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Health Savings Account Contributions Program **HSA Contributions Program**

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Booklets

OBTAINING AND CHANGING COVERAGES

EMPLOYEE ELIGIBILITY

Full-Time Employee Eligibility

Full-Time Employee

Definitions
Spouse

Only you, and not your Eligible Dependents, may make Benefit Program elections. If you have properly enrolled in any Benefit Program, you are a "Participant" in the Plan. Any Eligible Dependents properly enrolled in the Plan are "Covered Dependents."

Unless otherwise specified in the enrollment materials, an applicable Insurance Contract or in the applicable Booklets, you must enroll yourself in a Benefit Program in order to also enroll your Eligible Dependents in that Benefit Program.

Open Enrollment

Each year the Employer establishes an "Open Enrollment Period" during which you can make new benefit elections for the upcoming Plan Year. To make your elections, you must complete the enrollment process as directed by the Plan Administrator prior to the end of the Open Enrollment Period.

The choices you make during the Open Enrollment Period will be effective on the first day of the upcoming Plan Year. Once the Plan Year begins, your choices are irrevocable and will remain in effect without any changes permitted through the remainder of the Plan Year, unless you are entitled to a Special Enrollment Period or a Change Event occurs. You may, however, change your Employee Contributions under the HSA Contributions Program on a prospective basis at any time.

If the Open Enrollment Period occurs while you are on an Employer-approved leave during which your benefits continue, you will be contacted and allowed to make an election during the Open Enrollment Period. If the Open Enrollment Period occurs while you are on an Employer-approved leave during which your benefits do <u>not</u> continue, you will be allowed to make an election for the new Plan Year when you return from your leave as long as you are eligible to participate upon your return.

If you enroll in the Medical/Rx, Dental, Vision, Dependent Care FSA, Health Care FSA, or HSA Contributions Programs, you will be automatically enrolled in the Pre-Tax Payment Program. However, if you are enrolled in the Orange Plan under the Medical/Rx Program because you met the eligibility criteria described in the section titled "Additional Eligibility Rules for the Medical/Rx Program" beginning on page 4, you are not eligible to pay for that coverage through the Pre-Tax Payment Program, and you must pay for your coverage on an after-tax basis.

Failure to Timely Enroll

Initial Enrollment Period

Open Enrollment Period

;

;

Additional Change Events for Medical/Rx Program

Marketplace

Additional Change Event for Dependent Care FSA Program

Consistency Rule

not

not

provide additional documentation for certain Change Events (e.g., a marriage certificate if you wish to add a new Spouse to your benefits coverage). The change request must be filed on or before the date that is 30 days after the date of the Change Event. The change in coverage generally will be effective as of the first payro ll period following notification, or as soon as administratively possible thereafter. However, if the Change Event is birth or adoption of an

coverage may be retroactively terminated

VISION PROGRAM

For a description of the Vision Program benefits, please refer to the Booklets provided by the Claims Administrator listed in Appendix B (Benefit Program Information Chart).

LONG-TERM DISABILITY PROGRAM

For a description of the Long-Term Disability Program benefits, including optional benefits available for purchase under the Program, please refer to the Booklet provided by the Claims Administrator listed in Appendix B (Benefit Program Information Chart).

LIFE/AD&D INSURANCE PROGRAM

For a description of the Life/AD&D Insurance Program benefits, including optional benefits available for purchase under the Program, please refer to the applicable Booklet provided by the Claims Administrator listed in Appendix B (Benefit Program Information Chart).

GROUP TRAVEL ACCIDENT PROGRAM

For a description of the Group Travel Accident Program benefits, please refer to the Booklet provided by the Claims Administrator listed in Appendix B (Benefit Program Information Chart).

EAP

For a description of the EAP benefits, please refer to the Booklet provided by the Claims Administrator listed in Appendix B (Benefit Program Information Chart).

PRE-TAX PAYMENT PROGRAM

The Pre-Tax Payment Program allows you to pay for benefits under the following Benefit Programs on a tax-free basis: Medical/Rx Program coverage obtain other than by reason of meeting the eligibility criteria described in the section titled "Additional Eligibility Rules for Medical/Rx Program" beginning on page 4, and Dental, Vision, Health Care FSA, and Dependent Care FSA Programs. Employee Contributions for all other coverage will be paid on an after-tax basis.

