gravie

ANNUAL COMPLIANCE NOTICES
2024

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A. Summary of Benefits and Coverage (SBC)

As required by the Patient Protection and Affordable Care Act (ACA), the SBC is an informational summary of your benefits and coverage under the SPD, including coverage examples, that is prepared in a uniform style. If there is a conflict between the SPD and the SBC, the SPD governs and the TPA will administer your coverage in accordance with the SPD.

B. Privacy

This Plan is subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule. In accordance with the HIPAA Privacy Rules, the Plan and the TPA acting on the Plan's behalf, maintains, uses, or discloses your Protected Health Information for purposes such as claims processing, utilization review, quality assessment, case management and otherwise as necessary to administer the Plan or as may be required or permitted by law. You can obtain a copy of the Plan's Notice of Privacy Practices (which summarizes the Plan's HIPAA Privacy Rule obligations, your HIPAA Privacy Rule rights and how the Plan may use or disclose health information protected by the HIPAA Privacy Rule) from the Plan Administrator.

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Rule, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals participating in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified within the meaning of the Privacy Rule, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use Protected Health Information (PHI), including electronic Protected Health Information (ePHI) for Plan Administration functions, as defined below, the Plan Sponsor agrees to the following provisions, which are more fully described in the Plan's Notice of Privacy Practices, distributed to Covered Persons upon enrollment and available upon request from the Plan Administrator:

a) Not use or further disclose PHI other than as permitted or required by this document or as required by law (as defined by the Privacy Rule);

b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan or the Plan Administrator on behalf of 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 or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization that meets the requirements of the Privacy Rule;

d) Report to the Plan any PHI use or disclosure that is inconsistent with the permitted uses or disclosures of which the Plan Sponsor becomes aware;

e) Make available PHI for access to PHI requests in accordance with Section 164.524 of the Privacy Rule (45 CFR § 164.524);

f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Rule (45 CFR § 164.526);

g) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Rule (45 CFR § 164.528);

h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan, or the Plan Administrator on behalf of the Plan, available to the Secretary of the US Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Rule (45 CFR § 164.500 et seq.);

i) If feasible, return or destroy all PHI received from the Plan, or the Plan Administrator on behalf of 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, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

j) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Rule (45 CFR § 164.504(f)(2)(iii)), is established as follows:

i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor shall be given access to the PHI to be disclosed:

- Those individuals identified in the Plan Sponsor's HIPAA Policies and Procedures and in Exhibit A of Gravie's Plan Sponsor Certification form.

ii. The access to and use of PHI by the individuals described previously shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

iii. If any of the individuals described previously do not comply with the provisions of the Plan Document (as amended) relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Plan Sponsor further agrees that it will undertake the following requirements with respect to ePHI (terms used that are not otherwise defined herein will have the meaning attributed to them under the Standards for Security Standards for the Protection of Electronic Protected Health Information, Title 45, Parts 160 and 164, Subpart C, of the Code of Federal Regulations, promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91):

a. Implement adequate administrative, physical, and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

b. Ensure that the adequate separation described above between the Plan and the Plan Sponsor in its capacity as other than the Plan Administrator is supported by reasonable and appropriate security measures.

c. Ensure that any agent, including a subcontractor, to whom it provides e-PHI received from the Plan agrees to implement reasonable and appropriate security measures to protect the e-PHI.

d. Report to the Plan any material Security Incident of which it becomes aware not already known by the Plan.

"Plan Administration" functions are defined as activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. "Plan Administration" functions do not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan, or the Plan Administrator on behalf of the Plan, shall disclose PHI to the Plan Sponsor only upon receipt of a written certification by the Plan Sponsor that (a) the Plan Document contains the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Rule (45 CFR § 164.504(f)(1)(iii)), the Plan, the Plan Administrator on behalf of the Plan may disclose to the Plan Sponsor information about whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator, or Gravie to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to claims for benefits under the Plan. Such disclosures shall be made in accordance with the Privacy Rule.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Rule.

C. Statement of Rights Under the Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Plan because of the Women's Health and Cancer Rights Act of 1998 (WHCRA) and state law. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Such coverage may be provided subject to the same annual deductibles and coinsurance and other Plan provisions as may be deemed appropriate and as are consistent with those established for other medical and surgical benefits under the Plan. Please refer to your Summary of Benefits for a full description of coverage under the Plan.

D. Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal and state law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the group health plan or health issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans or health issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification as described in the pre-certification provisions of the Benefit Schedule.

E. Family and Medical Leave Act (FMLA)

If you are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no

interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date you notify the Employer that you do not intend to return to work. You are responsible for all required contributions.

If you do not return after an approved leave of absence, coverage may be continued under the "COBRA Continuation Coverage" section, provided that you elect to continue under that provision. If you return to work immediately following your approved FMLA leave, no new waiting periods will apply.

FMLA applies to employees of a covered employer that work at a worksite within 75 miles of where that employer employs at least 50 employees.

F. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of Benefits. Covered employees who are absent due to service in the uniformed services and/or their covered dependents may continue coverage pursuant to USERRA for up to 24 months after the date the covered employee is first absent due to uniformed service duty.

Eligibility. A covered employee is eligible for continuation under USERRA if the covered employee is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered dependents who have coverage under the Plan immediately prior to the date of the covered employee's covered absence are eligible to elect continuation under USERRA.

Upon the covered employee's return to work immediately following the covered employee's leave under USERRA, no new waiting periods will apply.

Premium Payment. If continuation of Plan coverage is elected under USERRA, the covered employee or covered dependent is responsible for payment of the applicable cost of coverage. If the covered employee is absent for not longer than 31 calendar days, the cost will be the amount the covered employee would otherwise pay for coverage. For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the covered employee's share and any portion previously paid by the Employer.

Duration of Coverage. Elected continuation coverage under USERRA will continue until the earlier of:

1. Twenty-four months, beginning the first day of absence from employment due to service in the uniformed services;

2. The day after the covered employee fails to apply for or return to employment as required by USERRA, after completion of a period of service;

3. The early termination of USERRA continuation coverage due to the covered employee's court-martial or dishonorable discharge from the uniformed services; or

4. The date on which this Plan is terminated.

The continuation available under USERRA does not affect continuation available under "COBRA Continuation Coverage." Covered employees should contact their Employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the Employer of any changes in marital status or a change of address.

Return to Work Requirements. Under USERRA a covered employee is entitled to return to work following an honorable discharge as follows:

1. Less than 31 days service: By the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight-hour rest period.

2. Thirty-one to 180 days: The covered employee must apply for reemployment no later than 14 days after completion of military service.

3. One hundred and eighty-one days or more: The covered employee must apply for reemployment no later than 90 days after completion of military service.

4. Service-connected injury or illness: Reporting or application deadlines are extended for up to two years for persons who are hospitalized or convalescing.

G. Michelle's Law

Under Michelle's Law, group health plans and health insurers are prohibited from terminating the coverage of a student dependent whose enrollment in a plan requires student status at a postsecondary educational institution, if the student status is lost because of a qualifying Medically Necessary Leave of Absence.

Michelle's Law applies to a group health plan or related insurance coverage only if the plan or insurer receives written certification by the student dependent's treating physician stating that (1) the child is suffering from a serious illness or injury and (2) the Leave of Absence (or other change in enrollment) is Medically Necessary.

A student dependent is one who, regarding group health plan or health insurance coverage is both:

1. A dependent child, under the plan's or coverage's terms, of a participant or beneficiary in the plan or coverage.
2. Was enrolled in the plan or coverage, on the basis of being a student at a postsecondary educational institution, immediately before the first day of the Medically Necessary Leave of Absence involved.

H. Qualified Medical Child Support Order (QMCSO) / National Medical Support Notice (NMSN)

With respect to the component benefit programs, the Plan extends medical benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO) or any National Medical Support Notice (NMSN), pursuant to state law**.**

A medical child support order is a judgment, decree, or order (including an approval of a property settlement) that:

- Is made pursuant to state domestic relations law (including a community property law) or certain other state laws relating to medical child support; and
- Provides for child support or health benefit coverage for a child of a participant under a group health plan and relates to benefits under the plan.

The Plan has procedures for determining whether an order qualifies as a QMSCO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

I. COBRA Continuation Coverage

NOTE: The Consolidated Omnibus Budget Reconciliation Act (COBRA) generally requires employers with 20 or more employees who sponsor group health plans to offer employees, their spouses, and their dependents a

temporary period of continued health care coverage if they lose coverage through the employer's plan. State COBRA laws may apply to businesses with less than 20 full-time employees.

