Steptoe LLP

Wrap Benefit Plan

Master Summary Plan Description

Amended/Restated Effective January 1, 2024

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

Table of Contents

1. Definitions 1
2. Introduction 2
3. General Information about the Plan 2
4. Eligibility and Participation Requirements 4
5. Summary of Plan Benefits 7
6. Grandfathered Status under the Affordable Care Act 9
7. How the Plan Is Administered 9
8. Circumstances Which May Affect Benefits 10
9. Amendment or Termination of the Plan 11
10. No Contract of Employment 11
11. No Assignment 11
12. Claims Procedure 12
13. Statement of ERISA Rights 13
14. General Information 15
15. Benefit Program Information 18
Appendix A: COBRA Continuation 24
Appendix B: Medicare Part D 28
Appendix C: Cafeteria Plan and FSA Provisions 30
Appendix D: Notice of HIPAA Privacy Practices 63
Appendix E: Authorized Representatives 68

1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

“Affordable Care Act” means the Patient Protection and Affordable Care Act, as amended.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

"Company" means Steptoe LLP, or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

"DCAP" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

"Employee" means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency. Unless otherwise specified, references to “employee” also include K-1 partners.

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

"Health FSA" means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

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

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Plan" means the Steptoe LLP Wrap Benefit Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information about the Plan

Plan Name:	Steptoe LLP Wrap Benefit Plan.
Type of Plan:	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
Plan Year:	January 1 to December 31.
Plan Number:	516
Effective Date:	January 1, 2014. The Plan has been amended several times since its original effective date, most recently as of January 1, 2023.
Funding Medium and Type of Plan Administration:	Some benefits under the Plan are self-funded, and some are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO. The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below.

	For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The Company may hire a third party administrator (a "TPA") to process claims. Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on r6equest for each of the benefit programs, as applicable. The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.
Plan Sponsor:	The employer is the Plan Sponsor. Steptoe LLP 1330 Connecticut Avenue, NW Washington, D.C., 20036 202-429-3000
Plan Sponsor's Employer Identification Number:	52-1349790
Insurance Companies/HMO:	See a complete list under the heading Plan Provider Information later in this document.
Plan Administrator:	Attention: Chief People Officer Steptoe LLP 1330 Connecticut Avenue, NW Washington, D.C., 20036 202-429-3000
Named Fiduciary:	Steptoe LLP 1330 Connecticut Avenue, NW Washington, D.C., 20036 202-429-3000
Agent for Service of Legal Process:	Attention: General Counsel Steptoe LLP 1330 Connecticut Avenue, NW Washington, D.C., 20036 202-429-3000 Service for legal process may also be made on the Plan Administrator.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage. ***Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment.*** However you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. ***Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.***

Eligible Dependent Status

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on "full-time" employees as defined by the ACA. A "full-time" employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the look-back method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

K-1 partners are not considered to be employees for purposes of the ACA.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state "premium assistance" through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis. You may also pre-pay contributions in advance of an anticipated leave on a pre-tax basis, and in limited and

approved circumstances, you may make catch-up contributions upon return from leave on a pre-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated or you may re-enroll for the remainder of the coverage period or plan year.

People Operations must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Total Rewards Team before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

5. Summary of Plan Benefits

Benefits and Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or

limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered “Creditable Coverage” under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA, WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women’s Health and Cancer Rights Act (WHCRA) of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998. 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 lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of “essential health benefits” are no longer permitted under the major medical plans offered by the Plan. For more information on

"essential health benefits" refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Total Rewards Team, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. Grandfathered Status under the Affordable Care Act

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not "grandfathered health plans" under the Affordable Care Act:

- UHC HSA PPO
- UHC PPO 90/70
- UHC PPO 100/50
- UHC Medicare Supplement

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated "A" or "B"). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

7. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The

administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurance Company

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

11. No Assignment

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take

action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

In its discretion, the Plan Administrator may voluntarily pay (or cause to be paid) benefits directly to an out-of-network hospital, facility, or other health care provider on behalf of a participant or beneficiary covered under this plan, and such payment will not constitute an assignment of rights or benefits and will not be deemed a waiver of this no assignment provision as to that participant or beneficiary or any other participant or beneficiary covered under this plan.

12. Claims Procedure

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

13. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: Cafeteria Plan, Health Savings Account (HSA), Dependent Care FSA (DCAP).

Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on 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, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care 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.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator 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 that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you 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 you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Questions

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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.

14. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be an asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company

contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest $1 or $10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the District of Columbia, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions – Benefit Programs Subject to ERISA

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
Medical and Pharmacy	Fully-Insured / United Healthcare PPOs	0729633	Regular employees and partners working an average of 24+ hours per week and retired partners. Coverage is generally available for legal spouse/domestic partner and children.	Date of hire, after proper election filed.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage is usually available.	UnitedHealthcare at: P.O. Box 30559 Salt Lake City, UT 84130 (866) 473-9032
Medical and Pharmacy	Fully-Insured / United Healthcare Medicare Supplement	0729633	Retired partners with Medicare eligibility. Coverage is generally available for legal spouse/domestic partner and children.	Date of retirement, after proper election filed.	At the end of the month in which coverage is dropped.	UnitedHealthcare at: P.O. Box 30559 Salt Lake City, UT 84130 (866) 473-9032
Expatriate Medical / Pharmacy / Dental / Vision	Fully-Insured / Cigna Global	04684B	Regular expatriates, inpatriates, third country nationals, and select key local nationals working an average of 24+ hours per week. Coverage is generally available for legal spouse/domestic partner and children.	Date of hire or eligibility, after proper election filed.	At the end of the month in which coverage is dropped or employment is terminated.	Cigna at: (800) 441-2668

