISA and to the extent such laws are applicable to the Plan. Such laws shall include, but not be limited to, the Americans with Disabilities Act ("**ADA**") and the Small Business Job Protection Act ("**SBJPA**").

11.11 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 the Plan, 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 the Plan provides medical and surgical benefits and mental health benefits or substance use disorder benefits, then the Plan 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.

11.12 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.

11.13 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, except to the extent that such health benefits are not subject to the Affordable Care Act.

11.14 Controlling Law.

The Plan shall be construed, regulated and administered under the laws of the State of Texas without regard to its conflicts of law principles, except as preempted by ERISA or other controlling federal law.

ARTICLE XII
IMPORTANT ERISA INFORMATION

Name of Plan: Consolidated Communications, Inc. Employee Assistance Program.

Plan Sponsor: Consolidated Communications Holdings, Inc., 121 South 17th Street, Mattoon, Illinois 61938-3987.

Plan Administrator: Consolidated Communications Inc., c/o Human Resources Department, 350 S. Loop 336 W., Conroe, TX 77304.

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

Employer Identification Number: 02-0636095.

Plan Number: 504.

Type of Plan: The Plan is an "employee welfare benefit plan" subject to ERISA which provides personal counseling services and other employee assistance benefits through a "risk shifting" insurance-type contract, purchased by the Plan Sponsor or the Employer from an EAP Provider.

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 EAP Provider(s) to determine eligibility for benefits 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., 350 South Loop 336 W, Conroe, TX 77304.

EAP Provider(s):

Location	EAP Provider
All Employees not residing in California	Beacon Health Options, Inc. 200 State Street, Suite 302 Boston, MA 02109
Employees residing in California	Valueoptions of California, Inc. (California Employees) 5665 Plaza Drive, Suite 400 Cypress, CA 90630

Plan Year: The Plan and its records are kept on a Plan Year basis. The Plan Year is the 12-month period beginning each January 1st and ending on December 31st.

Sources of Contributions: The adopting Employers pay the costs for coverage.

Collective Bargaining: The Plan is maintained 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 union 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 union 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 XIII
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 covered persons and other 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 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.

[Appendices A, B and C follow.]

SPD OF THE CONSOLIDATED COMMUNICATIONS, INC.
EMPLOYEE ASSISTANCE PROGRAM

APPENDIX A

As of January 1, 2020, other than as specified in the definition of "Employer" in the Plan, there are no additional adopting Employers of the Plan.

SPD OF THE CONSOLIDATED COMMUNICATIONS, INC.
EMPLOYEE ASSISTANCE PROGRAM

APPENDIX B

The Schedule of Benefits, as attached hereto and as it may be modified from time to time by the Plan Sponsor, is incorporated in its entirety by reference into this SPD.

SPD OF THE CONSOLIDATED COMMUNICATIONS, INC.
EMPLOYEE ASSISTANCE PROGRAM

APPENDIX C

As of January 1, 2020, the Plan covers all eligible Employees and Employees subject to collective bargaining agreements between the Employer and the following unions:

- International Brotherhood of Electrical Workers (AFL-CIO) Local Nos. 71, 89, 124, 236, 949, 2320, 2326, 2327, and 6513; and

- Communication Workers of America Local Nos. 1115, 1400, 3171, 6218, 6312, and 13000.