The covered employee, the covered spouse and covered dependent children may continue coverage under the Plan when a qualifying event occurs. You may elect COBRA for yourself regardless of whether the covered employee or other eligible dependents in your family elect COBRA. A covered employee and a covered spouse may elect COBRA on behalf of each other and/or their covered dependent children. If a loss of coverage qualifying event occurs:

1. In certain cases, the covered employee may continue his or her coverage and may also continue coverage for his or her covered spouse, covered dependent children, domestic partners and covered dependent children of the domestic partner when coverage would normally end

2. In certain cases, the covered spouse and covered dependent children may continue coverage when coverage would normally end. A domestic partner and the covered dependent children of the domestic partner may not continue coverage except as a dependent of a covered employee at the option of the covered employee;

3. Coverage will be the same as that for other similar covered persons; and

4. Continuation coverage under this Plan ends when this Plan terminates or as explained in detail on the following Continuation Chart. The covered employee, the covered spouse and covered dependent children may, however, be entitled to continuation coverage under another group health plan offered by the Employer. You should contact the Employer for details about other continuation coverage.

For additional information about your rights and obligations under the Plan and/or federal COBRA law, you should contact the Employer.

The Plan's designated COBRA Administrator may change from time to time. When that happens, you will be notified of the new COBRA Administrator.

Qualifying Events

1. Loss of coverage under this Plan by the covered employee due to one of these events:
   a. Voluntary or involuntary termination of employment of the covered employee for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the covered employee.
   c. Layoff of the covered employee.
   d. Leave of absence of the covered employee.
   e. Early retirement of the covered employee.

2. Loss of coverage under this Plan by the covered spouse and/or covered dependent children due to one of these events:
   a. Voluntary or involuntary termination of employment of the covered employee for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the covered employee.
   c. Layoff of the covered employee.
   d. Leave of absence of the covered employee.
   e. Early retirement of the covered employee.
   f. Covered employee becoming entitled to Medicare.
   g. Divorce or legal separation of the covered employee.
   h. Death of the covered employee.

3. Loss of coverage under this Plan by the covered dependent child due to loss of "dependent child" status under this Plan.

4. Loss of coverage under this Plan due to the bankruptcy of the Employer under Title XI of the United States Code. For purposes of this qualifying event (bankruptcy), a loss of coverage includes a substantial elimination of coverage that occurs within one year before or after commencement of the bankruptcy proceeding. Applies to the covered retiree, the covered spouse and covered dependent children.

Required Procedures

When the initial qualifying event is death, termination of employment or reduction in hours (including leave of absence, layoff, or retirement), or Medicare entitlement of the covered employee, or the bankruptcy of the Employer, the Plan Administrator will offer continuation coverage to qualified covered persons. You do not need to notify the Plan Administrator of these qualifying events. However, for other qualifying events including divorce or legal separation of the covered employee and loss of dependent child status, COBRA continuation is not available to you if you do not provide timely, written notice to the Plan Administrator as required below by the Plan. You must also provide timely, written notice to the designated COBRA Administrator of other events, such as a Social Security disability determination or second qualifying events, in order to be eligible for an extension of COBRA continuation as required by the Plan as stated in this section. To elect COBRA, you must make a timely, written election as required by the Plan as stated in this section.

What the Plan Administrator must do:

1. Provide initial general COBRA notices as required by law;

2. Determine if the covered person is eligible to continue coverage according to applicable laws;

3. Notify persons of the unavailability of COBRA continuation;

4. Notify the covered person of the covered person's rights to continue coverage provided that all required notice and notification procedures have been followed by the covered employee, covered spouse and/or covered dependent children;

5. Inform the covered person of the premium contribution required to continue coverage and how to pay the premium contribution; and

6. Notify the covered person when the covered person is no longer entitled to COBRA or when the covered person's COBRA continuation is ending before expiration of the maximum (18, 29, 36 month) continuation period.