[1] Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
Dental	Fully-Insured / MetLife	119349	Regular employees and partners working an average of 24+ hours per week and retired partners. Coverage is generally available for legal spouse/domestic partner and children.	Date of hire, after proper election filed.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage is usually available.	MetLife at: P.O. Box 981282 El Paso, TX 79998 (859) 389-6505
Vision	Fully-Insured / VSP	30107556	Regular employees and partners working an average of 24+ hours per week and retired partners. Coverage is generally available for legal spouse/domestic partner and children.	Date of hire, after proper election filed.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage is usually available.	VSP at: P.O. Box 385018 Birmingham, AL 35238 (800) 877-7195
Health FSA	Self-Funded / Navia Benefit Solutions	SJ0	Regular employees working an average of 24+ hours per week. Partners are not eligible. Expenses of spouses and children generally can be reimbursed at employee election.	Date of hire, after proper election filed.	Immediately upon termination of employment. Continuation coverage usually is available unless Health FSA is "overspent".	Navia Benefit Solutions at: P.O. Box 53250 Bellevue, WA 98015 (425) 452-3500
Employee Assistance Program	Fully-Insured / TELUS Health	N/A	Regular employees and partners working an average of 24+ hours per week.	Date of hire.	90 days after employment is terminated. Continuation coverage is usually available.	TELUS Health at: (877) 510-0556
Group Term Life	Fully-Insured / MetLife	119349	Regular employees and partners working an average of 24+ hours per week. Coverage is generally available for legal	Date of hire.	Immediately upon termination of employment.	MetLife at: P.O. Box 14590 Lexington, KY 40511 (570) 558-8645

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
			spouse/domestic partner and children.			
Group Accidental Death & Dismember-ment	Fully-Insured / MetLife	119349	Regular employees and partners working an average of 24+ hours per week. Coverage is generally available for legal spouse/domestic partner and children.	Date of hire.	Immediately upon termination of employment.	MetLife at: P.O. Box 14590 Lexington, KY 40511 (570) 558-8645
Long Term Disability	Fully-Insured / MetLife	119349	Regular employees and partners working an average of 24+ hours per week.	Date of hire.	Immediately upon termination of employment.	MetLife at: P.O. Box 14590 Lexington, KY 40511 (800) 230-9531
Short Term Disability	Self-Funded / MetLife	119349	Regular employees working an average of 24+ hours per week. Partners are not eligible.	Date of hire.	Immediately upon termination of employment.	MetLife at: P.O. Box 14590 Lexington, KY 40511 (800) 230-9531

[1] Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Summary of Eligibility and Participation Provisions – Benefit Programs Not Subject to ERISA

Note: This section lists benefit programs that are not subject to ERISA. These benefits are included here for reference purposes only. If you have any questions about eligibility or participation, contact the Plan Administrator

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[2]	To File a Claim, Contact:
Health Savings Account (HSA) (Not subject to ERISA)	Self-Funded / Optum Health Bank	729633	Regular employees and partners working an average of 24+ hours per week who are enrolled in the UHC PPO HSA plan, and meet IRS eligibility requirements for the HSA.	First of the month following date of hire, after election and establishment of account.	Date qualifying coverage is dropped or immediately upon termination of employment.	Optum Health Bank at: (866) 234-8913
Dependent Care Flexible Spending Account (FSA) (Not subject to ERISA)	Self-Funded / Navia Benefit Solutions	SJ0	Regular employees working an average of 24+ hours per week. Partners are not eligible.	Date of hire, after proper election filed.	Immediately upon termination of employment.	Navia Benefit Solutions at: P.O. Box 53250 Bellevue, WA 98015 (425) 452-3500
Health Advocacy (Not subject to ERISA)	Fully-Insured / Health Advocate	N/A	Regular employees and partners working an average of 24+ hours per week.	Date of hire.	Immediately upon termination of employment.	Health Advocate at: (866) 695-8622
Medical Accident (Not subject to ERISA)	Fully-Insured / Aflac	21048	Regular employees and partners working an average of 24+ hours per week. Coverage is generally	First of the month following enrolment.	Immediately upon termination of employment.	Aflac at: agi-claimsimaging@caicworksite.com (800) 433-3036

[2] Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[2]	To File a Claim, Contact:
			available for legal spouse/domestic partner and children.		Continuation coverage is usually available.	
Critical Illness (Not subject to ERISA)	Fully-Insured / Aflac	21048	Regular employees and partners working an average of 24+ hours per week. Coverage is generally available for legal spouse/domestic partner.	First of the month following enrollment.	Immediately upon termination of employment. Continuation coverage is usually available.	Aflac at: agi-claimsimaging@caicworksite.com (800) 433-3036
Commuter Benefit (Not subject to ERISA)	Self-Funded / HealthEquity (WageWorks)	N/A	Regular employees working an average of 24+ hours per week. Partners are not eligible.	First of the month, after proper election is filed.	Date coverage is dropped or immediately upon termination of employment.	HealthEquity (WageWorks) at: (877) 924-3967
Identity Theft (Not subject to ERISA)	Fully-Insured / LifeLock	N/A	Regular employees and partners working an average of 24+ hours per week.	First of the month following enrollment.	Immediately upon termination of employment.	LifeLock at: (800) 607-9174
Pre-Paid Legal (Not subject to ERISA)	Fully-Insured / MetLaw	119349	Regular employees and partners working an average of 24+ hours per week.	Date of hire, after proper election filed.	Immediately upon termination of employment.	MetLaw at: (800) 438-6388
Individual Disability (IDI) (Not subject to ERISA)	Fully-Insured / MetLife	N/A	Partners working an average of 24+ hours per week.	First of the month following enrollment.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage is usually available.	MetLife at: (571) 213-5890

Additional Information on ACA FT Status Determination

Under the ACA, employers are required to report specific benefits information to IRS on "full-time" employees as defined by the ACA. A "full-time" employee is generally an employee who works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility.

New employees hired to work full-time. If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group medical plan coverage as of your date of hire.

