IMA Group Health and Welfare Benefits Plan

Plan Document and Summary Plan Description

January 1, 2025

IMA Group Health and Welfare Benefits Plan

Preamble

A. Prior to January 1, 2025, IMA Financial Group, Inc. (the "Plan Sponsor") sponsored the IMA Group Health and Flexible Spending Account Plan – Plan 501 ("Plan 501") and the IMA Group Disability, Life, and Accident Plan – Plan 504 ("Plan 504").

B. Effective January 1, 2025, the Plan Sponsor merged Plan 504 with and into Plan 501.

C. Effective January 1, 2025, the Plan Sponsor caused Plan 501 to be amended and restated on the terms and conditions set forth in this plan document and to be re-named as the "IMA Group Health and Welfare Benefits Plan."

Plan Document and Summary Plan Description

1. Introduction and Important Notices

1.1 Name of Plan. The name of this Plan is the IMA Group Health and Welfare Benefits Plan. This Plan document is effective as of January 1, 2025.

1.2 Purpose of Plan. The purpose of this Plan is to provide Eligible Employees of the Plan Sponsor, and Eligible Employees of other Employers that have adopted this Plan, with certain specified benefits. This Plan is designed to be funded by Employee contributions and by Employer non-elective contributions. For certain qualified benefits, participation in this Plan is available on a pre-tax basis through the Cafeteria Plan. For certain other benefits, participation in this Plan is available on a post-tax basis.

1.3 Written Plan Document and Summary Plan Description. This document serves as both the written plan document and the Summary Plan Description for the Plan, as required under ERISA. It is very important to review this document carefully, including the definitions, to confirm a complete understanding of the benefits available, as well as your responsibilities, under the Plan. This document also explains the operation of certain pre-tax elections under the Plan Sponsor's Code Section 125 cafeteria plan (the "Cafeteria Plan"), but it is only a summary of the Cafeteria Plan, and it may omit details which may be of importance to you in a given situation. If there is any conflict between this document and the formal Cafeteria Plan documents, the terms and conditions of the Cafeteria Plan documents will control.

1.4 Multiple Component Benefits. This Plan offers multiple component benefits to Participants in accordance with the applicable Sub-Plan Documents and Benefit Descriptions. The component benefits available under this Plan as of the effective date of this document are set forth on Exhibit A hereto. The Plan Administrator may elect to treat separate component benefits, or groups of component benefits, as separate plans. A component benefit treated as a separate plan will not be subject to the requirements of ERISA solely because other component benefits are subject to ERISA (or would be subject to ERISA if treated as separate plans).

1.5 Documents Incorporated by Reference. The Cafeteria Plan is incorporated herein by reference. Benefits under this Plan may be paid from the general assets of the Employer, funded through a trust, or funded through the purchase of a group insurance policy or policies offered by an Insurance Carrier. If the Employer elects to fund benefits under this Plan through a trust, the trust document is incorporated herein by reference. Currently, the description of benefits, as well as certain

eligibility rules, waiting periods, and benefit limitations, are set forth in the applicable Sub-Plan Documents and Benefit Descriptions. The Sub-Plan Documents and Benefit Descriptions, along with any applicable certificates of insurance, riders, or insurance policies, are incorporated in this document by reference and constitute the "IMA Group Health and Welfare Benefits Plan."

1.6 Sub-Plan Documents and Benefit Description. You are encouraged to carefully review the Sub-Plan Documents and Benefit Descriptions in their entirety. You should pay particular attention to the limitations and exclusions described in the Sub-Plan Documents and Benefit Descriptions, and any required conditions precedent to receiving benefits (e.g., prior authorization), before incurring any claim for benefits. In addition, coverage may be reduced or unavailable for goods or services obtained out of network. If you have lost or misplaced one or more of your Sub-Plan Documents or Benefit Descriptions, a replacement will be furnished without cost to you upon request to the Plan Administrator.

1.7 Priority Among Documents. If any provision of this document conflicts with, or is inconsistent with, any other document related to a component benefit program offered under this Plan (including, but not limited to, any Sub-Plan Document, Benefit Description, or insurance policy), the Plan Administrator will attempt to construe this document and the conflicting document or documents as consistently as possible, but the Sub-Plan Documents, Benefit Descriptions, and insurance policies will take priority over this document as to the scope and description of benefits provided under this Plan, and this document will take priority as to any other matters regarding the Plan, including eligibility for benefits under the Plan.

1.8 Notice Under Newborns' and Mothers' Health Protection Act of 1996. Group health plans and health insurance issuers offering group insurance coverage 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 normal vaginal delivery, or less than 96 hours following a caesarian section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

1.9 Notice Under Women's Health and Cancer Rights Act of 1998. Federal law provides that group health plans and health insurance issuers providing health insurance coverage in connection with group health plans must provide certain medical and surgical benefits with respect to a mastectomy. If you are a participant in the plan, or a beneficiary of the plan, and you receive benefits in connection with a mastectomy and you elect breast reconstruction in connection with that mastectomy, the plan must provide coverage for: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and, physical complications of all stages of mastectomy including lymphedemas. The above coverage is subject to any deductibles and co-insurance provisions contained within the plan.

1.10 Notice of Special Enrollment Rights.

(a) **Late Enrollees.** If you decline enrollment in group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in such group health coverage if you or your dependents lose eligibility for that other coverage (or if another employer stops contributing toward your or your dependents' other coverage). However, you generally must request enrollment within 30 days after your or your dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

(b) **New Dependents.** 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. However, you generally must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(c) **Requesting Special Enrollment.** To request special enrollment or obtain more information, contact the Plan Administrator at the address or phone number provided in this Summary Plan Description.

1.11 Notice Regarding Patient Protections. If you have coverage under a non-grandfathered group health plan that permits or requires the designation of a primary care provider, the following special rights are available:

(a) You have the right to designate any primary care provider who participates in the plan's network and who is available to accept you and your family members. For information on how to select a primary care provider, and for a list of the plan's participating primary care providers, consult the Benefit Description or contact the Plan Administrator.

(b) For children, you may designate a pediatrician as the primary care provider.

(c) If the plan provides coverage for obstetric or gynecological care, you do not need prior authorization to obtain access to obstetric or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, consult the Benefit Description or contact the Plan Administrator.

1.12 Notice Regarding Children's Health Insurance Program. Medicaid and the Children's Health Insurance Program ("CHIP") offer free or low-cost health coverage to qualifying children and families. If you are eligible for health coverage under the Plan but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you are eligible for premium assistance under Medicaid or CHIP, the Plan may be required to permit you and your dependents to enroll in the Plan, so long as you request coverage within 60 days of being determined eligible for premium assistance.

2. Definitions

When the following words and phrases appear in this document, they have the following meanings, unless the context clearly indicates otherwise:

2.1 "ACA" means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

2.2 "Administrator" or **"Plan Administrator"** means the Plan Sponsor or one or more person(s) or entities designated by the Plan Sponsor to carry out various administrative and other duties with respect to the Plan in a manner consistent with the terms of the Plan and ERISA.

2.3 **"Benefit Description(s)"** means the document(s) (including, but not limited to, schedules of benefits, benefit description booklets, certificates of insurance, certificates of coverage, insurance contracts, or other similar documents) describing benefits provided under the component benefit programs offered from time to time pursuant to this Plan.

2.4 **"Cafeteria Plan"** means the cafeteria plan established by the Plan Sponsor in accordance with Section 125 of the Code.

2.5 **"Carrier"** or **"Insurance Carrier"** means any insurance company providing underwriting and/or group benefits for the Plan.

2.6 **"Claims Administrator"** means the person(s) or entity(ies) duly authorized by the Plan Sponsor and/or the Plan Administrator to administer all or part of the Plan.

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

2.8 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time, and corresponding provisions of future United States revenue laws, along with any applicable proposed, temporary, or final regulations issued by the United States Treasury.

2.9 **"Eligible Employee"** means an Employee of the Employer who has met the eligibility conditions of the Plan or one or more component benefits. The determination whether an individual constitutes an "Eligible Employee" for purposes of the Plan and any component benefit will be made by the Employer, subject to the approval and consent of the Plan Administrator in its sole discretion.

2.10 **"Employee"** means an individual who is a common-law employee of the Employer, subject to the following limitations:

(a) An "Employee" does not include any individual classified, treated, or characterized by the Employer as an independent contractor, consultant, leased employee, or temporary agency employee or otherwise not treated by the Employer as an "Employee" for purposes of the Plan.

(b) An "Employee" does not include any individual covered under the provisions of a collective-bargaining agreement unless such collective-bargaining agreement specifically provides for participation in the Plan.

The determination whether an individual constitutes an "Employee" for purposes of the Plan will be made by the Employer, subject to the approval and consent of the Plan Administrator in its sole discretion. Said determination will apply for all purposes of the Plan and regardless of whether an individual is later classified by any governmental agency, court, tribunal, governing body, or any other person or entity as a common-law employee of the Employer. It is the intent hereof that the Employer, subject to the approval and consent of the Plan Administrator, in its sole discretion, will decide which individuals are classified as Employees for purposes of the Plan.

2.11 **"Employer"** means the Plan Sponsor, the IMA Foundation, and any other affiliated employer within the meaning of Code Section 414(b), (c), or (m) that adopts this Plan for the benefit of its Employees.

2.12 **"Enrollment Period"** means the time period established by the Plan Administrator in which benefit elections must be made.

2.13 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time, and corresponding provisions of similar, future United States laws dealing with employee benefit plans.

2.14 **"FMLA"** means the Family and Medical Leave Act of 1993, as amended.

2.15 **"GINA"** means the Genetic Information Nondiscrimination Act of 2008.

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

2.17 **"HITECH"** means the Health Information Technology for Economic and Clinical Health Act.

2.18 **"Highly Compensated Employee"** means an individual defined by Code Section 125.

2.19 **"Key Employee"** means an individual defined by Code Section 416(i)(1).

2.20 **"Membership Costs"** means an Eligible Employee's contribution for the Eligible Employee's share of the cost of selected component benefits under this Plan, as determined by the Employer and/or Plan Administrator from time to time.

2.21 **"MHPA"** means the Mental Health Parity Act.

2.22 **"MHPAEA"** means the Mental Health Parity and Addiction Equity Act.

2.23 **"Michelle's Law"** means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

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

2.25 **"Other Welfare Benefits"** has the meaning set forth in Section 3.3

2.26 **"Participant"** means any Eligible Employee (or as the context requires any eligible dependent) who is qualified in accordance with Article 3, and who remains as such under this Plan. Where the context requires, the term "Participant" also includes a former Participant.

2.27 **"Plan"** means the IMA Group Health and Welfare Benefits Plan, as set forth herein, together with any and all amendments and supplements to this plan document. The Plan Sponsor may maintain other documents that relate to the Plan, such as the Cafeteria Plan and a plan document or summary plan description for one or more of the component benefits.

2.28 **"Plan Sponsor"** means IMA Financial Group, Inc. and any successor thereto.

2.29 **"Plan Year"** means the 12-month period commencing January 1.

2.30 **"Sub-Plan Document"** means any separate plan document describing the terms and conditions applicable to one or more component benefit programs offered under this Plan.

2.31 **"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

2.32 **"WHCRA"** means the Women's Health and Cancer Rights Act of 1998.