To the extent Employee Contributions are required for benefits you elect under the Benefit Programs subject to the Pre-Tax Payment Program, you agree to have the Employer reduce your compensation to cover the cost of those benefits. Because your compensation is reduced, the amount of your federal payroll and Social Security taxes, as well as most state and municipal taxes, will also be reduced.

The Pre-Tax Payment Program may not be used to purchase individual health plan coverage or coverage obtained through the Marketplace.

COBRA Premiums

DEPENDENT CARE FSA PROGRAM

Example:

	Using Dependent Care FSA Program	Not Using Dependent Care FSA Program
Your Net Take Home Pay	**$42,750**	**$42,000**
Your Tax Savings	**$750**	**N/A**

Dependent Care Flexible Spending Account

Dependent Care FSA

Annual Contribution Amount

Full-Time Student

Amount That Can Be Reimbursed to Participants

Eligible Dependent Care Expenses

Qualifying Individual

Federal Dependent Care Tax Credit

Provider Information

Example:
You earn $30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Health Care Expenses will be $1,

Amount Available for Reimbursement

Carry-Over Amounts

Carry-Over Amount

Forfeiture of Amounts in Your Health Care FSA

If you join the Plan after the start of the year and have not been previously covered under a high deductible health plan, the amount you may contribute without restriction is also prorated for the number of months you are covered by the HDHP option (and are otherwise eligible to contribute to an HSA). However, the IRS has a special rule that allows you to fund your HSA up to the annual contribution limit for the calend ar year if you are covered by an HDHP in December of that calendar year. To take advantage of this rule, you are required to remain covered under a high deductible health plan (and not otherwise be disqualified from contributing to an HSA) until the end of the *following* calendar year. If you fail to remain HSA-eligible throughout the following calendar year, you would have to pay income taxes, plus an additional 10% penalty tax, on the contributions above your prorated contribution limit, unless you lose your HSA eligibility based on disability or death.

You are responsible for determining whether you are eligible to contri bute to an HSA each month and for adjusting your HSA contributions ac cordingly. For more information, you should read IRS Publication 969.

Changing HSA Contributions

You can elect to begin or end contributions, or increase or decrease contributions, to your HSA at any time. These changes will not affect your prior contribution s, but only contributions you make going forward. Your change will go into effect with the ne xt payroll period that begins after you have successfully submitted your election change, or as soon thereafter as administratively feasible.

Recording Contributions

Because you are the owner of your HSA, you are responsible for keeping track of how much has been deposited into your account. The Employer will keep track of HSA contributions made through this Plan; however, yo u will be responsible for keeping track of contributions made

those described in the Booklets, the Booklets will control. If the Bookle ts for a Benefit Program do not contain claims procedures, the procedures described in this section for that Benefit Program will apply.

General Rules
A “Claim ”

Deadline for Post-Service Claims Under Medical/Rx, Dental, Vision, and EAP Programs

You are encouraged to submit your Post-Service Claims under the Medical/Rx, Dental, Vision, and EAP Programs as soon as possible after you incur the expense. Unless otherwise specified in the applicable Insurance Contracts or Booklets, Post-Service Claims under these Programs must be submitted within 12 months of the date the expense was incurred.

Filing an Appeal

Review of Appeal

Notice of Determination on Appeal

Filing an Appeal

Filing Civil Action

Failure of Claims Administrator to Follow Procedures

Claims Under the Long-Term Disability Program and Claims Under Other Benefit Programs for Benefits Conditioned Upon the Claims Administrator's Determination of Disability

Filing a Claim

Filing an Appeal

Notice of Determination on Appeal

Filing Civil Action

Failure of Claims Administrator to Follow Procedures

Claims Under Dependent Care FSA Program

Filing a Claim

Notice of Initial Claim Denial

Filing an Appeal

explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Claims Based Solely on Eligibility to Participate in Plan or Benefit Program and Claims of ERISA or Code Violations