New employees hired to work a part-time, variable hour or seasonal schedule. If you are hired into a part-time position, a position where your hours vary and Steptoe LLP is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee. Your 12-month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average 130 or more hours a month over that 12 month period, you will be full time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends. Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing employees. Steptoe LLP uses the look-back measurement method to determine group medical plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which Steptoe LLP counts employee hours to determine which employees work full-time. An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect for a 12-month stability period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Steptoe LLP uses the standard measurement period and associated stability period annual cycle set forth below.

Measurement Period: Starts: November 1. Duration: 12 months. Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility.

Stability Period: Starts: January 1. Duration: 12 months. Time to determine which you will be considered "full-time" or "part-time" for medical plan eligibility – based on hours worked during preceding Measurement Period.

Appendix A: COBRA Continuation

GENERAL NOTICE OF YOUR RIGHTS
GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

THIS LETTER IS FOR YOUR INFORMATION ONLY. PLEASE RETAIN FOR FUTURE REFERENCE. THERE HAS NOT BEEN A CHANGE IN YOUR STATUS WITH YOUR COMPANY.

This letter contains important information about your employee benefits plan(s). Please read the entire letter.

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the Steptoe LLP group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan's "Summary Plan Description" or contact the Steptoe LLP Plan Administrator at (202) 429-3000. Also, you may visit the Department of Labor website (www.dol.gov) for more information on COBRA. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Qualifying Events

If you are an employee of Steptoe LLP covered by the Group Health Plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with Steptoe LLP;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

1. The death of the employee;
2. A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with Steptoe LLP;
3. The employee's divorce or legal separation;
4. The employee became entitled to Medicare prior to his/her qualifying event; or
5. The dependent child ceases to be a dependent child under the Group Health Plan.

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Steptoe LLP and that bankruptcy results in the loss of coverage of any retired employee under the Group Health Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

You may have other options available to you when you lose group health coverage?

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Coverage Provided

Under COBRA, the employee or a family member has the responsibility to inform the Steptoe LLP Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the date of the event. Steptoe LLP has the responsibility to notify the administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. When the administrator is notified that one of these events has happened, the administrator will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to inform the Steptoe LLP Plan Administrator that you want to continue coverage under COBRA.

If you elect COBRA, Steptoe LLP is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage. If you do not choose COBRA on a timely basis, your group health insurance coverage will end.

Period of Coverage

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months. Also, if you or your spouse gives birth to or adopts a child while on COBRA, you will be allowed to change your coverage status to include the child. The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, a qualified beneficiary must notify the Steptoe LLP Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the Steptoe LLP Plan Administrator within 30 days of any final determination that the individual is no longer disabled. If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

1. Divorce or legal separation
2. Death
3. Medicare entitlement
4. Dependent child ceasing to be a dependent

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the Steptoe LLP Plan Administrator within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA.

Health FSA Information

COBRA coverage under the Steptoe LLP Health FSA will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Steptoe LLP Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Steptoe LLP Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Steptoe LLP Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Navia Benefit Solutions at (425) 452-3490 during business hours for more information.

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Steptoe LLP during the covered employee's period of employment with Steptoe LLP is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Are there other coverage options besides COBRA Continuation Coverage

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Plan Contact Information

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

To ensure that all covered individuals receive information properly and timely, it is important that you notify our Customer Service Department at (425) 452-3490 of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted to us in writing. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

If you have any questions about COBRA, please contact our Customer Service Department at (425) 452-3490 during business hours.

Sincerely,

Navia Benefit Solutions

Steptoe LLP
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WAIVER OF ENROLLMENT NOTIFICATION REVISED 11/97

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents, if any, waive coverage due to coverage under another plan, and desire to participate in the plan offered at a later date, coverage may be subject to treatment as a late enrollee. If you decline enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after such marriage, birth of a child or placement of a child for adoption.

PRE-EXISTING CONDITION EXCLUSION

A pre-existing condition is an injury or sickness which was diagnosed or treated or for which prescription medications or drugs were prescribed or taken within the six months ending on the person's date of hire. A pre-existing condition does not include pregnancy or apply to newborn children or newly adopted children. To shorten or eliminate the period of time during which the pre-existing condition applies, you have the right to provide evidence of continuous creditable coverage. Any or all of the plans that provide prior coverage must give you a Certificate of Creditable Coverage. If necessary, the insurance carrier of this employer will assist in obtaining this certificate from the prior coverage. You will be notified of any pre-existing condition exclusion period, if one applies, upon receipt of a Certificate of Creditable Coverage. Limited or no coverage is provided for eligible expenses which result from a pre-existing condition until the earlier of the date you have had continuous creditable coverage for a period of six consecutive months and have not received treatment for the pre-existing condition or the date you have had continuous creditable coverage for 12 months. (NOTE: Under the Affordable Care Act, a group health plan must eliminate any pre-existing condition limitations as of the first day of the plan year that begins in 2014.)

CERTIFICATE OF CREDITABLE COVERAGE

If you have a Certificate of Creditable Coverage you should attach it to your enrollment form and submit it to your group administrator for processing. If you receive the certificate after submitting your enrollment form, please forward it to your group administrator at your first opportunity.

If you have any questions about COBRA, please contact our Customer Service Department at (425) 452-3490 during business hours.

Sincerely,

Navia Benefit Solutions

Appendix B: Medicare Part D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Steptoe LLP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Steptoe LLP has determined that the prescription drug coverage offered by the Steptoe LLP Wrap Benefit Plan – specifically the UHC 100/50 PPO, UHC 90/70 PPO, UHC HSA-PPO and UHC Medicare Supplement - is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Steptoe LLP coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Steptoe LLP Wrap Benefit Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage. Note that prescription coverage through the Firm is tied to medical enrollment, and if you decide to drop your prescription coverage offered through the Firm, you (and any covered dependents) will also lose medical coverage.