What You must do:

1. You must notify the Plan Administrator in writing of a divorce or legal separation within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

2. You must notify the Plan Administrator in writing of a covered dependent child ceasing to be eligible within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

3. You must submit your written notice of a qualifying event within the 60-day timeframe, as explained previously in paragraphs 1 and 2, using the Plan's approved notice form. (You may obtain a copy of the approved form from the Plan Administrator.) This notice must be submitted to the Plan Administrator in writing and must include the following:
   - The name of the Plan;

- The name and address of the covered employee or former covered employee;
- The names and addresses of all applicable dependents;
- The description and date of the qualifying event;
- Requested documentation pertaining to the qualifying event such as: decree of divorce or legal separation; and
- The name, address and telephone number of the individual submitting the notice. This individual can be a covered employee, former covered employee, dependent, or a representative acting on behalf of the employee or dependent.

All written notices as described previously in paragraphs 1, 2, and 3, under "What You must do" must be timely sent to the Plan Administrator at the address indicated in the section of this SPD entitled "Specific Information About Your Plan."

You must follow the Plan's procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this SPD, unless a different procedure is expressly required by the Employer or its COBRA administrator.

4. To elect continuation, you must notify the designated COBRA Administrator of your election in writing within 60 calendar days after the date the covered person's coverage ends, or the date the covered person is notified of continuation rights, whichever is later. To elect continuation, you must complete and submit your written election within the 60-day timeframe using the Plan's approved election form. (You may obtain a copy of the approved form from the designated COBRA Administrator.) This election must be submitted to the designated COBRA Administrator in writing at the address as described in this section; and

5. You must pay continuation premium contributions:
   a. The premium contribution to continue coverage is the combined Employer plus covered employee rate charged under the Plan, plus the Employer may charge an additional two percent of that rate. For a covered person receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium contribution for those additional months may be increased to 150% of the Plan's total cost of coverage. The continuation election form will set forth your continuation premium contribution rate(s).
   b. The first premium contribution must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the covered person's monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The covered person must pay subsequent premium contributions by check on or before the required due date, plus the 30-calendar day grace period required by law or such longer period allowed by the Plan.

What You must do to apply for COBRA extension:

A. Social Security Disability:

1. If you are currently enrolled in COBRA continuation under this Plan, and it is determined that you are totally disabled by the Social Security Administration within the first 60 calendar days of your current COBRA coverage, then you may request an extension of coverage provided that your current COBRA coverage resulted from the covered employee's leave of absence, retirement, reduction in hours, layoff, or the covered employee's termination of employment for reasons other than gross misconduct. To request an extension of COBRA, you must notify the designated COBRA Administrator in writing of the Social Security Administration's determination within 60 calendar days after the latest of:
   - The date of the Social Security Administration's disability determination;
   - The date of the covered employee's termination of employment, reduction of hours, leave of absence, retirement, or layoff; or
   - The date on which you would lose coverage under the Plan as a result of the covered employee's termination, reduction of hours, leave of absence, retirement, or layoff.

2. You must submit your written notice of total disability within the 60-day timeframe, as described previously in paragraph 1, and before the end of the 18th month of your initial COBRA coverage using the Plan's approved disability notice form. (You may obtain a copy of the approved form from the designated COBRA Administrator.) This notice must be submitted, in writing, to the Plan designated COBRA Administrator and must include the following:
   - The name of the Plan;
   - The name and address of the covered employee or former covered employee;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started your COBRA coverage;
   - The name of the disabled covered person;
   - The date the covered person became disabled;
   - The date the Social Security Administration made its determination of disability;
   - Requested copy of the Social Security Administration's determination of disability; and
   - The name, address and telephone number of the individual submitting the notice. This individual can be a covered employee, former covered employee, dependent, or a representative acting on behalf of the employee or dependent.

   You must follow the Plan's procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this SPD, unless a different procedure is expressly required by the Employer or its COBRA administrator.

   All written notices required for COBRA for a Social Security disability extension must be timely sent to the Plan Administrator at the address indicated in the section of this SPD entitled "Specific Information About Your Plan."

3. To elect an extension of COBRA, you must notify the designated COBRA Administrator of the Social Security Administration's determination, in writing, within the 60-calendar day and the initial 18-month continuation period timeframes, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the Plan's approved form; and

4. You must pay continuation premium contributions:
   a. The premium contribution to continue coverage is the combined Employer plus covered employee rate charged under the Plan, plus the Employer may charge an additional two percent of that rate. For a covered person receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium contribution for those additional months may be increased to 150% of the Plan's total cost of coverage. The disability notice form will set forth your continuation premium contribution rate(s).
   b. The first premium contribution must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the covered person's monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The covered person must pay subsequent premium contributions by check on or before the required due date, plus the 30-calendar day grace period required by law or such longer period allowed by the Plan.