Filing Civil Action

pay, offset any recovery, or in any way be responsible for any fee or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

You and your Covered Dependents must cooperate fully with the Plan Administrator to protect the Plan's right of reduction, recovery, reimbursement or subrogation and must sign any reimbursement or subrogation agreement or other document that may be requested by the Plan Administrator, although the plan may exercise its rights under this section whether or not any such agreement is requested or signed by you. You and your Covered Dependents are responsible for notifying the plan in writing of any claim you may have against another party who may be responsible for benefits paid under this Plan. Your notice must be provided within 30 days of the date that any notice is given to any party, including an attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to any injury, illness, or condition for which the Plan has paid benefits.

If you, your agent, a trust, or any other person or entity receive any proceeds of settlement or judgment on behalf of you or your Covered Dependent, and if the plan has a right to any portion of those proceeds, you, your agent, or the third party must hold those proceeds in trust for the plan. The plan may recover any expenses it incurs because you or your Covered Dependents failed to cooperate in enforcing the plan's rights under this section. If you or your Covered Dependents do not comply with this section, your right to benefits under the plan may be forfeited.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") provides Qualified Beneficiaries, upon the occurrence of a Qualifying Event, the right to continuation coverage under the Medical/Rx, Dental, Vision, EAP and Health Care FSA Programs beyond the time the coverage would normally end ("COBRA Continuation Coverage

Notice of Qualifying Event Required

The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the COBRA Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the reduction of your hours or end of your employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

For the other Qualifying Events (e.g., your divorce or legal separation, or your Child's losing eligibility for coverage as a dependent Child), you must notify the COBRA Administrator within 60 days after the Qualifying Event occurs. You must provide written notice of the Qualifying Event to the COBRA Administrator. Emailed notices or notices sent by facsimile will be considered written notices. Oral or voice-mailed notices will not be accepted.

Your notice must include: the name and contact information of the person giving notice, the name and address of the employee or former employee who is or was a Plan Participant, a description of the Qualifying Event, the date of the Qualifying Event, any documents or materials relevant to the Qualifying Event (e.g., a copy of a judgment of divorce in the event of a divorce), and the names, addresses, and Social Security numbers of the Covered Dependents affected by the Qualifying Event. Failure to notify the COBRA Administrator in a timely manner will mean that neither you nor your Covered Dependents will be able to elect COBRA Continuation Coverage for these Qualifying Events.

Electing COBRA Continuation Coverage

Once the COBRA Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. To elect Continuation Coverage, you must complete the election form and send it in according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, your Spouse may elect coverage even if you do not. COBRA Continuation Coverage may be elected for only one, several, or for all dependent Children who are Qualified Beneficiaries. A parent may elect or reject Continuation Coverage for any minor Children. You and your Spouse may elect Continuation Coverage for each other, but cannot reject coverage for the other person. After you have submitted your election forms, if it is determined that you or a Covered Dependent is not entitled to Continuation Coverage, you will be provided with a written explanation of why the election of Continuation Coverage could not be honored.

In considering whether to elect COBRA Continuation Coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible, such as a plan sponsored by your Spouse's employer, within 30 days after your group health plan coverage ends because of the Qualifying Events listed above. You will also have the same special enrollment right at the end of COBJ 11.1w [(en*e)5(fu wil7.8(h)-.an)-4.8( )-5.5(for)-5.4(w)-6(h Con)-5.66e-5.4

Cost of COBRA Continuation Coverage

Paying for COBRA Continuation Coverage

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Extending Length of COBRA Continuation Coverage

may be entitled to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage.

You or a Covered Dependent must notify the COBRA Administrator in writing on or before the 60th day after the latest of: (a) the date of th

Military Leave Continuation Coverage

Uses and Disclosures of PHI by Plan

Plan Administrative Functions

Plan Administration Functions

Privacy Obligations of Employer

Electronic Data Security Obligations of Employer

Qualified Medical Child Support Orders

QMCSO

procedures. Within a reasonable period of time after receipt of the order, the Plan Administrator will determine whether the order or NMSN is a QMCSO and notify the Participant and Alternate Recipient of its determination. If the order is an appropriately completed NMSN and it is deemed to be a QMCSO, the Plan Administrator will also, within 40 business days of receipt of the NMSN, notify the issuing court or agency and the custodial parent whether coverage is available to the child under the terms of the Plan and, if so, the steps to be taken to effectuate coverage.