If you do decide to join a Medicare drug plan and drop your Steptoe LLP medical and prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special

Enrollment Right. Retirees enrolled in the Medicare Supplement plan will not be able to re-enroll in the Steptoe LLP plan once coverage is dropped.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Steptoe LLP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Steptoe LLP changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2024
Name of Entity/Sender:	Steptoe LLP
Contact-Position/Office:	Judith Hagan
Address:	1330 Connecticut Avenue, NW Washington, DC 20036
Phone Number:	(202) 429-3000

Appendix C: Cafeteria Plan and FSA Provisions

TABLE OF CONTENTS

I. ARTICLE - PLAN DEFINITIONS

II. ARTICLE - PARTICIPATION

01. ELIGIBILITY
02. EFFECTIVE DATE OF PARTICIPATION
03. APPLICATION TO PARTICIPATE
04. TERMINATION OF PARTICIPATION
05. TERMINATION OF EMPLOYMENT
06. REINSTATEMENT OF A FORMER PARTICIPANT
07. DEATH

III. ARTICLE - CONTRIBUTIONS TO THE PLAN

01. SALARY REDIRECTION
02. APPLICATION OF CONTRIBUTIONS
03. PERIODIC CONTRIBUTIONS
04. EMPLOYER CONTRIBUTIONS

IV. ARTICLE - BENEFITS

01. BENEFIT OPTIONS
02. HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT
03. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT
04. HEALTH INSURANCE BENEFIT
05. DENTAL INSURANCE BENEFIT
06. VISION INSURANCE BENEFIT
07. GROUP TERM LIFE INSURANCE BENEFIT
08. LONG-TERM DISABILITY INSURANCE BENEFIT
09. SHORT-TERM DISABILITY INSURANCE BENEFIT
10. ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT
11. HEALTH SAVINGS ACCOUNT CONTRIBUTIONS
12. NONDISCRIMINATION REQUIREMENTS
13. NON-TAX DEPENDENT COVERAGE

V. ARTICLE - PARTICIPANT ELECTIONS

01. INITIAL ELECTIONS
02. SUBSEQUENT ANNUAL ELECTIONS
03. FAILURE TO ELECT
04. CHANGE IN STATUS

VI. ARTICLE - HEALTH FLEXIBLE SPENDING ACCOUNT

01. ESTABLISHMENT OF BENEFIT
02. DEFINITIONS
03. FORFEITURES
04. LIMITATION ON ALLOCATIONS
05. NONDISCRIMINATION REQUIREMENTS
06. COORDINATION WITH CAFETERIA PLAN
07. HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS
08. DEBIT AND CREDIT CARDS

VII. ARTICLE - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

01. ESTABLISHMENT OF ACCOUNT
02. DEFINITIONS
03. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS
04. INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS
05. DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS
06. ALLOWABLE DEPENDENT CARE REIMBURSEMENT
07. ANNUAL STATEMENT OF BENEFITS
08. FORFEITURES
09. LIMITATION ON PAYMENTS
10. NONDISCRIMINATION REQUIREMENTS
11. COORDINATION WITH CAFETERIA PLAN
12. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

VIII. ARTICLE - ERISA PROVISIONS

01. CLAIM FOR BENEFITS
02. APPLICATION OF BENEFIT PLAN SURPLUS
03. NAMED FIDUCIARY
04. GENERAL FIDUCIARY RESPONSIBILITIES
05. NONASSIGNABILITY OF RIGHTS

IX. ARTICLE - ADMINISTRATION

01. PLAN ADMINISTRATION
02. EXAMINATION OF RECORDS
03. PAYMENT OF EXPENSES
04. INSURANCE CONTROL CLAUSE
05. INDEMNIFICATION OF ADMINISTRATOR

X. ARTICLE - AMENDMENT OR TERMINATION OF PLAN

01. AMENDMENT
02. TERMINATION

XI. ARTICLE - MISCELLANEOUS

01. PLAN INTERPRETATION
02. GENDER AND NUMBER

03. WRITTEN DOCUMENT
04. EXCLUSIVE BENEFIT
05. PARTICIPANT'S RIGHTS
06. ACTION BY THE EMPLOYER
07. EMPLOYER'S PROTECTIVE CLAUSES
08. NO GUARANTEE OF TAX CONSEQUENCE
09. INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS
10. FUNDING
11. GOVERNING LAW
12. SEVERABILITY
13. CAPTIONS
14. CONTINUATION OF COVERAGE (COBRA)
15. FAMILY AND MEDICAL LEAVE ACT (FMLA)
16. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
17. UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)
18. COMPLIANCE WITH HIPAA PRIVACY STANDARDS
19. COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS
20. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT
21. GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)
22. WOMEN'S HEALTH AND CANCER RIGHTS ACT
23. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

XII. Appendix A

INTRODUCTION

The company amends and restates this Plan as of January 01, 2024 with an original effective date of January 1, 2014. Its purpose is to provide benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to elect between cash compensation or certain nontaxable benefit options as they desire. The Plan shall be known as the Steptoe LLP Flexible Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

I. ARTICLE - PLAN DEFINITIONS

01. **"Administrator"** means the Employer, unless another person or entity has been designated by the Employer pursuant to the Article titled: "Administration" to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including but not limited to the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.
02. **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in the Article titled: "Benefit Information".
03. **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under the Article titled: "Benefit Information". Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.
04. **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.
05. **"Compensation"** means the amounts received as compensation by the Participant from the Employer during a Plan Year.
06. **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

    "Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

    For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his or her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

    The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such

placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

07. **"Effective Date"** means January 01, 2018.

08. **"Election Period"** means the period, established by the Administrator, immediately preceding the beginning of each Plan Year, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to the Article titled: "Participant Elections".

09. **"Eligible Employee"** means any Employee who has satisfied the provisions of the Section titled: "Eligibility".

    An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

    An "Eligible Employee" shall exclude the following:

    - self-employed individuals

10. **"Employee"** means any person who is currently or hereafter employed by the Employer.

    The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

11. **"Employer"** means Steptoe LLP and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, or Adopting Employer.

12. **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

13. **"Grace Period"** means the two and one-half month period after the end of the Plan Year. The Grace Period allows a Participant with unused funds or contributions to be reimbursed for expenses incurred during the Grace Period. The effect of the Grace Period is that a Participant has up to 14 months and 15 days to use the funds for the Plan Year.