3. Eligibility and Enrollment

3.1 Employee Eligibility. Subject to any limitations on participation set forth in the Cafeteria Plan (if applicable to the selected component benefits), an Eligible Employee is any Employee who is eligible to participate in and receive benefits under one or more of the component benefit programs in accordance with the terms and conditions of the Plan, including the terms of any applicable Sub-Plan Document and Benefit Description for the component benefit program. An Eligible Employee begins participating in the Plan upon making a timely and complete election to participate in a component benefit program in accordance with the terms and conditions established for that program or, if earlier, upon meeting the eligibility criteria and becoming covered under a component benefit program that does not require enrollment or an election.

An Eligible Employee must also meet all of the following requirements to be eligible to participate in and receive benefits under one or more of the component benefit programs:

(a) Agree and elect in the manner established by the Plan Administrator to reduce their compensation to pay the Membership Costs (if any) with respect to such component benefit program.

(b) Satisfy, prior to enrollment, any conditions established by the Plan Sponsor, Carrier, or applicable Sub-Plan Document or Benefit Description for such component benefit program.

(c) Unless otherwise provided in this document or an applicable Sub-Plan Document, work an average of 20 or more hours per week.

(d) Satisfy any waiting period in an applicable Sub-Plan Document.

Coverage takes effect on the first day of the month once all eligibility requirements and waiting periods have been satisfied, so long as timely enrollment is completed.

All Eligible Employees are eligible to receive employee assistance program (EAP) benefits, after (1) completing one hour of service, and (2) satisfying such other conditions (if any) that may be established by the Carrier or a Benefit Description for obtaining EAP coverage.

Solely for purposes of group medical and prescription drug coverage under the Plan, an Eligible Employee will also include an Employee who is a Full-Time Employee within the meaning of the policy set forth as Exhibit B to this document

3.2 Cessation of Participation. In general, a Participant will cease to participate in selected component benefits under this Plan as of the earliest of the following dates:

(a) The date such component benefits are no longer offered under this Plan;

(b) The date this Plan terminates;

(c) The end of the last period for which the required contribution was paid; or

(d) The date the Participant is no longer an Eligible Employee or coverage otherwise terminates under the Plan, a Sub-Plan Document, or a Benefit Description.

If a Participant is on an approved leave of absence, coverage may be continued for the period (if

any) set forth in the applicable Sub-Plan Document or Benefit Description. To continue coverage, Participants must continue to pay their share of any required contribution for such coverage.

3.3 Other Welfare Benefits. All Employees are eligible to receive such other welfare benefits as the Employer elects to provide through this Plan from time to time (e.g., on-site medical clinic, vaccines, or wellness benefits), after completing one hour of service. Benefits described in this Section are hereafter referred to as "Other Welfare Benefits."

3.4 FMLA Leaves of Absence. The provisions of this Section will only apply in the event of a Participant's leave of absence that is covered by the FMLA. The determination whether a leave of absence is covered by the FMLA will be made by the Plan Administrator.

(a) **Health Benefits.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's health benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the cost of coverage.

The Employer may require Participants to continue all health benefits coverage while they are on paid leave, if Participants on non-FMLA paid leave are required to continue such coverage. In that case, the Participant's required share of the cost of coverage must be paid by the method normally used during any paid leave.

In the event of an unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her health benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her required share of the cost of coverage in one of the following ways:

(1) By sending monthly payments to the Employer by the due date established by the Employer.

(2) By either (A) having such amounts withheld from the Participant's ongoing compensation (if any), including vacation pay, sick pay, or paid time off; or (B) pre-paying all or a portion of the costs for the expected duration of the leave out of pre-leave compensation. To pre-pay costs, the Participant must make a special election to that effect before the date that such compensation would normally be made available.

(3) Under another arrangement agreed upon between the Participant and the Plan Administrator.

If the Employer requires all Participants to continue health benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required share of the cost of coverage until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the costs not paid by the Participant during the leave. Payment will be withheld from the Participant's compensation in the manner agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

If a Participant's health benefit coverage under one or more component benefits ceases

while on FMLA leave (e.g., for non-payment of the Participant's required share of the cost of coverage), then the Participant is permitted to re-enter the applicable component benefit upon return from such leave on the same basis as when the Participant was participating in the Plan before the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose health benefit coverage under one or more component benefits terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, so long as Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Special rules apply to reinstatement of coverage under a health FSA (if applicable), and the Sub-Plan Document and Benefit Description for the health FSA benefit (if the Plan includes a health FSA benefit) should be consulted for further information.

(b) **Non-Health Benefits.** If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as life insurance or dependent care benefits) is to be determined by the Employer's policy for providing such benefits when Participants are on non-FMLA leave. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Participant's share of the cost of coverage not paid by the Participant during the leave. Payment will be withheld from the Participant's compensation in the manner agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Participant's required share of the cost of coverage will be paid by pre-payment before going on leave, by sending payments to the Employer while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the applicable election change rules in the Cafeteria Plan will apply.

3.6 Eligibility When Re-Employed. If a Participant quits working after becoming eligible to participate and returns to work during the same plan year, special rules may apply to pre-tax elections made under the Cafeteria Plan. In some cases, the Participant may not be allowed to make a new election and will be required to continue the Participant's election in place at the time the Participant left employment, subject to recognized changes in status occurring during the Participant's absence.

3.7 Election Procedure and Enrollment. For each Plan Year, each Participant may elect to have such Participant's compensation reduced throughout the Plan Year and applied by the Employer toward payment of Membership Costs under this Plan.

Before the first pay day in a new Plan Year, and any other required time of enrollment, the Plan Administrator may provide new enrollment information to each Participant and to each other Employee who is expected to become eligible for participation. Enrollment must be completed in the manner established by the Plan Administrator during the Enrollment Period which will terminate before the beginning of the first pay period for which the Participant's new election will apply.

A new Participant or Eligible Employee who fails to make an election with respect to available component benefits under this Plan on or before the last day of the Enrollment Period will be deemed to have elected not to participate in such component benefits under this Plan.

A Participant who has previously elected to make contributions to a health FSA or dependent care FSA but who fails to make an election or re-enroll on or before the last day of the Enrollment Period for any subsequent Plan Year with respect to such contributions is deemed to have elected not to make such contributions for the subsequent Plan Year. Unless otherwise provided in the applicable Sub-Plan Document or Benefit Description or as required by the Plan Administrator, **a Participant who has previously elected (or is deemed to have elected) to participate in any other component benefits under this Plan but who fails to make an election or re-enroll on or before the last day of the Enrollment Period for any subsequent Plan Year is deemed to have made the same elections as were in effect just prior to the end of the preceding Plan Year**. The Participant is also deemed to have agreed to a reduction in compensation for the subsequent Plan Year equal to the Participant's share of the cost (as determined by the Employer) of providing benefits under such component benefit programs.

Notwithstanding the foregoing, the Plan Administrator may require a Participant to make a new election with respect to one or more available component benefits, if the Plan Administrator deems it necessary or desirable to do so. In such event, the Participant will be notified before the beginning of the Enrollment Period of the requirement to make a new election, and if the Participant fails to make a new election on or before the last day of the Enrollment Period, the Participant will be deemed to have elected not to participate in such component benefits for the subsequent Plan Year.

A Participant may change such Participant's medical coverage option (including deductible level) during the Plan Year only as follows: in the case of a special enrollment period under HIPAA due to the birth, adoption or placement for adoption of a child and marriage/divorce.

All elections, including permitted changes in elections, will be effective at such time as the Plan Administrator prescribes, and the Claims Administrator can accommodate, under uniform and reasonable policies and procedures established by the Plan Administrator (e.g., changes in elections under this Plan will be effective as of the first day of the month following timely notice).

3.8 Irrevocability of Election. Pre-tax elections made under the Cafeteria Plan (or deemed made) are irrevocable by the Participant during the Plan Year subject only to certain changes specifically set forth in the Cafeteria Plan. Changes in elections under the Cafeteria Plan will be coordinated to coincide with changes in elections under this Plan. Any other elections with respect to available component benefits under this Plan may be changed only as provided in the applicable Sub-Plan Documents and Benefit Descriptions.

3.9 Changes by Plan Administrator. The Plan Administrator may take such actions as the Plan Administrator, in its sole discretion, deems appropriate for the operation and maintenance of this Plan and/or to assure compliance with all applicable laws and regulations, including, without limitation, modifying elections by Highly Compensated Employees and/or Key Employees without the consent of such individuals and electing to treat separate benefit arrangements as separate plans.

3.10 Certain Other Changes in Elections. Notwithstanding the general rule that elections under the Cafeteria Plan are irrevocable, changes under the Cafeteria Plan generally are permitted in accordance with the following:

(a) You may be allowed to revoke your election and make a new election if you have a change in status and your election change is consistent with your change in status. Permissible status changes include the following:

(1) Events that change your legal marital status including marriage, death of a spouse, divorce, legal separation, or annulment.

(2) Events that change the number of your dependents including birth, death, adoption, or placement for adoption.

(3) Any of the following events that change your employment status or that of your spouse or dependent: termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, a change in worksite or a change in employment status with the consequence that the individual becomes or ceases to be eligible to participate in a cafeteria plan or other employee plan benefit of such person.

(4) Events that cause your dependent to satisfy or cease to satisfy the requirements for coverage including attainment of a specified age, changes in student status, or other similar circumstance.

(5) A change in the place of residence or worksite of you or your spouse or dependent.

(6) Any other change or revocation which the Plan Administrator determines will allow a change or revocation of an election during the plan year under the regulations or rulings of the Internal Revenue Service.

(b) In addition to the foregoing status changes, the following changes will also be allowed:

(1) In the case of a plan subject to the Health Insurance Portability and Accountability Act of 1996 you may be allowed to revoke an election for coverage under a group health insurance plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f).

(2) A conforming election under a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health insurance coverage for your child or for a foster child who is your dependent (the foregoing includes an election to provide coverage for the child if the order requires coverage for the child under your plan and cancellation of coverage for the child if the order requires the spouse or former spouse or other individual to provide coverage for the child and that coverage is in fact provided).

(3) If you or your spouse or dependent is enrolled in an accident or health plan of the employer and become enrolled under Medicare Part A or Part B of Title XVIII of the Social Security Act or Title XIX of the Social Security Act (other than coverage consisting solely of benefits described in Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines)) you may make a prospective election to cancel or reduce coverage for that individual.

(4) If you or your spouse or dependent loses coverage under Medicare or Medicaid, a prospective election may be made to commence or increase coverage of that individual.

(5) If you change from full-time status (reasonably expected to average 30 or more hours per week) to part-time status (reasonably expected to average less than 30 hours per week), you may revoke your election for group health plan coverage under the Cafeteria Plan, even if your change in status does not affect your eligibility for group health coverage. To revoke your election, you must represent

that you (and any related individuals who would also lose coverage) intend to enroll in another plan providing minimum essential coverage, with such other coverage taking effect no later than the first day of the second month following the date you revoke your election for employer coverage.

Note: This election change only applies to group health coverage that is minimum essential coverage and does not allow you to revoke coverage for health FSA, dental, vision, or supplemental insurance coverage.

(6) If you become eligible to enroll in a qualified health plan (QHP) through a public exchange, you may revoke your election for group health coverage under the Cafeteria Plan, so you can enroll in the QHP. To revoke your election, you must represent that you (and any related individuals who would also lose coverage) intend to enroll in the QHP, with such coverage taking effect no later than the day immediately following the date your employer-sponsored coverage ends.