B. Second Qualifying Events for Covered Dependents Only:

1. If you are currently enrolled in COBRA continuation under this Plan and the covered employee dies, or in the case of divorce or a legal separation of the covered employee, or a covered dependent child loses eligibility, then you may request an extension of coverage provided that your current COBRA coverage resulted from the covered employee's leave of absence, retirement, reduction in hours, layoff, or the covered employee's termination of employment for reasons other than gross misconduct or resulted from

a Social Security Administration disability determination. To request an extension of COBRA, you must notify the designated COBRA Administrator in writing within 60 calendar days after the later of:

- The date of the second qualifying event (death, divorce, legal separation, loss of dependent child status); or
- The date on which the covered dependent(s) would lose coverage as a result of the second qualifying event.

Note: This extension is only available to a covered spouse and covered dependent children. This extension is not available when a covered employee becomes entitled to Medicare.

2. You must submit your written notice of a second qualifying event within the 60-day timeframe, as previously described in paragraph 1, using the Plan's approved second event notice form. (You may obtain a copy of the approved form from the designated COBRA Administrator.) This notice must be submitted to the designated COBRA Administrator in writing and must include the following:
   - The name of the Plan;
   - The name and address of the covered employee or former covered employee;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started your COBRA coverage;
   - The description and date of the second qualifying event;
   - Requested documentation pertaining to the second qualifying event such as: a decree of divorce or legal separation or death certificate; and
   - The name, address and telephone number of the individual submitting the notice. This individual can be a covered employee, former covered employee, dependent, or a representative acting on behalf of the employee or dependent.

   You must follow the Plan's procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this SPD, unless a different procedure is expressly required by the Employer or its COBRA administrator.

   All written notices required for COBRA for a second qualifying event extension must be timely sent to the Plan Administrator at the address indicated in the section of this SPD entitled "Specific Information About Your Plan."

3. To elect an extension of COBRA, you must notify the designated COBRA Administrator of the second qualifying event in writing within the 60-calendar day timeframe, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the Plan's approved form; and

4. You must pay continuation premium contributions:
   a. The premium contribution to continue coverage is the combined Employer plus covered employee rate charged under the Plan, plus the Employer may charge an additional two percent of that rate. For a covered person receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium contribution for those additional months may be increased to 150% of the Plan's total cost of coverage. The election form will set forth your continuation premium contribution rates.
   b. The first premium contribution must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the covered person's monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium contributions by check on or before the required due date, plus the 30-calendar day grace period required by law or such longer period allowed by the Plan.

Additional Notices You Must Provide: Other Coverages, Medicare Entitlement and Cessation of Disability

You must also provide written notice of (1) your other group coverage that begins after COBRA is elected under the Plan; (2) your Medicare entitlement (Part A, Part B or both parts) that begins after COBRA is elected under the Plan; and (3) the covered person, whose disability resulted in a COBRA extension due to disability, being determined to be no longer disabled by the Social Security Administration.

Your written notice for the events previously described in this section must be submitted using the Plan's approved notification form within 30 calendar days of the events requiring additional notices as previously described**. The notification form can be obtained from the designated COBRA Administrator and must be completed by you and timely submitted to the designated COBRA Administrator at the address as described in the SPD.** In addition to providing all required information requested on the Plan's approved notification form, your written notice must also include the following:

- If providing notification of other coverage that began after COBRA was elected, the name of the covered person who obtained other coverage, and the date that other coverage became effective.
- If providing notification of Medicare entitlement, the name and address of the covered person that became entitled to Medicare and the date of the Medicare entitlement.
- If providing notification of cessation of disability, the name and address of the formerly disabled covered person, the date that the Social Security Administration determined that the covered person was no longer disabled and a copy of the Social Security Administration's determination.