14. **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit, or any self-funded arrangement providing any Benefit offered for health and welfare coverage to Eligible Employees of the Employer.

15. **"Insurance Premium Payment Plan"** means the plan of benefits contained in the "Benefit Options" section of this Plan, which provides for the payment of Premium Expenses.

16. **"Insurer"** means any insurance company that underwrites a Benefit or any self-funded arrangement under this Plan.

17. **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

18. **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to the Section titled: "Application to Participate" and has not for any reason become ineligible to participate further in the Plan.

19. **"Plan"** means the flexible benefits plan described in this instrument, including all amendments thereto.

20. **"Plan Year"** means the 12-month period beginning January 01 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

21. **"Premium Expenses"** or **"Premiums"** means the Participant's cost for the Benefits described in the Section titled: "Benefit Options".

22. **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

23. **"Run-out Period"** means the set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the Plan Year.

24. **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to the Section titled: "Salary Redirection". These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under the Article titled: "Participant Elections".

25. **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his or her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

26. **"Spouse"** means "spouse" as defined in an Insurance Contract, then, for purposes of coverage under that Insurance Contract only, "spouse" shall have the meaning stated in the Insurance Contract. In all other cases, "spouse" shall have the meaning stated under applicable federal or state law.

II. ARTICLE - PARTICIPATION

01. **ELIGIBILITY**

An individual is eligible to participate in this Plan if the individual:

a. is an Eligible Employee as defined in the Article titled: "Definitions"

b. is working an average of 24 hours or more per week; and

c. is eligible for the group medical plan

02. **EFFECTIVE DATE OF PARTICIPATION**

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan.

03. APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his or her Benefit elections pursuant to the Section titled: "Change in Status".

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance, unless the Employee elects, during the Election Period, not to participate in the Plan.

04. TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

a. **Termination of employment.** The termination of Participant's employment, subject to the provisions of the Section titled: "Termination of Employment"

b. **Death.** The Participant's death, subject to the provisions of the Section titled: "Death" or

c. **Termination of the plan.** The termination of this Plan, subject to the provisions of the Section titled: "Termination".

05. TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his or her participation in the Benefit Options provided under the Section titled: "Benefit Options" shall be governed in accordance with the following:

d. **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

e. **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment- related Dependent Care Expense reimbursements for expenses within 90 days after the end of the Plan Year, limited by the balance in the Participant's Dependent Care Flexible Spending Account as of the date of termination.

f. **Health FSA, COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year for which contributions to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account, shall be applied and administered consistent with such further rights that a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B and the Section titled: "Continuation of Coverage" of the Plan.

06. REINSTATEMENT OF A FORMER PARTICIPANT

An Employee whose participation terminates and returns to an eligible status less than thirty days

later may re-enroll within thirty days of returning to an eligible status with a commencement date of the first of the month following the adjusted eligibility date. An Employee who re-enrolls in a Health Flexible Spending Account or Dependent Care Account after such time must re-enter the Plan and reinstate their original elections for that Plan Year with adjustments to the annual election amount as the Administrator deems necessary to prorate the annual election amount over the remainder of the Plan Year. Expenses incurred by the employee during the time that the employee was not a Participant will not be covered expenses unless COBRA was elected pursuant to the Article titled: "Continuation of Coverage (COBRA)".

Any Employee who terminates employment and is rehired into an eligible status after thirty days from the date of termination will be treated as a new enrollee under the Plan. If such Employee returns within the same Plan Year, prior contributions made to the Health Flexible Spending Account and/or the Dependent Care Account will be taken into consideration so as not to exceed Plan or IRS maximums.

07. DEATH

If a Participant dies, his or her participation in the Plan shall immediately cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to a particular specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

III. ARTICLE - CONTRIBUTIONS TO THE PLAN

01. SALARY REDIRECTION

Subject to the provisions of the section titled "Employer Contributions," benefits under the Plan shall be financed by Salary Redirections sufficient to support the benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his or her pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participant's elections made under the Section titled: "Initial Elections".

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to the Section titled: "Initial Elections") and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under the Article titled: "Participant Elections" and are consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

02. APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

03. PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

04. EMPLOYER CONTRIBUTIONS

The Employer may provide non-elective contributions in the form of Employer Funding into the Health Flexible Spending Account and Dependent Care Spending Account to the extent as described in the Section Titled: "Limitation on Allocations". Such contributions may be prorated for Participants who begin participating in the middle of the Plan Year. Contributions or matching contributions made to the Health Flexible Spending Account and Dependent Care Spending Account generally do not count toward the annual contribution limit as described in the Section Titled: "Limitation on Allocations".

IV. ARTICLE - BENEFITS

01. BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

- Health Flexible Spending Account
- Dependent Care Flexible Spending Account

In addition, each Participant shall have a sufficient portion of his or her Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

- Group Term Life
- Long-Term Disability
- Short-Term Disability
- Group Medical Plan
- Group Dental Plan
- Group Vision Plan
- Accidental Death & Dismemberment

02. HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case the Article titled: "Health Flexible Spending Account" shall apply.

03. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case the Article titled: "Dependent Care Flexible Spending Account" shall apply.

04. **HEALTH INSURANCE BENEFIT**

a. **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

b. **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

05. **DENTAL INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

06. **VISION INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

b. **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

07. **GROUP TERM LIFE INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's group term life Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable group term life Insurance Contracts for use in providing this group term life insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such group term life Insurance Contract shall be determined therefrom, and such group term life Insurance Contract shall be incorporated herein by reference.

08. **LONG-TERM DISABILITY INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's long-term disability Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable long-term disability Insurance Contracts for use in providing this long-term disability insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such long-term disability Insurance Contract shall be determined therefrom, and such long-term disability Insurance Contract shall be incorporated herein by reference.