Note: This election change only applies to group health coverage that is minimum essential coverage and does not allow you to revoke coverage for health FSA, dental, vision, or supplemental insurance coverage.

(c) You may also be allowed to revoke a benefit election agreement for the balance of a plan year and make a new prospective election change if both the revocation and new election change is on account of and corresponds to an election change made under another employer's plan if (i) the other cafeteria plan or qualified benefit plan permits participants to make an election change under applicable IRS rules, or (ii) the plan year of this plan is different from the period of coverage under the other cafeteria plan or other qualified benefits plan.

(d) Also, if the cost of qualified benefits significantly increase or decrease during the plan year, the Plan Administrator may allow you to make a corresponding change in your election. Further, if you or your spouse or dependent experience a significant curtailment of coverage, the Plan Administrator may allow you to make certain prospective changes in your election.

Caution: Your ability to obtain or otherwise modify coverages under some of the above rules may be limited by the rules and requirements of any Insurance Carrier providing underwriting or benefits.

3.11 Automatic Termination of Election. Except as otherwise expressly provided in the Plan, elections made by a Participant (or deemed made) with respect to a coverage option will automatically terminate as of the date the individual ceases to participate with respect to such coverage option.

3.12 Qualified Medical Child Support Orders. To the extent required under ERISA Section 609(a), the Plan will extend benefits to an Eligible Employee's non-custodial child pursuant to a qualified medical child support order ("QMCSO"), including a National Medical Support Notice. The Plan has 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.

4. Plan Benefits and Funding

4.1 **Benefits.** A Participant will be subject to the Sub-Plan Documents and Benefit Description, and may not designate specific benefit arrangements or insurance policies contrary to the terms of the Sub-Plan Documents and Benefit Descriptions.

4.2 **Benefit Payments.** All benefits funded or provided through a policy or policies of insurance will be paid by the Insurance Carrier. The type and amount of benefits available will be governed by this Plan, the Sub-Plan Documents, and the Benefit Descriptions.

4.3 **Participant's Responsibilities.** Each Participant is responsible for providing the Plan Administrator the Participant's current address and, if requested by the Employer or Plan Administrator, the address, social security number, or other information of a covered spouse or dependent. The Plan Administrator will have no obligation or duty to locate a Participant.

4.4 **Right to Information.** Any person claiming benefits under the Plan must furnish the Plan Administrator (or its designee) with such information and documentation as may be necessary to verify eligibility for, or entitlement to, benefits under the Plan. The Plan Administrator (or its designee) will have the right and opportunity to have a covered individual examined when benefits are claimed and when, and so often as it may be, required during the pendency of any claim under the Plan.

4.5 **Circumstances that May Affect Benefits.** An Eligible Employee's benefits (and the benefits of the Eligible Employee's covered spouses and dependents) will cease when the Eligible Employee's participation in the Plan terminates (that is, when coverage ends), subject to any continuation coverage rights provided by law. Benefits also cease upon termination of the Plan. In both instances, expenses incurred before coverage ends generally remain payable. Other circumstances can result in the termination, reduction, recovery (e.g., through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied based on lack of medical necessity. The Sub-Plan Documents and Benefit Descriptions provide additional information.

4.6 **Funding.** The cost of coverage for Participants and their eligible spouses and dependents is paid in part by the Employer out of its general assets and in part by Participant contributions. Participant contributions will be used in their entirety before using Employer assets to pay for the cost of coverage under the Plan. Any refund, rebate, dividend, experience adjustment, or other similar payment or recovery relating to amounts paid toward the cost of coverage under the Plan will be allocated, consistent with the fiduciary obligations imposed by ERISA (if any), to first reimburse the Employer for costs it has paid.

4.7 **Cost of Spousal Coverage.** A Participant's premium for health coverage under this Plan will be increased by such amount (if any) as the Employer may from time to time determine if the Participant's spouse is enrolled in health coverage under this Plan and is eligible for coverage under any other group health insurance plan but has declined enrollment therein.

5. Continuation Coverage

5.1 **Continuation Coverage Under COBRA.** The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") enables employees that experience a "qualifying event" to continue group health plan coverage for 18, 29, or 36 months depending upon the nature of the "qualifying event."

COBRA continuation coverage can become available to you and to other members of your family

who are covered under a group health plan when you or your covered family members would otherwise lose your group health coverage. This section of your Summary Plan Description explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

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.

Description of COBRA Continuation Coverage

COBRA continuation coverage is a continuation of group health insurance coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under a group health plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualifying Events

If you are an employee, you will become a qualified beneficiary if you lose group health plan coverage because either one of the following qualifying events happens:

(a) Your hours of employment are reduced, or

(b) Your employment ends for any reason other than your gross misconduct.

If you are a spouse of an employee, you will become a qualified beneficiary if you lose group health plan coverage because any of the following qualifying events happens:

(a) Your spouse dies;

(b) Your spouse's hours of employment are reduced;

(c) Your spouse's employment ends for any reason other than his or her gross misconduct;

(d) Your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or

(e) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose group health plan coverage because any of the following qualifying events happens:

(a) The parent-employee dies;

(b) The parent-employee's hours of employment are reduced;

(c) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(d) The parent-employee becomes enrolled in Medicare (under Part A, Part B, or both);

(e) The parents become divorced or legally separated; or

(f) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer and that bankruptcy results in the loss of coverage of any retired employee covered under a group health plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under a group health plan.

When COBRA Continuation Coverage is Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee's becoming enrolled in Medicare (under Part A, Part B, or both), the Employer must notify the Administrator of the qualifying event within 30 days of any of these events.

A Qualified Beneficiary Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a qualified beneficiary must provide written notice of the qualifying event to the Administrator within 60 days after the qualifying event occurs (or, if later, the date coverage is lost as a result of the qualifying event), using the group health plan's notice procedures. If written notice of the qualifying event is not provided to the Administrator within this 60-day period, a spouse or dependent child that would otherwise lose group health plan coverage will not be given the opportunity to continue coverage.

How COBRA Continuation Coverage is Provided

Once the Administrator receives a timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiaries who are recognized by the group health plan as being entitled to elect COBRA continuation coverage with respect to the qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

A qualified beneficiary must elect COBRA continuation coverage within 60 days after the date notice of the right to elect COBRA continuation coverage is provided to the qualified beneficiary. If a qualified beneficiary does not elect continuation coverage within the 60-day election period, the qualified beneficiary will lose his or her right to elect continuation coverage.

The Trade Act of 2002 created a second 60-day election period for certain individuals that become

eligible for trade adjustment assistance pursuant to the Trade Act of 1974 ("TAA-eligible individuals"). In general, if a TAA-eligible individual loses health benefits coverage as a result of becoming a TAA-eligible individual (a "TAA-related loss of coverage") but does not elect COBRA continuation coverage within the general 60-day COBRA election period, the TAA-eligible individual may elect COBRA continuation coverage during the 60-day period beginning on the first day of the month in which he or she is determined to be a TAA-eligible individual, so long as the election is made no later than 6 months after the date of the TAA-related loss of coverage. More information about the Trade Act of 2002 is available at www.doleta.gov/tradeact/2002act_index.asp.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming enrolled in Medicare (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child under the group health plan, COBRA continuation coverage may last for up to a total of 36 months after the date of the qualifying event.

When the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became enrolled in Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may last for up to 36 months after the date of enrollment in Medicare. For example, if a covered employee becomes enrolled in Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months after the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If any qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and a qualified beneficiary provides timely written notice of the disability to the COBRA Administrator, all qualified beneficiaries receiving COBRA continuation coverage with respect to the same covered employee may be entitled to get up to 11 additional months of COBRA continuation coverage, for a total maximum of up to 29 months after the date of the qualifying event. The SSA's determination of disability must occur either before or during the first 60 days after the date of the qualifying event, and the disability must last at least until the end of the first 18 months after the date of the qualifying event. In general, a qualified beneficiary giving notice of a disability must provide written notice of the SSA's determination to the COBRA Administrator within 60 days after the latest of (i) the date of the SSA's determination, (ii) the date of the qualifying event, or (iii) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. In all events, a qualified beneficiary must give notice of a disability before the end of the first 18 months after the date of the qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Each qualified beneficiary who has elected continuation coverage with respect to the same covered

employee will be entitled to the 11-month disability extension if one of them qualifies. If the disabled qualified beneficiary is determined by the SSA to no longer be disabled, written notice of that fact must be given within 30 days after the SSA's determination using the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. Continuation coverage will cease for all qualified beneficiaries on the first day of the month that is 30 days after the date the SSA determines that the qualified beneficiary is no longer disabled. If timely written notice is not given that the qualified beneficiary is no longer disabled, coverage for all qualified beneficiaries may be retroactively cancelled and restitution to the group health plan may be required.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If, while receiving 18 months of COBRA continuation converge, a qualified beneficiary experiences another qualifying event that would have caused the qualified beneficiary to lose group health plan coverage if the first qualifying event had not occurred, the qualified beneficiary may get up to 18 additional months of COBRA continuation coverage, for a maximum of up to 36 months, if timely written notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the spouse and any dependent children getting COBRA if the employee or former employee dies, becomes enrolled in Medicare (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the group health plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred. In all of these cases, timely written notice of the second qualifying event must be given within 60 days after the date of the second qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Notwithstanding the foregoing provisions, COBRA continuation coverage will not be made available to any qualified beneficiary under a plan constituting a health care spending account plan for any plan year after the end of the plan year in which a qualifying event occurs if the following conditions are satisfied: (i) the plan is a health care spending account plan and excepted from compliance under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and (ii) the annual premium payment for COBRA continuation coverage equals or exceeds the maximum benefit available under the plan for the plan year.

Notice Procedures

Any notice you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must deliver your written notice to the COBRA Administrator at the addresses listed in this Summary Plan Description. If you mail your notice, it must be postmarked not later than the last day of the required notice period.

Any notice you provide must include the following:

(a) The name of the group health plan.

(b) The name and address of the employee covered under the group health plan.

(c) The name(s) and address(es) of the qualified beneficiary(ies).

(d) If the notice is a notice of a qualifying event or second qualifying event, the name of the qualifying event and the date it happened.

If the qualifying event is divorce or legal separation, the notice also must include a copy of the divorce decree or decree of legal separation. A notice of disability also must include the name of the disabled qualified beneficiary and a copy of the SSA's determination. If a qualified beneficiary is determined by the SSA to no longer be disabled, the notice of such determination also should include a copy of the SSA's determination.

Notice of a qualifying event or disability determination must be given using the group health plan's form. A copy of the necessary form may be obtained without charge by contacting the Administrator or COBRA Administrator.

Electing Continuation Coverage

To elect continuation coverage, you must complete the group health plan's election form and furnish it according to the directions of the form and the notice procedures specified above (see "Notice Procedures"). A copy of the required election form may be obtained from the Administrator or COBRA Administrator at no charge. Failure to make a timely written election will result in loss of the right to elect continuation coverage under the group health plan.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Additional information about whether to elect COBRA continuation coverage is available in Notice 98-12, which was prepared by the Internal Revenue Service and the Department of Labor and is available on the internet at www.dol.gov/ebsa. You also may contact the Administrator to obtain a copy of Notice 98-12.