If you do not provide this required additional notice, you must reimburse any claims mistakenly paid for expenses incurred after the following applicable date:

1. Your other group coverage begins;
2. Your Medicare Part A or Part B enrollment begins; or
3. Your disability ends.

CONTINUATION CHART

If coverage under this Plan is lost because this happens…	**Who is eligible to continue…**	**Coverage may be continued until the earliest of**: a) the date coverage would otherwise end under the Plan; or b) the end of the month in which the earliest of the following applicable events occurs:
The covered employee's leave of absence, early retirement, hours were reduced, layoff, or the covered employee's employment with the Employer ended for reasons other than gross misconduct.	Covered employee, covered spouse, and covered dependent children	• 18 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.
Death of the covered employee. Divorce or legal separation from the covered employee. Entitlement of the covered employee to Medicare within 18 months before the covered employee's hours were reduced or termination of employment for reasons other than gross misconduct. Covered person must provide timely notice of such event in accordance with the Plan's notice procedures previously described for such events.	Covered spouse and covered dependent children	• 36 months after continuation coverage began. • 36 months after entitlement of covered employee to Medicare but only for an event which is the covered employee's Medicare entitlement within 18 months before the covered employee's hours were reduced or termination of employment. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.
Loss of eligibility by a covered dependent child. Covered person must provide timely notice of such event in accordance with the Plan's notice procedures previously described for such events.	Covered dependent child	• 36 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.
The Employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code.	Covered retiree, covered spouse, and covered dependent children	• Lifetime continuation coverage for covered retiree. • 36 months after death of covered retiree for covered spouse and covered dependent children. • Coverage begins under another group health plan after COBRA is elected under the Plan.
The covered employee, covered spouse or covered dependent child is determined by the Social Security Administration to be totally disabled within the first 60 calendar days of COBRA continuation coverage that resulted from the covered employee's leave of absence, early retirement, reduction in hours, layoff, or the covered employee's termination of employment with the Employer for reasons other than gross misconduct. Timely notice of such disability must be provided by the covered person in accordance with the Plan's notice procedures previously described for COBRA extensions due to Social Security disability.	Covered employee, covered spouse, and covered dependent children	• 29 months after continuation coverage began or until the first month that begins more than 30 calendar days after the date of any final determination that covered employee, covered spouse, or covered dependent child is no longer disabled. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.

Special Enrollment Periods

If you are a covered employee, covered spouse, or covered dependent who is enrolled in continuation coverage under this Plan due to a qualifying event (and not due to another enrollment event such as a special or annual enrollment), the Special Enrollment Period provisions of this SPD as referenced in the section which describes eligibility and enrollment will apply to you during the continuation period required by federal law as such provisions would apply to an active eligible covered employee. Eligible dependents that are newborn children or newly adopted children (as described in the eligibility and enrollment section) that are acquired by a covered employee during such covered employee's continuation period required by federal law and are enrolled through special enrollment, are entitled to continue coverage for the maximum continuation period required by law.

If the continuation period required by federal law has been exhausted, and you are enrolled for additional continuation coverage pursuant to state law, if applicable, or the eligibility provisions of this plan, you may be entitled to the special enrollment rights upon acquisition of a new dependent through marriage, birth, adoption, placement for adoption, or legal guardianship, as referenced in the section entitled Special Enrollment Period for Covered Persons due to the Acquisition of New Dependents.

Special Rule for Persons Qualifying for Federal Trade Act Adjustments

Federal trade act laws give special COBRA rights to covered employees who terminate employment or experience a reduction of hours, and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under federal laws, including the Trade Adjustment Assistance Reauthorization Act of 2015.

If you qualify or may qualify for trade adjustment assistance, contact the Plan Administrator for additional information. You must contact the Plan Administrator promptly after qualifying for trade adjustment assistance or you will lose your special COBRA rights.

Written Notices Required for COBRA Continuation

All notices, elections and information required to be furnished or submitted by a covered person, covered spouse, or covered dependent children for purposes of COBRA continuation must be submitted in writing by U.S. mail or hand-delivery, or as previously described in this section. Oral communications, including phone calls, voice mails or in-person statements and electronic e-mail do not constitute written notice and are not acceptable for COBRA purposes under the Plan.