If the Plan Administrator determines that an order or NMSN is not a QMCSO, the notice will include an explanation of the defective or missing provisions.

The Participant and each Alternate Recipient have the right to request in writing, within 30 days after being notified of the Plan Administrator's determination, that the Plan Administrator reconsider its determination of the order or NMSN. The Participant and each Alternate Recipient may present additional materials to the Plan Administrator for review. The Plan Administrator will provide sufficient information for the Participant and/or Alternate Recipient to understand available options and to assist in appropriately completing the order or NMSN. If the Plan Administrator requests additional information or material, you will be given a reasonable period of td35.5(masssubder)-5.4(or)-6(A5.5ga)-5Tj T*DAlter0005 Tc .a.[(reason-5.6(ben will p

or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits in accordance with any assignment of rights made by or on behalf of that individual as required under a State Medicaid Plan pursuant to Section 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to the individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law that provides that the State has acquired the rights with respect to the individual to payment for those items and services under this Plan.

Maternity Benefits

Pursuant to federal law, the Plan, or any insurance issuer providing coverage for maternity benefits under the Plan, will 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 normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's treating physician, after consultation with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours, as the case may be). The Plan will not require a medical provider to obtain authorization from the Plan (or the insurance issuer) for prescribing a length of stay not in excess of the above periods. Nothing in this provision, however, requires that a woman covered under this Plan give birth in a hospital or stay in the hospital a fixed period of time following the birth of her Child.

Post-Mastectomy Benefits

To the extent the Plan (or any insurance issuer) provides benefits for mastectomies, it will also provide coverage for reconstructive surgery of either or both breasts following a mastectomy (including for the purpose of attaining a symmetrical appearance) and for the treatment of physical complications at all stages of the mastectomy and the recovery period, including lymphedemas.

Genetic Information Nondiscrimination Act

The Plan complies with the Genetic Information Nondiscrimination Act of 2008. Participants and Eligible Dependents are not required to undergo genetic testing, nor shall the Plan use genetic information related to any employee or family member to determine eligibility to participate in the plan or to determine any required Employee Contribution for any health benefit provided under the plan.

Mental Health Parity and Addiction Equity Act

The Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") to the extent MHPAEA is applicable to the Plan. Nothing in the Plan will be construed to require any Benefit Program to

Indemnification

The Employer will indemnify each employee to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act, except when it is judicially determined to be due to the gross negligence or willful misconduct of the employee. The Employer may choose, at its own expense, to purchase and keep in effect sufficient liability insurance to cover any claim, loss, damage, expense, or liability arising from any employee's action or failure to act.

Type of Plan
The Plan is a welfare benefit pl

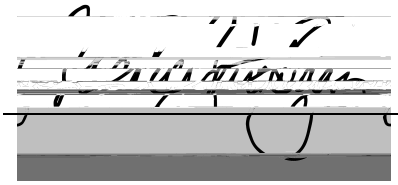
Construction

Non-Assignability of Rights

Errors

INDEX OF DEFINED TERMS

EXECUTION



APPENDIX A

PLAN DOCUMENTS CHART
Effective July 1, 2020

Benefit Program	Insurance Policy/Contract (if applicable)	Booklets

APPENDIX B

BENEFIT PROGRAM INFORMATION CHART
Effective July 1, 2020

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Medical/Rx Program	**Self-Funded**	
Dental Program	**Insured**	

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Long-Term Disability Program	Insured	
Life /AD&D Insurance Program	Insured	
Group Travel Accident	Insured	
EAP	Self-Insured	
Pre-Tax Payment Program	N/A	
Dependent Care FSA Program	N/A	

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Health Care FSA Program	**Self-Insured**	
HSA Contributions Program	**N/A**	
COBRA Administrator	**N/A**	