Cost of Continuation Coverage

Generally, each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary will be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. You should contact the Administrator or COBRA Administrator for the required payment for continuation coverage.

Other coverage options may cost less. For example, you may be able to get coverage through the

Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace or vice versa?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful. If you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

(a) **Premiums.** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

(b) **Provider Networks.** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

(c) **Drug Formularies.** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

(d) **Severance Payments.** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time.

(e) **Service Areas.** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

(f) **Other Cost-Sharing.** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Payment For Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the election form, but you will not be covered under the group health plan until you make timely payment. You must make your first payment for continuation coverage not later than 45 days after the date of your election. (The date of your election is the date the election form is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full within this 45-day period, you will lose all COBRA continuation coverage rights under the group health plan.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent month of coverage. Although periodic payments are due on the applicable due date, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If you do not make your payment on the applicable due date, however, the group health plan may elect to suspend your coverage until payment is made, with coverage reinstated retroactively if payment is made within the grace period.

If your coverage is suspended, any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the group health plan.

You are responsible for making sure your payment amounts are correct. You may contact the Administrator or COBRA Administrator to confirm the correct amount of your payments. Your payments for continuation coverage must be sent to the COBRA Administrator listed at the beginning of this Summary Plan Description**.**

Conversion Rights

If a qualified beneficiary's COBRA continuation coverage ends because the qualified beneficiary has reached the end of the maximum coverage period described above (see "Length of COBRA Continuation Coverage"), a conversion insurance option may be available. In general, a qualified beneficiary may have the right to convert group health plan coverage to an individual policy of group health insurance if the qualified beneficiary applies promptly under the terms and conditions of the conversion provisions (if any) contained in the group health plan. For more information concerning conversion policies, please contact the COBRA Administrator.

Early Cessation of COBRA Continuation Coverage

COBRA continuation coverage will be terminated prior to the expiration date of the continuation period otherwise applicable (see "Length of COBRA Continuation Coverage" above) under the following circumstances:

(a) The employer (including any affiliate of the employer) ceases to provide any group health plan to any employee;

(b) Any required premium is not paid in full on time;

(c) A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition (other than an exclusion or limitation that does not apply to, or is satisfied by, such beneficiary by reason of chapter 100 of title 26, part 7 of subtitle B of ERISA);

(d) A qualified beneficiary becomes enrolled in Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage; or

(e) If a qualified beneficiary is receiving extended disability coverage, upon a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary is no longer disabled, in which case coverage will end the month that begins more than 30 days following the date of such determination.

Continuation coverage may also be terminated for any reason the group health plan would terminate coverage of a participant or dependent not receiving continuation coverage (such as fraud).

Other Coverage Options Besides COBRA

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.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator (or Plan Administrator, if there is no separate COBRA Administrator). 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.

Address Changes and Records

You should let the Administrator and COBRA Administrator, as applicable, know about any changes in the addresses of participants or beneficiaries under the group health plan that are, or may become, qualified beneficiaries under the group health plan. You should also keep a copy, for your records, of any notices you provide.

5.2 Continuation of Coverage Under USERRA. USERRA establishes continuation of coverage rights for certain Participants serving in the uniformed services. Continuation coverage under USERRA will be provided to the extent required by USERRA. Any election made by a USERRA-covered Participant pursuant to USERRA will also be an election under COBRA, if applicable, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA provide a Participant (or a covered spouse or dependent child, if any) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures applicable to COBRA coverage will also apply to USERRA coverage, unless compliance with such policies and procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

5.3 Continuation Coverage Under Other Law. Continuation of coverage will be made available under the Plan to the extent required by any other applicable law.

5.4 Special Rule for Other Welfare Benefits. Any COBRA qualified beneficiary who is covered under the Plan only for Other Welfare Benefits will be deemed to have timely elected to continue such coverage under this Plan upon the occurrence of a COBRA qualifying event. Benefits will continue for such qualified beneficiary until the end of the maximum COBRA coverage period, except that continuation coverage for Other Welfare Benefits will not terminate solely by reason of non-payment of premiums.

6. Plan Sponsor Authority and Actions

6.1 Plan Sponsor Duties. The Plan Sponsor will have the authority and responsibility for:

(a) Determining the design of this Plan, including the right to amend or terminate this Plan and the right to designate coverage options available pursuant to this Plan;

(b) The designation and removal of all fiduciaries of this Plan; and

(c) The exercise of all functions and powers as may be necessary to the operation of this Plan, except such functions as are assigned to others pursuant to this Plan.

6.2 Delegation of Duties. The Plan Sponsor may delegate its duties and responsibilities under this Plan to other persons.

6.3 Action by Plan Sponsor. Whenever the Plan Sponsor under the terms of this Plan is permitted or required to do or perform any act or matter or thing, it must be authorized by the Plan Sponsor's governing board or body or performed by an officer or other delegate thereunto duly authorized by such board or body.

7. Administration of Plan

7.1 Plan Administrator. The administration of this Plan will be under the supervision of the Plan Administrator. It will be a principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them. The Plan Administrator will have full power to administer this Plan in all of its details. For this purpose, the Plan Administrator's powers include, but are not limited to, the authority, in addition to all other powers provided by this Plan, to:

(a) Determine in its sole and absolute discretion the eligibility of any individual to participate in this Plan and of any individual to receive benefits under this Plan;

(b) Make discretionary interpretations regarding the terms of this Plan and make any factual findings with respect to any issue arising under the Plan, its interpretation to be final and conclusive on all persons claiming benefits under this Plan;

(c) Review and render decisions respecting benefit elections under this Plan;

(d) Make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of this Plan;

(e) Appoint such agents, specialists, legal counsel, accountants, consultants, or other persons as the Administrator deems advisable to assist in administering this Plan;

(f) Allocate and delegate its responsibilities under this Plan and designate other persons to carry out any of its responsibilities under this Plan;

(g) Be responsible for all reporting and disclosure requirements for this Plan under the law;

(h) Receive from the Plan Sponsor, Employer, Employees, Participants, and other persons such information as will be necessary for the proper administration of this Plan;

(i) Furnish to the Plan Sponsor upon request, such reports with respect to the administration of this Plan as are reasonable and appropriate; and

(j) Maintain all records of this Plan.

Notwithstanding the foregoing, the Plan Administrator's authority under this Section 9.1 will not extend to any matter as to which an administrator under any other plan is empowered to make determinations under such other plan.

7.2 Examination of Records. The Administrator will make available to each Participant and his or her duly authorized representative such of the records under this Plan as pertain to such Participant, for examination at reasonable times during normal business hours.

7.3 Reliance. In administering this Plan, the Administrator will be entitled to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by agents, specialists, legal counsel, accountants, consultants or other persons with whom the Administrator may contract for specific services or advice.

7.4 Named Fiduciary. The Administrator will be the "named fiduciary" for purposes of this Plan, except to the extent another person or entity is specifically named as the fiduciary with respect to a particular function (e.g., determination of a claim or appeal).

7.5 Discretion. Any discretion or judgment to be exercised by the Administrator will be exercised in the Administrator's sole and absolute discretion. If the Administrator is an individual, and if the Administrator's discretionary authority under this Plan must be exercised with respect to himself as a Participant, then such discretionary authority will be exercised solely and exclusively by the Plan Sponsor. If the Administrator is a committee, and if the Administrator's discretionary authority under this Plan must be exercised with respect to any member of the committee as a Participant, then such discretionary authority will be exercised solely and exclusively by the other members of the committee. If there are no such members of the committee, such discretionary authority will be exercised solely and exclusively by the Plan Sponsor.

7.6 Nondiscriminatory Exercise of Authority. Whenever, in the administration of this Plan, any discretionary action by the Administrator is required, the Administrator will exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially similar treatment.

7.7 Committee. If the Administrator is a committee of two or more persons, each member of the committee will be appointed by the Plan Sponsor. Such committee will act by a decision of a majority. When the membership of such committee is an even number and a majority decision cannot be obtained, the Plan Sponsor will decide the issue. Notwithstanding the foregoing, the committee may empower any member of the committee or such other person or persons as the committee may designate to act on behalf of the committee, such authorization to remain in effect until revoked by the committee. A dissenting committee member who, within a reasonable time after he has knowledge of any action or failure to act by the majority, registers his dissent in writing delivered to the other committee members and the Plan Sponsor, will not be responsible for any such action or failure to act.

7.8 Compensation and Expenses. The Plan Sponsor will pay to the Administrator and/or the Claims Administrator, at least annually, reasonable compensation for the Administrator's services hereunder at a rate to be agreed upon from time to time, unless the Administrator or Claims

Administrator (if the Administrator is a committee, any member of the committee) is then receiving compensation as an Employee of the Employer. All expenses of the Administrator may be paid or reimbursed by the Employer. Such expenses may include any expenses incident to the performance of the Administrator's duties and responsibilities, including, but not limited to, fees of agents, specialists, legal counsel, accountants, consultants and other persons, and other costs of administering this Plan.

7.9 **Resignation and Removal.** The Administrator or Claims Administrator may resign or may be removed by the Plan Sponsor at any time, with or without cause, such resignation or removal to be accomplished by the giving of 30 days' prior written notice. Upon such resignation or removal, the Plan Sponsor will appoint a successor Administrator or Claims Administrator, as the case may be, to whom the then Administrator or Claims Administrator will transfer all documents and records relating to this Plan. Such successor Administrator or Claims Administrator will thereupon succeed to all of the powers, title, rights, duties and immunities given to the Administrator or Claims Administrator, as the case may be, under this Plan. In the case where the Administrator is a committee, a resignation of the Administrator will be considered to have occurred only if at least 50% or more in number of the members of such committee have resigned. Where less than that number has resigned, the other members of the committee will continue to function as the Administrator under this Plan. In such event, the Plan Sponsor will appoint an additional person to fill each vacancy. However, no additional action will be needed to continue the viability of the committee as the Administrator. The same principles will apply for removal of members of the committee.

8. Claims for Benefits

8.1 **Claims Deferral.** Any claim which arises under this Plan for which benefits are paid by an Insurance Carrier will not be subject to review by the Employer, Claims Administrator, or Plan Administrator, and neither the Employer nor the Claims Administrator or Plan Administrator will have authority under this Article as to any matter to which another administrator or Insurance Carrier is empowered to make determinations under such policy of insurance or contract. It is the intent hereof that this Plan will defer to such Insurance Carrier's claims procedure.

8.2 **Claims for Fully Insured Benefits.** To obtain benefits, not otherwise automatically reimbursed or paid, from an Insurance Carrier, a claimant must follow the Insurance Carrier's claims procedures, which may require the claimant to complete, sign, and submit a written claim on the Insurance Carrier's claim form. Forms are available from the Insurance Carrier or applicable administrator.

The Insurance Carrier will decide a claimant's claim in accordance with its reasonable claims procedures, as required by ERISA. The Insurance Carrier has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide the claim. If the Insurance Carrier denies the claim, in whole or in part, the claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the claimant may appeal to the Insurance Carrier for a review of the denied claim. The Insurance Carrier will decide the claim appeal in accordance with its reasonable claims procedures, as required by ERISA. If a claimant fails to appeal on time, the claimant may lose the right to file suit in a state or federal court, as the claimant will not have exhausted the claimant's internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

Claimants should refer to the applicable Sub-Plan Documents and Benefit Descriptions for more

information about how to file a claim and for details regarding the applicable claims procedures.