09. **SHORT-TERM DISABILITY INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's short-term disability Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable short-term disability Insurance Contracts for use in providing this short -term disability insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such short-term disability Insurance Contract shall be determined therefrom, and such short-term disability Insurance Contract shall be incorporated herein by reference.

10. **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's accidental death and dismemberment Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable accidental death and dismemberment Insurance Contracts for use in providing this accidental death and dismemberment insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such accidental death and dismemberment Insurance Contract shall be determined therefrom, and such accidental death and dismemberment Insurance Contract shall be incorporated herein by reference.

11. **HEALTH SAVINGS ACCOUNT CONTRIBUTIONS**

a. Participants may elect to make contributions on a pre-tax basis to a Health Savings Account (“HSA”). The HSA is not an employer-sponsored benefit plan. It is an individual trust or custodial account that Participants open and which may be used to reimburse Participants for eligible medical expenses as set forth in Code Section 223.

12. **NONDISCRIMINATION REQUIREMENTS**

a. **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

b. **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination is prohibited by Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator

decides to reduce contributions or non- taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his or her non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his or her non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non- taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

13. NON-TAX DEPENDENT COVERAGE

a. If (i) Employee Salary Redirections are made to fund Benefits under the Plan, and (ii) the Employer allows a Participant to elect to cover a Non-Tax Dependent through the Participant's coverage under group Medical, Dental or Vision benefit(s), a Participant who elects to participate in the Salary Redirection program may pay on a pre-tax basis through salary reduction contributions the Participant's portion of the premium cost of coverage under the Employer's Medical, Dental or Vision Benefits, provided that the full fair market value of such Medical, Dental or Vision coverage for any such Non-Tax Dependent shall be includible in the Participant's gross income as a taxable benefit in accordance with applicable federal income tax rules. For purposes of this Plan, the Participant electing coverage for Non- Tax Dependent(s) shall be treated as receiving, at the time that coverage is received, cash compensation equal to the full fair market value of such coverage and then as having purchased the coverage with after-tax employee contributions.

b. Notwithstanding the foregoing, no medical care or dependent care expenses incurred by or with respect to a Non-Tax Dependent of a Participant shall be eligible for reimbursement as eligible expenses under the Health Flexible Spending Account or Dependent Care Flexible Spending Account.

V. ARTICLE - PARTICIPANT ELECTIONS

01. INITIAL ELECTIONS

An Employee who meets the eligibility requirements of the Section titled: "Eligibility" on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his or her effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

02. SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form or electronically, as provided by the Administrator, which spending account Benefit options he wishes to participate in. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which immediately follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

a. A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

b. A Participant may terminate his or her participation in the Plan by notifying the Administrator in writing or by electronic notification, as determined by the Employer, during the Election Period that he does not want to participate in the Plan for the next Plan Year;

c. An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in the Section titled: "Change of Status".

03. **FAILURE TO ELECT**

With regard to Benefits available under the Plan for which no Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits, subject to the provisions of the Section titled: "Change in Status" below.

With regard to Benefits available under the Plan for which Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

04. **CHANGE IN STATUS**

a. **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict with any of the provisions of this Plan, then such rules and regulations shall control. See below in this Section for other situations in which changes in Benefit elections are permitted.

   In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains eligibility for coverage under any other plan, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan is consistent with that change in status only if coverage for that individual becomes applicable or is increased under said other plan. Also, if the Participant, Spouse or Dependent loses eligibility for coverage under any other plan, then a Participant's election under the Plan to start or increase coverage for that individual under the Plan is consistent with that change in status only if coverage for that individual ceases or is decreased under said other plan.

   Regardless of the consistency requirement, if the individual, or the individual's Spouse or Dependent, becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

   Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the

Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

1. Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;
2. Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
3. Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;
4. Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and
5. Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

b. **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

c. **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) (collectively, an "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) that requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

1. The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or
2. The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan, and such coverage is actually provided.

d. **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of

the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

e. **Cost increase or decrease.** Notwithstanding subsection (a), if the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

   A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

f. **Loss of coverage.** Notwithstanding subsection (a), if the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

g. **Addition of a new benefit.** Notwithstanding subsection (a), if, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly- added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

h. **Loss of coverage under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

i. **Change of coverage due to change under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse, former Spouse's employer or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse, former Spouse's employer or Dependent's employer permits its participants to make a change; or

   (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse, former Spouse's employer or Dependent's employer.

j. **Change in dependent care provider.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in a dependent care provider. The availability of dependent care services from a new dependent care provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

k. Notwithstanding subsection (a), a Participant may prospectively revoke his or her election of group health plan coverage if (i) the Participant changes from full-time employment (i.e., an average of 30 hours of service per week) to part-time employment (i.e., an average of less than 30 hours of service per week), even if the Participant continues to be eligible for coverage under the group health plan, and (ii) the Participant, and any related individuals whose coverage is also to be revoked, intend to enroll in another plan that provides minimum essential coverage and is effective no later than the first day of the second month after the month during which the revocation is effective.

l. Notwithstanding subsection (a), a Participant may prospectively revoke his or her election of group health plan coverage if (i) the Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace, or seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period, and (ii) the Participant, or any covered dependents intend to enroll in a Qualified Health Plan through a Marketplace that is effective no later than the day immediately following the effective date of the revocation.

m. **Health Savings Account changes** Notwithstanding subsection (a), with regard to the Health Savings Account Benefit specified in the Article titled: "Benefits", a Participant who has elected to make elective contributions under such arrangement may modify or revoke the election prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder.

n. **Health Flexible Spending Account cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

VI. ARTICLE - HEALTH FLEXIBLE SPENDING ACCOUNT

01. ESTABLISHMENT OF BENEFIT

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of allowable Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Participant's Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

02. DEFINITIONS

For the purposes of this Article and the Plan, the terms below have the following meanings:

a. **"Health Flexible Spending Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by the Participant, his or her Spouse and his or her Dependents may be reimbursed.

b. **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

1. one of the 5 highest paid officers;
2. a shareholder who owns (or is considered to own, applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
3. among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

c. **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his or her tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

   A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his or her Spouse or Dependent.

d. A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

e. The definitions of the Article titled: "Plan Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

03. FORFEITURES

The amount in the Health Flexible Spending Account as of the end of the allowable 2.5 month Grace Period, as defined in the Article titled: "Definitions", of the normal Plan Year (including any applicable run-out period and the processing of all claims for such Plan Year pursuant to the Section titled: "Health Flexible Spending Account Claims" hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

04. LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary redirections that may be allocated to the Health Flexible Spending Account by a Participant in any Plan Year is $3,200.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code.