J. Fraud, Misrepresentation, Rescission and Right to Audit

It is your responsibility to confirm the accuracy of statements made by the Plan Administrator or the TPA, in accordance with the terms of this SPD and other plan documents. Your coverage may not be retroactively terminated unless you request it or you (or someone acting on your behalf) falsifies information, submits fraudulent, altered, or duplicate billings, allows another person not covered under the Plan to use your coverage, or performs an act or practice that constitutes fraud or intentional misrepresentation (including an omission) of material fact under the terms of the Plan. Notwithstanding, you may be terminated, including being retroactively terminated, due to your failure to timely pay your required contributions.

Determination of your coverage will be made at the time a claim is reviewed. In addition, the Plan Administrator may require you to furnish proof of your eligibility status and may, at reasonable times and upon reasonable notice, audit or have audited your records regarding eligibility, enrollment, termination, contributions, and the coverage provided under the Plan. If the Plan Administrator determines that, after reasonable requests, you have failed to provide adequate records or sufficient proof of your eligibility status, the Plan Administrator may, in its sole discretion, rescind or terminate your coverage to the extent permitted by law.

K. Balance Billing Under the No Surprises Act

(1) If you receive emergency services (for which benefits are provided under this SPD) because of an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department, which is a non-participating provider, then such non-participating provider may not bill you, and may not hold you liable, for any amount for such emergency services which is more than the copayment requirement for such services by participating providers under this SPD.

(2) If a non-participating provider furnishes health care services other than emergency services (for which benefits are provided under this SPD) to you at a hospital or ambulatory surgical center, which is a participating provider, then:

a) The non-participating provider may not bill you, and may not hold you liable, for any amount for such health care services furnished by such non-participating provider with respect to a visit at the hospital or ambulatory surgical center which is more than the deductible requirements for such services under this SPD; unless;

b) The health care services are not ancillary services and the non-participating provider satisfies the notice and consent criteria in paragraph (c).

c) The non-participating provider provides to the covered person:

i. A written notice in paper or electronic form, as selected by you, that contains the following information:

- A statement that the provider is a non-participating provider;
- The good faith estimated amount that such non-participating provider may charge you for the health care services involved (and any other related health care services reasonably expected to be furnished by the non-participating provider), including notification that the provision of the estimate or consent does not constitute a contract with respect to the estimated charges or a contract that binds the covered person to be treated by the hospital, ambulatory surgical center, or non-participating provider;
- A statement that prior notification or other care management limitations may be required in advance of receiving such health care services at the hospital or ambulatory surgical center;
- A statement that consent to receive such health care services from such non-participating provider is optional and that the covered person may instead seek care from an available participating provider and in that event the cost-sharing responsibility of the covered person

would not exceed the responsibility that would apply with respect to such health care services furnished by a participating provider.

ii. A consent form that must be signed by the covered persons before such health care services are furnished and that:

- Acknowledges that the covered person has been:
  - Provided with the written notice described in paragraph (i) of this subsection, in the form selected by the covered person; and
  - Informed that the payment of such charge by the covered person might not accrue toward meeting any limitation that your coverage places on cost sharing, including an explanation that such payment might not apply to an in-network deductible or out-of-pocket maximum applied under your coverage;
- States that by signing the consent form, the covered person agrees to be treated by the non-participating provider and understands the covered person may be balance billed and subject to cost sharing requirements that apply to health care services furnished by the non-participating provider; and
- Documents the time and date on which the covered person received the written notice described in paragraph (i) of this subsection and the time and date on which the covered person signed the consent form to be furnished such health care services by such non-participating provider.

The No Surprises Act prohibits balance billing in most circumstances. If you have questions regarding what constitutes a "Balance" bill, please contact Customer Service at the number listed on the inside cover of the SPD.

L. Genetic Information Nondiscrimination Act (GINA)

Notwithstanding any provision of this Plan to contrary, this Plan shall be operated and maintained in a manner consistent with GINA. GINA prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

M. Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost-sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

N. No Surprises Act Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Some states have their own surprise billing laws that protect consumers against surprise medical bills. Visit https://www.cms.gov/files/document/nsa-state-laws.pdf for more information about your rights under state law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Some states have their own surprise billing laws that protect consumers against surprise medical bills. Visit https://www.cms.gov/files/document/nsa-state-laws.pdf for more information about your rights under state law.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may submit a complaint at https://www.cms.gov/medical-bill-rights/help/submit-a-complaint

Visit https://www.cms.gov/nosurprises and https://www.cms.gov/medical-bill-rights/know-your-rights/using-insurance for more information about your rights under federal law.