8.3 Claims for Self-Funded Benefits. To obtain self-funded benefits, not otherwise automatically reimbursed or paid, a claimant must complete, sign, and submit a written claim form to the Plan Administrator (or designated Claims Administrator) on a form available from the Plan Administrator (or designated Claims Administrator).

The Plan Administrator (or designated Claims Administrator) will decide a claimant's claim in accordance with its reasonable claims procedures, as required by ERISA. The Plan Administrator (or designated Claims Administrator) has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide the claim. If the Plan Administrator (or designated Claims Administrator) denies the claim, in whole or in part, the claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the claimant may appeal for a review of the denied claim, as provided in the applicable claims procedures. The Plan Administrator (or designated Claims Administrator) will decide the claim appeal in accordance with its reasonable claims procedures, as required by ERISA. If a claimant fails to appeal on time, the claimant may lose the right to file suit in a state or federal court, as the claimant will not have exhausted the claimant's internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). The claims procedures established by the Plan Administrator (or designated Claims Administrator) may, but need not necessarily, include a voluntary second level of appeal of an adverse benefit determination.

Claimants should refer to the applicable Sub-Plan Documents and Benefit Descriptions for more information about how to file a claim and for details regarding the applicable claims procedures.

8.4 Claims Procedures. The procedures applicable to claims and appeals under this Plan will be as follows, unless otherwise provided in an applicable Sub-Plan Document or Benefit Description.

(a) **Claims Adjudication.** The Plan Administrator is responsible for evaluating all claims for benefits under the Plan. The Plan Administrator will decide a post-service claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The claimant will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Administrator is expected to be made. The claimant will be given 45 days in which to complete an incomplete claim. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

If the Plan Administrator denies a claim, in whole or in part, the claimant will be furnished with a written notice of adverse benefit determination setting forth:

(1) The specific reason or reasons for the denial,

(2) Reference to the specific Plan provision on which the denial is based,

(3) A description of any additional material or information necessary for the claimant to complete the claim and an explanation of why such material or information is necessary, and

(4) Appropriate information as to the steps to be taken if the claimant wishes to appeal the Plan Administrator's determination, including the right to submit written comments and have them considered, the right to review (on request and at no charge) relevant documents and other information, and the right to file suit under ERISA with respect to any adverse determination after appeal of the claim.

(b) **Right to Appeal.** If a claim is denied in whole or in part, the claimant may appeal to the Plan Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Plan Administrator's initial notice of adverse benefit determination, or else the claimant will lose the right to appeal the denial. If the claimant does not appeal on time, the claimant will also lose the right to file suit in court, as the claimant will have failed to exhaust the claimant's internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A written appeal should state the reasons that the claim should not have been denied. It should include any additional facts and/or documents that support the claim. The claimant may also ask additional questions and make written comments, and the claimant may review (on request and at no charge) documents and other information relevant to the appeal. The Plan Administrator will review all written comments submitted with the appeal.

(c) **Decision on Appeal.** The Plan Administrator will review and decide an appeal within a reasonable time not longer than 60 days after it is submitted and will notify the claimant of its decision in writing. The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with an appeal will be provided to the claimant.) If the decision on appeal affirms the initial denial of a claim, the claimant will be furnished with a notice of adverse benefit determination on review setting forth:

(1) The specific reason(s) for the denial,

(2) The specific Plan provision(s) on which the decision is based,

(3) A statement of the right to review (on request and at no charge) relevant documents and other information,

(4) If the Plan Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request, and

(5) A statement of the claimant's right to bring suit under ERISA § 502(a).

Additional information may be provided in connection with the denial of a claim for group health benefits, as required under ERISA and the ACA.

Legal action with respect to any claim may not be started until the claimant has exhausted the internal administrative appeal rights provided by the Plan.

(d) **Pre-Service Claims.** A claim is a "pre-service claim" if the Plan conditions receipt of benefits, in whole or in part, on receiving approval in advance of obtaining medical care (e.g., benefits requiring prior authorization). An initial pre-service claim will be decided within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. Written notification of the decision on a pre-service claim will be provided to the claimant whether or not the decision is adverse.

(e) **Urgent Care Claims.** An "urgent care claim" is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function, or would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. On receipt of a pre-service claim, a determination will be made as to whether it involves urgent care. A claim will be treated as an urgent care claim if a physician with knowledge of the claimant's medical condition indicates that the claim involves urgent care. An initial urgent care claim will be decided as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. Written notification of the decision on an urgent care claim will be provided to the claimant whether or not the decision is adverse. Appeal of an urgent care claim may be submitted to the Plan Administrator by telephone, fax, or email. The appeal of a denied urgent care claim will be decided as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt by the Plan of the request for review.

(f) **Concurrent Care Claims.** A decision on a "concurrent care claim" occurs when the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (1) when reconsideration of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; and (2) when an extension is requested beyond the initially approved period of time or number of treatments. If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the claim will be decided within no more than 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims. A decision by the Plan to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the claimant. Notification to the claimant of a decision by the Plan to reduce or terminate an initially approved course of treatment will be provided sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse decision and receive a decision on review prior to the reduction or termination. If the claimant does not file an appeal within 30 days of the claimant's receipt of the notification of the decision to reduce or terminate the approved course of treatment, the Plan may reduce or terminate the approved course of treatment. The appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment will be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend any concurrent care decision will be decided in the

appeal timeframe for pre-service, urgent care, or post-service claims, as appropriate to the request.

(g) **Incorrectly Filed Claims.** These claims procedures do not apply to any request for benefits that is not properly made, except that (1) in the case of an incorrectly filed pre-service claim, the claimant will be notified as soon as possible but no later than 5 days following receipt by the Plan of the incorrectly filed claim; and (2) in the case of an incorrectly filed urgent care claim, the claimant will be notified as soon as possible but no later than 24 hours following receipt by the Plan of the incorrectly filed claim.

(h) **Incomplete Claims.** If any information needed to process a claim is missing, as determined by the Plan, the claim shall be treated as an incomplete claim.

(1) **Incomplete Urgent Care Claims.** If an urgent care claim is incomplete, the Plan shall notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the claimant unless the claimant requests written notice. The notification will describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Plan shall decide the claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information; or (b) the end of the period of time provided to submit the specified information.

(2) **Other Incomplete Claims.** If a pre-service or post-service claim is incomplete, the Plan may deny the claim or may take an extension of time, as described below. If the Plan takes an extension of time, the extension notice shall include a description of the missing information and shall specify a period, of no less than 45 days, within which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

(i) **Designating an Authorized Representative.** An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under these claims procedures. No person (including a treating health care professional) will be recognized as an authorized representative until the Plan receives an appointment of authorized representative form signed by the claimant, except that for urgent care claims the Plan shall, even in the absence of a signed form, recognize a health care professional with knowledge of the claimant's medical condition (e.g., the treating physician) as the claimant's authorized representative, unless the claimant provides specific written direction otherwise. An appointment of authorized representative form may be obtained from, and completed forms must be submitted to, the Plan Administrator. Once an authorized representative is appointed, the Plan will direct all information and notices. regarding the claim to the authorized representative. The claimant will be copied on all notifications regarding decisions unless the claimant provides specific written direction otherwise. Where appropriate, references in these claims procedures to "claimant" include the claimant's authorized representative.

(j) **Requesting External Review.** In the case of a claim involving group health plan benefits (other than a claim under a plan or component benefit solely providing excepted benefits), a claimant may request external review of an adverse benefit determination by filing a request for external review within 4 months after the date of receipt of a notice of a final adverse benefit determination. The request for external review must be made in writing to the Plan Administrator.

8.5 Finality of Decisions. The Plan Administrator (or designated Claims Administrator) has full discretion in determining any matter regarding a claim for benefits or other claims involving the Plan. The decision of the Plan Administrator (or designated Claims Administrator) upon review of any claim shall be binding upon a claimant, their heirs and assigns, and all other persons claiming by, through or under a claimant.

8.6 Limitation of Claims Procedure. Except as otherwise required under and subject to the terms of an applicable Sub-Plan Document or Benefit Description, any claim under the Plan must be submitted within 12 months from the earlier of:

(a) The date on which the claimant learned of facts sufficient to enable him to formulate such claim, or

(b) The date on which the claimant reasonably should have been expected to learn of facts sufficient to enable him to formulate such claim.

8.7 Special Rulings. To resolve problems concerning the Plan and to apply the Plan in unusual factual circumstances, the Plan Administrator (or designated Claims Administrator) may make special rulings. Such special rulings will be in writing on a form to be developed by the Plan Administrator (or designated Claims Administrator). In making its rulings, the Plan Administrator (or designated Claims Administrator) may consult with third-party administrators, legal, accounting, and other counsel or advisers. Once made, special rulings shall be applied uniformly, except that the Plan Administrator (or designated Claims Administrator) will not be bound by such rulings in future cases unless the factual situation of a particular case is identical to that involved in the special ruling. Special rulings shall be made in accordance with all applicable law and in accordance with the Plan. It is not intended that the special ruling procedure will be used frequently but that it should be followed only in extraordinary situations. The Plan Administrator (or designated Claims Administrator) at all times will have the final decision as to whether resort will be made to this special ruling feature.

8.8 Uncashed Checks. If the Plan (through the Employer or a Claims Administrator or an Insurance Carrier) makes payment of an approved benefit claim and the check for such benefit claim remains uncashed (regardless of the reason) for a period of more than one year after the issue date of the check, then the payee will forfeit all rights for reimbursement or payment of such benefit claim under the terms of the Plan and will not be entitled to reinstate rights with respect to such benefit claim at any time thereafter.

9. Legal Actions

9.1 Limitations on Legal Actions. A claimant may not bring any legal action in court with respect to the Plan or any component benefit under the Plan until the claimant has exhausted all applicable internal claim and appeal procedures. The following requirements shall also apply:

(a) **Fully Insured Benefits.** Any legal action with respect to a claim for fully insured benefits must be brought within the time period prescribed in the applicable contract or policy of insurance or as otherwise prescribed by the Insurance Carrier.

(b) **Other Benefits.** Unless otherwise provided in an applicable Sub-Plan Document, any legal action with respect to any other claim for benefits under the Plan must be brought on or before the earliest to occur of the following:

(1) The date that is one year after the date a final determination of the claim has been made in accordance with the applicable claim and appeal procedures (or the date such final determination should have been made in accordance with such procedures).

(2) With respect to a claim for benefits, the date that is two years after the date of the service, treatment, or other occurrence on which the claim is based.

(3) With respect to a claim regarding eligibility, the date that is one year after the date on which the action giving rise to the eligibility claim occurred.

The failure to file a legal action in court before the expiration of the applicable deadline will bar any legal action.

9.2 Forum Selection. Unless otherwise provided in an applicable Sub-Plan Document, any action arising out of or in connection with the Plan may only be brought in the United States District Court for the District of Kansas.