05. NONDISCRIMINATION REQUIREMENTS

a. **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

b. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section and/or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

06. COORDINATION WITH CAFETERIA PLAN

All Participants under the Plan are eligible to receive Benefits under this Health Flexible Spending Account. Enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible

Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

07. **HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS**

a. **Expenses must be incurred during Plan Year.** All eligible Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed, subject to the Section titled: "Termination of Employment", even though the submission of such a claim occurs after his or her participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

b. **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his or her Spouse or Dependents.

c. **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time after incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

d. **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within the 2.5 month Grace Period, as defined in the Article titled: "Definitions" or within 90 days after the end of the Plan Year, that Medical Expense claim shall not be considered for reimbursement by the Administrator. Moreover, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after the end of the Plan Year.

08. **DEBIT AND CREDIT CARDS**

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

a. **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other

plan covering health benefits.

b. **Card issuance.** Such card shall be issued upon the Participant’s Effective Date of Participation and reissued or remain in effect for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant’s death

or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

c. **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in the Section titled: "Limitation on Allocations".

d. **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

e. **Card use.** The cards shall only be used for Medical Expense purchases as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, including, but not limited to, the following:

1. Co-payments for doctor and other medical care;
2. Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;
3. Purchase of medical items such as eyeglasses, syringes, crutches, etc.

f. **Substantiation.** Such purchases by the cards shall be subject to confirmation by the Administrator, usually by requiring the Participant to submit a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation by the Administrator.

g. **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

1. Repayment of the improper amount by the Participant;
2. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law;
3. Claims substitution or offset of future claims until the amount is repaid; and
4. If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

VII. ARTICLE - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

01. ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment- Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

02. DEFINITIONS

For the purposes of this Article and the Plan, the terms below shall have the following meaning:

a. **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

b. **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

c. **"Employment-Related Dependent Care Expenses"** means the amounts paid for those expenses of a Participant that, if paid by the Participant, would be considered employment related expenses under Code Section 21(b)(2). Generally, they include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period during which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for, the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

1. If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment Related Dependent Care Expenses only if incurred for a Qualifying Dependent (as defined in the "Definitions" Section of the Article titled: "Dependent Care Flexible Spending Account") who regularly spends at least eight (8) hours per day in the Participant's household;

2. If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

3. Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid to or incurred by a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

d. **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

1. a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

2. a Dependent or Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

3. a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

e. The definitions of the Article titled: "Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

03. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

04. INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the amount of Cafeteria Plan Benefit Dollars that he has elected to apply toward his or her Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

05. **DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of the Participant pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof.

06. **ALLOWABLE DEPENDENT CARE REIMBURSEMENT**

Subject to limitations contained in the Section titled: "Limitation on Payments" below, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

07. **ANNUAL STATEMENT OF BENEFITS**

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under the Section titled: "Definitions" during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

08. **FORFEITURES**

The amount in the Participant's Dependent Care Flexible Spending Account as of the end of the allowable 2.5 month Grace Period, as defined in the Article titled: "Definitions", of the normal Plan Year (and after the applicable run-out period and processing of all claims for such Plan Year pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

09. **LIMITATION ON PAYMENTS**

a. **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any tax year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000.00 (or cannot exceed $5,000 as provided under Code Section 129 or $2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

10. **NONDISCRIMINATION REQUIREMENTS**

a. **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination is prohibited under Code Section 129(d).

b. **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of (i) the stock of, or (ii) the capital or profits interest in, the Employer.

c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination is prohibited by Code Section 129, it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be

reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

11. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

12. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS**

The Administrator shall direct the payment of all qualified Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

a. The Dependent or Dependents for whom the services were performed;

b. The nature of the services performed for the Dependent, the cost of which the Participant wishes reimbursement;

c. The relationship, if any, of the person performing the services to the Participant;

d. If the services are being performed by a child of the Participant, the age of the child;

e. A statement as to where the services were performed;

f. If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

g. If the services were being performed in a day care center, a statement:

1. that the day care center complies with all applicable laws and regulations of the state of residence,

2. that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

3. of the amount of fee paid to the provider.

h. If the Participant is married, a statement containing the following:

1. the Spouse's salary or wages, if he or she is employed, or

2. if the Participant's Spouse is not employed, that

i. he or she is incapacitated, or

ii. he or she is a full-time student attending an educational institution, and the months of the year during which he or she attends such institution.

i. **Claims for reimbursement.** If a Participant fails to submit a claim within 2.5 month Grace Period, as defined in the Article titled: "Definitions", or within 90 days after the end of the Plan Year, that Dependent Daycare claim shall not be considered for reimbursement by the Administrator.

VIII. ARTICLE - ERISA PROVISIONS

01. CLAIM FOR BENEFITS

a. **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

b. **Health FSA claims.** If a Participant fails to submit a claim under the Health Flexible Spending Account within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 90 days after the end of the Plan Year. Once a claim is submitted, the following timetable for claims and the rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the claim:

Notification of	15 days
Response by Participant	45 days
Review of claim denial	30 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

1. The specific reason or reasons for the denial.
2. Reference to the specific Plan provisions on which the denial was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review.
5. 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 Claim.
6. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided with the denial free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a decision on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the claim determination;
2. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review 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 claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

c. **Forfeitures.** Any balance remaining in the Participant's Dependent Care Flexible Spending Account or Health Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to the Section titled: "Forfeitures", whichever is applicable. Provided, any provision of the Plan to the contrary notwithstanding, where a Participant has properly appealed the denial of a claim and the appeal has not been finally resolved or the appeal has been finally resolved in favor of the Participant, no forfeiture shall take place as to any such balance in dispute. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited and returned to the Employer following a reasonable time after the date any such payment first became due.