10. Amendment

10.1 Right to Amend. The Plan Sponsor reserves the right, at will, at any time and from time to time, to modify, alter, or amend this Plan and/or the component benefits available under this Plan (including, without limitation, modifying any retiree medical coverage or making any retroactive modification, alteration, or amendment), in whole or in part, and any such modification, alteration, or amendment will be binding upon the Plan Administrator, any Claims Administrator, any adopting Employers, the Employees, the Participants, and all other persons. But the duties, powers, and liabilities of a Claims Administrator will not be substantially increased without the Claims Administrator's written consent. All amendments to this Plan must be in writing.

10.2 Retiree Coverage. In addition to the rights set forth in Section 10.1, the Plan Sponsor reserves all rights to make changes at any time in any benefits or other provisions relative to retiree benefits and/or coverage. Those changes could include the complete termination of benefits for all individuals, certain groups of individuals, or specified individuals; however, continuation of coverage rights under federal law, if any are then applicable, will be provided. In addition, the Employer reserves the right to make changes at any time and from time to time in the portion of the cost of such coverage to be paid by one or more classes of covered individuals. If required by law, a Participant will be given notice of any change which adversely affects benefits, costs, etc. and can cease participation if the change is not acceptable. No one will, however, acquire any vested (nonforfeitable) right to have benefits, costs, or other Plan provisions remain unmodified or in effect.

11. Termination

11.1 **Termination of Plan.** The Plan Sponsor has established this Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Plan Sponsor will have no obligation whatsoever to maintain this Plan, or any part of this Plan or the component benefits available under the Plan, for any given length of time and may at will, and at any time, discontinue or terminate this Plan in whole or in part without liability. In addition, an adopting Employer will have the right to discontinue or terminate its participation in this Plan as to its Employees.

11.2 **Termination Procedures.** Upon termination of this Plan, the Plan Sponsor will give notice of the same to all Participants, all individuals then receiving benefits under this Plan, the Plan Administrator, any Claims Administrator, and any other affected person. Further, upon termination of this Plan, all elections and reductions in compensation related to this Plan will terminate.

12. HIPAA Privacy and Security

12.1 **Purpose.** This Article establishes the framework for the Plan's compliance with 45 C.F.R. Parts 160 and 164, Subparts A and E (the "HIPAA Privacy Rule") and 45 C.F.R. Parts 160 and 164, Subparts A and C (the "HIPAA Security Rule"). It will only be applicable if and to the extent mandated by HIPAA and its accompanying regulations. In the case of any conflict between the provisions of this Article and the rules set forth in HIPAA or the regulations issued pursuant thereto, this Article will be interpreted in accordance with the then-current applicable rules and regulations.

12.2 **Privacy Officer, Security Officer, and Contact.** To the extent required under the HIPAA Privacy Rule and the HIPAA Security Rule, the Plan Administrator will designate an individual to serve as the Privacy Officer for the Plan and an individual to serve as the Security Officer for the Plan. The Privacy Officer and the Security Officer may be the same individual and each will serve at the pleasure of the Plan Administrator. The Privacy Officer will be responsible for oversight of all activities required for the Plan to satisfy the HIPAA Privacy Rule, and the Security Officer will be responsible for the development and implementation of the policies and procedures required by the HIPAA Security Rule for the Plan. In addition, to the extent required under the HIPAA Privacy Rule, the Plan Administrator will designate a contact person or office responsible for receiving complaints and providing further information regarding privacy issues under the HIPAA Privacy Rule.

12.3 **Definitions.** The following terms will have the meaning as set forth in this Article unless the context clearly indicates to the contrary.

(a) **"Business Associate"** has the meaning set forth in 45 C.F.R. § 160.103.

(b) **"Health Care Operations"** has the meaning set forth in 45 C.F.R. § 164.501.

(c) **"Payment"** has the meaning set forth in 45 C.F.R. § 164.501.

(d) **"Plan Administration Purposes"** means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring.

(e) **"Protected Health Information"** or **"PHI"** has the meaning set forth in 45 C.F.R. § 160.103.

(f) **"Electronic PHI"** has the meaning set forth in 45 C.F.R. § 160.103.

(g) **"Summary Health Information"** means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom health benefits have been provided under the Plan; and (2) from which the information described at 45 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(h) **"Underwriting Purposes"** means, with respect to the Plan, (1) rules for, or determination of, eligibility (including enrollment and continued eligibility) for, or determination of, benefits under the Plan or related coverage or policy (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan or related coverage or policy (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any pre-existing condition exclusion under the Plan or related coverage or policy; and (4) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. Notwithstanding the preceding sentence, however, Underwriting Purposes does not include determinations of medical appropriateness where an individual seeks a benefit under the Plan or related coverage or policy.

12.4 Permitted Uses and Disclosures of PHI. The following provisions address permitted uses and disclosures of PHI by the Plan.

(a) **Enrollment and Disenrollment Information.** The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) **Summary Health Information.** The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, so long as the Plan Sponsor requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan. Notwithstanding the preceding sentence, however, the Plan may not use or disclose PHI that is genetic information for Underwriting Purposes.

(c) **Plan Administration Purposes.** Unless otherwise permitted by law, and subject to the conditions described in Section 12.5 and obtaining written certification pursuant to Section 12.9, the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI and Electronic PHI to the Plan Sponsor, so long as the Plan Sponsor uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes. Plan Administration Purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions. Enrollment and disenrollment functions performed by the Plan Sponsor are performed on behalf of Plan participants and beneficiaries and are not Plan Administration Purposes. Enrollment and disenrollment information held by the Plan Sponsor is held in its capacity as an employer and is not PHI.

(d) **Compliance with Regulations.** Notwithstanding any provisions of this Plan to the contrary, in no event is the Plan Sponsor permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 C.F.R. § 164.504(f).

(e) **Payment, Health Care Operations, and Legal Requirements.** The Plan and its Business Associates may use PHI for Payment and Health Care Operations, and as specifically required by law.

(f) **Minimum Necessary.** Except as provided in 45 C.F.R. § 164.502(b)(2), when using or disclosing PHI or when requesting PHI from another covered entity or business associate, the Plan and its Business Associates will make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

12.5 Conditions of Disclosure for Plan Administration Purposes. The Plan Sponsor agrees that, with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. § 164.508) disclosed to it by the Plan or a health insurance issuer or HMO on behalf of the Plan, the Plan Sponsor will:

(a) Not use or further disclose the information other than as permitted or required by the Plan documents or as otherwise required by law;

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

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

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

(e) Make available PHI in accordance with 45 C.F.R. § 164.524;

(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

(h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services (or its delegate) for purposes of determining compliance by the Plan with the HIPAA Privacy Rule;

(i) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such 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

(j) Ensure adequate separation between the Plan and the Plan Sponsor as set forth in Section 12.6

12.6 Adequate Separation. Except for certain summary health and enrollment information (including, but not limited to, coverage information and contributions paid by Participants and the Plan Sponsor), access to PHI by employees of the Plan Sponsor will be limited to employees serving as benefit administrators and advisors and employees in the Plan Sponsor's legal, finance, and information technology departments assigned to assist the above individuals. No other employee will have access to PHI except as shared directly by a Participant or pursuant to a written document either designating the employee as a personal representative of the Participant or authorizing the employee to receive for a limited time information related to a specific claim or series of claims. With respect to electronic PHI, appropriate security measures will be utilized to prevent employees other than those identified herein from gaining access to such information. The Plan Sponsor will establish sanctions to be imposed in the event an employee improperly uses or discloses PHI.

12.7 Compliance with HIPAA Security Rule. In compliance with the HIPAA Security Rule, the Plan Sponsor will take the following actions with respect to any Electronic PHI it creates, receives, maintains, or transmits on behalf of the Plan, other than enrollment/disenrollment information, Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. § 164.508:

(a) **Safeguard for Protected Health Information.** The Plan Sponsor will implement reasonable and appropriate administrative, technical, and physical safeguards to protect the confidentiality, integrity, and availability of the electronic PHI it creates, receives, maintains, or transmits for or on behalf of the Plan.

(b) **Reporting Security Incidents.** The Plan Sponsor will provide a written report regarding any security incidents, as defined in 45 C.F.R. § 164.304, involving electronic PHI, to the Plan.

(c) **Subcontractors and Other Agents.** The Plan Sponsor will ensure that any agents and subcontractors to whom it provides electronic PHI received from the Plan or created or received by the Plan Sponsor on behalf of the Plan agree in a written contract to implement reasonable and appropriate security measures to protect such information.

12.8 Use of De-identified Data. Nothing herein will limit the ability of the Plan or the Plan Sponsor from using or disclosing information that has been de-identified pursuant to 45 C.F.R. § 164.514.

12.9 Certification of Plan Sponsor. The Plan (or a health insurance issuer or HMO with respect to the Plan) will disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii) and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 12.5.

By adoption of this Plan document and delivery of a copy of the Plan document to the privacy official, the Plan Sponsor certifies that (1) the provisions of 45 C.F.R. § 164.504(f)(2)(ii) have been incorporated into the Plan document; and (2) the Plan Sponsor has agreed to the conditions of disclosure set forth in Section 12.5.

12.10 Hybrid Entity Election. This Plan includes multiple component benefit programs, some of which are group health benefits and others of which are non-group health benefits. As a result, this Plan

elects to be treated as a "hybrid entity" as defined in 45 C.F.R. § 164.103. The health care component of this Plan consists of the group health benefits. The non-health care component of this Plan consists of all other benefits under the Plan. The Plan and Employer intend to comply with HIPAA with respect to only the health care component of the Plan and to ensure adequate separation between the health care component and the non-health care component. To the extent required by HIPAA, the Plan and the Plan Sponsor will ensure compliance with the safeguard requirements relating to hybrid entities as set forth in 45 C.F.R. § 164.105(a).

13. Miscellaneous Provisions

13.1 Communication to Participants. The Plan Sponsor will notify all Participants of the availability and terms of this Plan.

13.2 Limitation of Rights. Neither the establishment of this Plan nor any amendment thereof will be construed as giving to any Employee or other person any legal or equitable right against the Plan Administrator, any Claims Administrator, the Plan Sponsor, any Employer, or any other person, except as expressly provided herein, and in no event will the terms of employment or service of any Employee be modified or in any way be affected hereby.

13.3 Nonassignability of Rights.

(a) **General.** The right of any person to receive any benefit under this Plan will not be alienable by such person by assignment or any other method (except as provided in the applicable Sub-Plan Document or Benefit Description) and will not be subject to be taken by such person's creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized.

(b) **No Assignment of Certain Group Health Claims.** No claim for self-insured group health benefits under the Plan, and no rights related directly or indirectly to any such claim (including, without limitation, the right to pursue an internal claim or appeal, the right to pursue litigation for payment of benefits, the right to pursue litigation for breach of fiduciary duty, the right to pursue litigation to recover any statutory penalties, or the right to assign payment), may be assigned to an out-of-network hospital, facility, or other healthcare provider without the Plan Administrator's written consent. In its discretion, the Plan Administrator may voluntarily pay benefits directly to an out-of-network hospital, facility, or other healthcare provider on behalf of a covered individual, and such payment will not constitute an assignment of rights or benefits and will not be deemed a waiver of this provision as to that covered individual or any other covered individual.

13.4 No Guarantee of Tax Consequences. Neither the Plan Administrator, any Claims Administrator, an Employer, nor the Plan Sponsor makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant will be excludible 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 with respect to salary reduction amounts or otherwise. It will be the obligation of each Participant to determine whether each payment is excludible 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 excludible.

13.5 Indemnification of Employer by Participants. Each Participant will indemnify and reimburse the Employer for any liability the Employer may incur for failure to withhold federal or state income tax, social security tax, unemployment tax, or other required amounts from any payment or

reimbursement. However, such indemnification and reimbursement will not exceed the amount of additional federal and state income tax that the Participant would have owed if the payment or reimbursement had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax, unemployment tax, or other required amounts that would have been paid on such compensation, less any such additional income tax, Social Security tax, unemployment tax, or other required amounts actually paid by the Participant.

13.6 Binding on Successors. This Plan will be binding upon all persons entitled to benefits under this Plan, their respective heirs and personal representatives, upon the Employer, its successors and assigns, and upon the Plan Administrator and its successors.

13.7 Headings. The headings used in this Plan are inserted for reference purposes only and will not be deemed to limit or affect in any way the meaning or interpretation of any of the terms or provisions herein.

13.8 Separate Liability. Except to the extent imposed by law, no fiduciary will have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by this Plan, by ERISA, the Code, or by any regulations or rulings issued under ERISA or the Code. No fiduciary will have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities, it has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

13.9 Word Usage. Wherever any words are used herein in the masculine or neuter gender, they will be construed as though they were used in the feminine, masculine, or neuter gender, as the context may require, and vice versa, and wherever any words are used herein in the singular form they will be construed as though they were also used in the plural form, as the context may require, and vice versa.

13.10 Severability. If any provision of this Plan is held invalid or unenforceable, such invalidity or unenforceability will not affect any other provisions thereof, and the Plan will be construed and enforced as if such provisions had not been included.

13.11 Adoption by Other Employers. Any entity with employees now in existence or hereafter formed or acquired, which is not already an Employer under the Plan, and which is otherwise legally eligible, may in the future, with the consent and approval of the Plan Sponsor adopt the Plan for all or any classifications of persons in its employment, and thereby, from and after the specified effective date, become an Employer under the Plan. However, the sole and absolute right to amend the Plan is reserved to the Plan Sponsor. The adoption will become, as to the adopting entity and its employees, a part of the Plan, and may contain such specific changes or variations in Plan provisions as may be acceptable to the Plan Sponsor. It will not be necessary for the adopting entity to sign or execute the original or the amended Plan documents. The Plan Sponsor may on notice to any adopting Employer withdraw its consent and approval for such entity to be an adopting Employer of the Plan. The administrative powers and control of the Plan Sponsor as provided in the Plan, including the sole right of amendment and of appointment and removal of the Plan Administrator, will not be diminished by reason of the participation of any such adopting entity in the Plan.

Any entity that is an adopting employer of the Plan immediately before an amendment and

restatement of the Plan will continue as an adopting employer of the Plan following amendment and restatement of the Plan (subject to the Plan Sponsor's right to withdraw its consent and approval for such entity to be an adopting employer, as described herein), and any entity that is an adopting employer of any merged plan immediately before merger of such merged plan into the Plan will automatically become an adopting employer of the Plan as of the date of the merger (subject to the Plan Sponsor's right to withdraw its consent and approval for such entity to be an adopting employer, as described herein).

13.12 Erroneous Payments/Fraud or Misrepresentation. If any person receives any payment that the Plan Administrator in its sole discretion later determines the person was not entitled to receive, such person will be required to make reimbursement to the Plan. The Plan Administrator will have the right to offset any future payment against amounts that the person was not otherwise entitled to receive. In addition, if any person obtains coverage and/or benefits or other payments under the Plan by reason of any direct or indirect act of fraud or misrepresentation (including fraud or misrepresentation by omission), as determined by the Plan Administrator in its sole discretion, such individual will be required to make restitution to, and/or pay any direct or indirect fees, expenses, costs, losses, or other damages suffered by, the Plan and/or the Employer by reason of such act of fraud or misrepresentation in such amount or amounts as may be determined by the Plan Administrator, in its sole discretion. The Plan Administrator also may take such other and further action with respect to such individual as it deems necessary or appropriate, including, but not limited to, retroactively terminating such individual's participation in the Plan.

13.13 No Contract of Employment. Nothing contained herein will be construed to constitute a contract of employment between an Employer and any Employee or other individual. Nothing herein contained will be deemed to give any Employee or other individual the right to be retained in the employ of an Employer or to interfere with the right of the Employer to discharge any Employee or other individual at any time without regard to the effect such discharge might have on the Employee or other individual as a Participant under the Plan.

13.14 Indemnification by Employer. Each Employer will indemnify and save harmless each member of its governing body and any Employee of the Plan Sponsor (or any Employer), from and against losses resulting from liability to which they may be subjected by reason of any act or conduct (except willful or wanton misconduct) in their official capacities in the administration of this Plan. Expenses will include the amount of any settlement or judgment, costs, counsel fees, and related charges reasonably incurred in connection with a claim asserted, or a proceeding brought in settlement thereof. The foregoing right of indemnification will be in addition to any other rights to which any such person may be entitled as a matter of law. The indemnification provision of this Section will not relieve such person of any liability he may have under ERISA for breach of a fiduciary duty.

13.15 Use of Electronic Media. Notwithstanding any provision of the Plan to the contrary, including provisions requiring the use of a written instrument, the Plan Administrator may establish procedures for the use of electronic media in communications and transactions between or among the Plan, the Plan Administrator, and/or Participants. But any procedures involving the transmission or communication of PHI must conform to Article 12 of the Plan. Electronic media may include, but are not limited to, the Internet, e-mail, Intranet systems, and automated telephonic response systems.

13.16 GINA Compliance. In accordance with Title I of GINA, in no event will the Plan or any of its insurers discriminate against any Participant on the basis of genetic information with respect to eligibility, premiums, or contributions.

13.17 Governing Law. It is the intention of the Plan Sponsor that, to the extent applicable, the Plan will comply, and will be interpreted, construed, and administered in a manner that complies, with the requirements of all applicable laws, including, without limitation, ERISA, HIPAA, COBRA, USERRA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, GINA, the ACA, and the Internal Revenue Code. To the extent not preempted by the laws of the United States of America, the Plan will be governed, construed, and administered under the laws of the State of Kansas.

13.18 Notices. Except as otherwise provided in this Plan, any notices or communications required to be given herein by any Participant, Employer, the Plan Sponsor, the Plan Administrator, or duly authorized Claims Administrator, will be deemed given when delivered or when placed in the United States mail in an envelope addressed to the last communicated address of the person to whom the notice is being given, with adequate postage thereon prepaid. Notices or communications also may be given by electronic means in appropriate cases in accordance with procedures established by the Plan Administrator.

13.19 Subrogation and Reimbursement. The following provisions will apply to component benefits offered under this Plan to the maximum extent permitted by law.

(a) **Right to Subrogation.** The Plan shall be subrogated in the full amount of any payments made by the Plan or any of the Plan's component benefits to or on behalf of any Participant, dependent, or other individual ("Covered Person") with respect to any and all causes of action, claims, or right of payment the Covered Person has or may have against any person or entity, including, but not limited to, any tortfeasor, any person or entity legally responsible for the tortfeasor's conduct, or any insurer (including but not limited to any third-party insurer, first-party insurer (i.e., uninsured motorist or underinsured motorist), and any worker's compensation insurer), for any injury or damages to the Covered Person which results in payment(s) being made by the Plan or any of the Plan's component benefits.

(b) **Right of Reimbursement.** The Plan shall also have a right of reimbursement against any Covered Person in the full amount of any payments made by the Plan or any of the Plan's component benefits to or on behalf of any Covered Person to the extent the Covered Person settled, obtained a judgment, or otherwise received monies from any person or entity, including, but not limited to, any tortfeasor, any person or entity legally responsible for the tortfeasor's conduct, or any insurer (including but not limited to any third-party insurer, first-party insurer (i.e., uninsured motorist or underinsured motorist), and any worker's compensation insurer), for any injury or damages to the Covered Person which results in payment(s) being made by the Plan or any of the Plan's component benefits. In addition, the right of reimbursement exists if the Covered Person fails to protect the Plan's subrogation claim or lien.

(c) **Subrogated or Reimbursable Claim.** The Plan's right to subrogation and right of reimbursement with respect to any benefits paid by the Plan or any of the Plan's component benefits are collectively known as a "Subrogated or Reimbursable Claim." For any Subrogated or Reimbursable Claim, the Covered Person is hereby deemed to have acknowledged and agreed to the following:

(1) The right to subrogation and right of reimbursement shall include any amounts paid or payable by the Plan or any of the Plan's component benefits or by any stop-

loss or similar excess insurance carrier that provides coverage in connection with the Plan or any of the Plan's component benefits.

(2) The right to subrogation and right of reimbursement shall also be effective and in full force on behalf of or against the Covered Person's estate, heirs, executors, power-of-attorneys, administrators, personal representatives, or any other person or entity that has the right to seek from another person or entity the types of payment(s) that were paid by the Plan or any of the Plan's component benefits to or on behalf of the Covered Person.

(3) The Covered Person will include the full amount of payments that are, or would be, a Subrogated or Reimbursable Claim (including any future amounts reasonably anticipated to be paid) in any demand, claim, or legal action against any person, entity, or insurer.

(4) The Covered Person will repay immediately to the Plan the full amount of payments that are, or would be, a Subrogated or Reimbursable Claim from any monies received by settlement, judgment, or any other recovery, including any expenses and costs incurred by the Plan in collecting these amounts (collectively known as "Recoverable Amounts"). The Recoverable Amounts shall not be reduced by the Covered Person's attorney fees, other costs or expenses, comparative negligence, or for any other reason whatsoever. Any equitable or common law doctrines that might apply to reduce the Recoverable Amounts in any way, including, but not limited to, the "make whole doctrine" and the "common fund doctrine," will not apply. The Plan shall be entitled, in all cases, to 100% reimbursement of the Recoverable Amounts.

(5) The Plan shall have an equitable lien for the full amount of the Recoverable Amounts, and the Plan shall have the right of first priority from dollar one. The Recoverable Amounts shall be paid to the Plan in full without regard to whether the Covered Person has been made whole or otherwise fully compensated for the Covered Person's injuries, losses, or damages. The Recoverable Amounts shall be paid to the Plan in full without regard to how such the Covered Person's claims or recoveries are designated, defined, or described, including, but not limited to, whether the Covered Person's claims or recoveries are designated, defined, or described as for (i) past or future damages; (ii) loss of consortium; (iii) non-economic damages, such as pain and suffering or mental distress; (iv) lost or future loss of income or wages; (v) any damages that are unrelated to the Covered Person's health or injuries; or (vi) damages specifically to one Covered Person when there are multiple Covered Persons who have claims arising out of the same event or circumstances which gave rise to the Subrogated or Reimbursable Claim. The Plan may intervene in any action to protect and enforce its lien.

(6) The Covered Person will cooperate with the Plan in asserting its rights and the Covered Person's rights with respect to any Subrogated or Reimbursable Claim, including but not limited to supplying the Plan with any and all information and executing any and all instruments the Plan requests for this purpose.

(7) If any recovery by the Covered Person exceeds the amount of Plan benefits paid to the date of such recovery, the excess will be credited or offset against future

payments of Plan benefits, and these future Plan benefits are presumed to have been included in the claim leading to such recovery.