02. **APPLICATION OF BENEFIT PLAN SURPLUS**

Any forfeited amounts credited to the benefit plan surplus may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

03. **NAMED FIDUCIARY**

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

04. GENERAL FIDUCIARY RESPONSIBILITIES

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

a. for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

b. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

c. in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

05. NONASSIGNABILITY OF RIGHTS

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so alienated or subjected shall not be recognized, except to such extent as may be required by law.

IX. ARTICLE - ADMINISTRATION

01. PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person or persons, including, but not limited to, one or more Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer or may be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery if no date is specified. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of ERISA, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

a. To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

b. To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

d. To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

e. To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

f. To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

g. To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such should be paid. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

h. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609 ; and

i. To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

02. EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, such records as pertain to their interest under the Plan.

03. PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

04. INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer or other benefit program that is self-insured whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

05. INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

X. ARTICLE - AMENDMENT OR TERMINATION OF PLAN

01. AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state and local laws, statutes and regulations.

02. TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such accounts shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

XI. ARTICLE - MISCELLANEOUS

01. PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in the Section titled: "Severability".

02. GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

03. WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

04. EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

05. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

06. ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by the Employer.

07. EMPLOYER'S PROTECTIVE CLAUSES

a. **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

b. **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

08. NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

09. INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant

as regular cash compensation, plus the Participant's share of any Social Security tax and Medicare tax that would have been paid on such compensation, less any such additional income tax, Social Security tax, and Medicare tax actually paid by the Participant.

10. FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11. GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event does the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of District of Columbia.

12. SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

13. CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

14. CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

15. FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

16. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

17. UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

18. COMPLIANCE WITH HIPAA PRIVACY STANDARDS

a. **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

b. **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

c. **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term

"payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information will not be used or disclosed for underwriting purposes.

d. **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

1. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

2. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

ii. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

iii. mitigation of any harm caused by the breach, to the extent practicable; and

iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

e. **Certification.** The Employer must and hereby does provide certification to the Plan that it agrees to adopt all required provisions as mandated under HIPAA for all non-exempt group health plans, including the following:

1. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

5. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

6. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

7. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

9. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information 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 information infeasible; and

10. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

19. **COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS**

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

f. **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

g. **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

h. **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Section titled: "Compliance with HIPAA Privacy Standards".

20. **MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

21. **GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

22. **WOMEN'S HEALTH AND CANCER RIGHTS ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

23. **NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

Appendix A

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. This Appendix A is designed to supersede any FSA appeal language contrary to the below. If a Claim under the Plan is denied in whole or in part, you will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure.

A level one appeal must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of your appeal (for example, your original claim, denial, claim documentation, and other correspondence or records). You may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. If you disagree with the level one appeal decision you may submit a request for a level two appeal to be determined by the Employer. You must submit a request for a level two appeal within 60 days of receipt of the level one denial notice. You will be notified within 30 days after the Employer receives the level two appeal (extended by reasonable time if necessary). The Employer has the exclusive right to interpret the appropriate plan provisions. Decisions of the Employer are conclusive and binding.

In the case of a claim under the Plan, the following timetable for claims applies:

Notification of whether claim is accepted or denied: 30 days

Extension due to matters beyond the control of the Plan: 15 days

Denial or insufficient information on the claim:

Notification of: 15 days

Response by Participant: 45 days

Review of claim denial: 30 days

You must file your level one appeal by submitting a written request by email, fax, or mail. Indicate level one appeal on the email, fax, or letter. You must submit a level one appeal before you can submit a level two appeal . For the **level one appeal** submit to:

Email: claims@naviabenefits.com (please send via secure or encrypted message only) Fax: 425-451-7002 or 866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review (if applicable);

(e) 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 claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

If your level one appeal is denied, you will have 60 days following receipt of the denial notification in which to appeal the decision in a level two appeal to your employer. You may submit written comments, documents, records, and other information relating to the claim (for example, your level one appeal, the original claim, denial, claim documentation, and other correspondence or records). If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

You must file your level two appeal by submitting a written request by email, fax, or mail. Indicate level two appeal on the email, fax, or letter. For the **level two appeal** submit to:

Email: claims@naviabenefits.com (please send via secure or encrypted message only) Fax: 425-451-7002 or 866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The level two appeal review 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 claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual. If applicable to your plan, you may have a right to bring a civil action under ERISA § 502(a) if you file a level two appeal and your request for benefits is denied.

Appendix D: Notice of HIPAA Privacy Practices

Steptoe LLP Wrap Benefit Plan

PRIVACY PRACTICES NOTICE

(Version 05/01/2013)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Contact Office.

Contact Office: Washington, DC

Privacy Official: Chief Innovation Officer and Practice Support

Telephone: 202-429-3000

Health Plans Covered by this Notice

This notice applies to the privacy practices of the health plans listed below. They may share

with each other your medical information, and the medical information of others they service, for the health care operations of their joint activities.

Healthcare Flexible Spending Account

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **January 1, 2023**, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may

revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group health plan document for a full explanation of those limitations.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;

- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request in writing to our Contact Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request **{in writing}** to the contact at the end of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the contact at the end of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for

communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

QB\21643961.1

Appendix E: Authorized Representatives

Appointment of Authorized Representative

I, _____

[name of claimant]

hereby appoint_____ to act on my behalf

[name of Authorized Representative]

or on behalf of_____

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

□ Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

_____ _____

Claimant's signature Date

Accepted:_____ _____

Authorized Representative's signature Date

Witness:_____ _____

Witness signature Date