Example: A Covered Person receives a $250,000.00 recovery. The Plan had paid benefits of $100,000.00 and received the full $100,000.00 back via reimbursement. The Plan shall have a credit or offset in the amount of $150,000.00 against any future claims for Plan benefits that are made by the Covered Person until the value of the additional claimed benefits exceeds $150,000.00. After the $150,000.00 is reached, the Covered Person may have the right to additional Plan benefits.

(8) The Covered Person will be personally liable to the Plan for the amount of benefits paid by the Plan, including for any attorney fees, expenses, or other costs incurred by the Plan in asserting its right of reimbursement against the Covered Person or any other person or entity.

(d) **Cooperation.** As a condition precedent to the Plan making any disbursement with respect to benefits which are or may be the subject of any Subrogated or Reimbursable Claim, the Plan Administrator may require the Covered Person or someone legally qualified and authorized to act for such person, to expressly confirm their agreement to the above in writing and to execute any and all other documents reasonably necessary for the Plan to assert its rights, all in such form as the Plan Administrator may determine from time to time. Such written confirmation is not, however, required for enforcement of the Plan's rights to subrogation and rights of reimbursement. In addition, no Covered Person may take any action which prejudices, diminishes, or is otherwise detrimental to the Plan's rights to subrogation and rights of reimbursement hereunder.

(e) **No Plan Obligation.** To the extent the Plan paid benefits to or for the benefit of a Covered Person, the Plan may pursue any and all claims that the Covered Person may have against a third party so the Plan may recover its payments, but the Plan has no legal obligation to pursue any other claims on behalf of the Covered Person. The Plan may enforce the same in its own name or in the name of the Covered Person.

(f) **Notification of Plan Administrator.** As a condition precedent to the Plan making any disbursement with respect to benefits which are or may be the subject of any Subrogated or Reimbursable Claim, a Covered Person will notify the Plan Administrator in writing of the events or circumstances giving rise to the Subrogated or Reimbursable Claim at the earliest reasonable opportunity. The Covered Person will also provide periodic status reports to the Plan Administrator at all significant stages of any dealings with a third party who may have liability or that may make payments with respect to the Subrogated or Reimbursable Claim, the stages including, but not limited to: (i) retention of counsel, (ii) the initiation or prosecution of court or administrative proceedings, (iii) the initiation or advancement of settlement discussions or negotiations, (iv) the making of payments pursuant to a settlement or judgment, or (v) at such other times as requested by the Plan Administrator.

14. ERISA Information

14.1 Name of Plan and Plan Number.

IMA Group Health and Welfare Benefits Plan – Plan Number 501

14.2 Name and Address of Plan Sponsor.

IMA Financial Group, Inc.
430 E. Douglas, Suite 400
Wichita, Kansas 67202

The following entity is an adopting employer of the Plan:

The IMA Foundation
1705 17th Street, Suite 100
Denver, Colorado 80202

A complete list of other employers sponsoring the Plan (if any) may be obtained by participants and beneficiaries upon written request to the Plan Administrator.

14.3 Employer Identification Number.

48-0805634

14.4 Plan Administrator.

IMA Financial Group, Inc.
430 E. Douglas, Suite 400
Wichita, Kansas 67202
(316) 267-9221

14.5 Plan Administration. The Plan is administered by IMA Financial Group, Inc., which is the "plan administrator" for the Plan. The organizations described on Exhibit A provide administrative services to the Plan in connection with one or more component benefits, including review and payment of claims.

14.6 COBRA Administration. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") enable employees to continue group health plan coverage for certain periods of time. In order to preserve certain important rights under COBRA and/or USERRA, you may be required to provide certain notices to the Plan Administrator or COBRA Administrator(s) within specified times as provided by applicable law and Plan rules. (See the "Continuation Coverage" section of this Summary Plan Description).

The COBRA Administrator for the Plan is:

ThrivePass
600 Highway 169 South, Suite 1680
St. Louis Park, MN 55426
(866) 855-2844
cobra@thrivepass.com

14.7 Agent for Service of Legal Process.

IMA Financial Group, Inc.
Attn: General Counsel
430 E. Douglas, Suite 400
Wichita, Kansas 67202

Service of legal process may also be made upon the Plan Administrator.

14.8 Plan Year. The Plan operates on a 12-month period commencing January 1. In general, accounting is done as of the last day of the plan year.

14.9 Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under such plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to

know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from a plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse a plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. In all cases, however, you may not file suit in federal court unless and until you have exhausted any and all administrative remedies and review procedures available to you by law or under the terms of the Plan. 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, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the 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.

In Witness Whereof, the Plan Sponsor has caused this document to be executed in its name and behalf, to be effective as of January 1, 2025.

IMA Financial Group, Inc.

By:_____
Name:_____
Title:_____

Exhibit A
Component Benefits
(As of January 1, 2025)

Benefit	Carrier or Service Provider	Insured Status
Medical	UMR 1.800.826.9781 MedCost (ECM only) 1.800.795.1023	Self-Insured
Medical	Kaiser Permanente 1.800.464.4000 Kaiser Permanente – Hawaii 1.800.966.5955 HMSA 1.800.776.4672	Fully Insured
Prescription Drugs	RxBenefits 1.800.334.8134 PrudentRx 1.888.203.1768 SouthernScrips (ECM only) 1.800.710.9341	Self-Insured
Specialty Surgery	Lantern Care 1.855.413.7196	Self-Insured
Joint Therapy	Regenexx 1.866.494.0623	Self-Insured
Dental	Delta Dental of Kansas 1.800.234.3375	Self-Insured
Vision	VSP 1.800.877.7195	Self-Insured
Health and Dependent Care FSA	HealthEquity 1.877.924.3967	Self-Insured
Life, AD&D, Disability, Critical Illness, and Accident Insurance	Lincoln Financial Group www.lincolnfinancial.com	Fully Insured
EAP	Headspace 1.855.420.0734	Self-Insured

Benefit	Carrier or Service Provider	Insured Status
Telemedicine	Teladoc 1.800.835.2362 1-800MD (ECM only) 1.800.530.8666	Self-Insured
Telemedicine	Kaiser Virtual Care 1.800.464.4000	Fully Insured
Family Forming Benefits	Maven support@mavenclinic.com	Self-Insured
Business Travel Accident	Zurich HRBenefits@imacorp.com	Fully Insured
Global Travel Assist	Europ Assistance USA 1.800.243.6108	Fully Insured
Health Savings Account* *Payroll deductions only. Health savings accounts are not offered as an ERISA benefit plan.	HealthEquity 1.866.346.5800	N/A

Exhibit B
Full-Time Employee Policy

1. Preliminary Matters

1.1 Purpose. The Plan Sponsor is adopting this policy for purposes of identifying Full-Time Employees with respect to Code §4980H and for purposes of identifying Eligible Employees with respect to group medical and prescription drug coverage under the Plan. An Employee's designation as a Full-Time Employee under this policy will not apply for any other purpose, including for purposes of determining eligibility for any other benefits provided by the Employer.

1.2 Relationship Between Full-Time Status and Eligibility for Medical Coverage. All Employees who are determined to be Full-Time Employees with respect to a given period of time are Eligible Employees with respect to group medical and prescription drug coverage under the Plan during that period of time.

In addition, an Employee who is otherwise an Eligible Employee within the meaning of the Plan (i.e., is a regular common law employee of the Employer who is working at least 20 hours per week and who meets the other eligibility requirements set forth in the Plan and any applicable Sub-Plan Documents) will be eligible for group medical and prescription drug coverage under the Plan, whether or not the Employee is a Full-Time Employee.

In all cases, an Eligible Employee's coverage under the Plan will take effect only if the employee (1) enrolls for coverage within the enrollment period established by the Plan Administrator, (2) agrees and elects at the time and in the manner established by the Plan Administrator to pay the Eligible Employee's share of the cost (if any) for the tier of coverage selected by the employee, and (3) satisfies any other conditions established by the Plan Administrator for enrollment in the Plan.

1.3 Modification. This policy is established as a part of the Plan and may be modified or amended in the same manner as the Plan.

2. Plan Sponsor Elections

2.1 Election to Use Look-Back Measurement. The Plan Sponsor elects to use the Look-Back Measurement Method with respect to all Employees for purposes of identifying those Employees who are Full-Time Employees.

2.2 Election of Standard Measurement Period. The Standard Measurement Period is a 12-month period beginning November 1 each year and ending the following October 31.

2.3 Election of Standard Stability Period. The Standard Stability Period is the 12-month period beginning January 1 each year and ending the following December 31. The same Standard Stability Period applies with respect to Employees who are determined to be Full-Time Employees during the Standard Measurement Period and Employees who are determined not to be Full-Time Employees during the Standard Measurement Period.

2.4 Election of Standard Administrative Period. The Standard Administrative Period is the period beginning on November 1 each year and ending the following December 31.

2.5 Election of Initial Measurement Period. With respect to a New Employee who is a Part-Time Employee, Variable-Hour Employee, or Seasonal Employee, the Initial Measurement Period is the

12-month period beginning on the first day of the calendar month following the Employee's Start Date.

2.6 **Election of Initial Stability Period.** With respect to a New Employee who is a Part-Time Employee, Variable-Hour Employee, or Seasonal Employee, except as provided in Section 3.2(b)(4), the Initial Stability Period is the 12-month period beginning on the first day of the second calendar month after the end of the Initial Measurement Period.

2.7 **Election of Initial Administrative Period.** With respect to a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the Initial Administrative Period means all periods of time between the Employee's Start Date and the beginning of the Employee's Initial Stability Period other than the Employee's Initial Measurement Period.

2.8 **Taking Special Unpaid Leave Into Account.** For purposes of determining an Employee's average Hours of Service during a Measurement Period, the average Hours of Service for that Measurement Period are determined by computing the average after excluding any periods of Special Unpaid Leave during that Measurement Period and by using that average as the average for the entire Measurement Period.

3. Identification of Full-Time Employees

3.1 Ongoing Employees.

(a) **Employees Determined to Be Full-Time.** An Ongoing Employee who is determined to be a Full-Time Employee during a Standard Measurement Period will be considered a Full-Time Employee under this policy for each calendar month during the Standard Stability Period associated with that Standard Measurement Period.

(b) **Employees Determined Not to Be Full-Time.** An Ongoing Employee who is determined not to be a Full-Time Employee during a Standard Measurement Period will not be considered a Full-Time Employee under this policy for any calendar month during the Standard Stability Period associated with that Standard Measurement Period.

3.2 New Employees.

(a) **New Full-Time Employees.** A New Employee who is reasonably expected at his or her Start Date to be a Full-Time Employee (and is not a Seasonal Employee) is considered a Full-Time Employee for purposes of this policy beginning on the Employee's Start Date.

(1) **Factors for Determining Full-Time Status.** Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee who is not a Seasonal Employee is reasonably expected at his or her Start Date to be a Full-Time Employee:

(A) Whether the Employee is replacing an Employee who was (or was not) a Full-Time Employee.

(B) The extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 30 Hours of Service per week during recent Measurement Periods.

(C) Whether the job was advertised or otherwise communicated to the Employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average 30 or more Hours of Service per week or less than 30 Hours of Service per week.

(2) **Transition to Ongoing Employee.** Once a New Employee who is a Full-Time Employee has been employed for an entire Standard Measurement Period, the Employee becomes an Ongoing Employee, and the Employee's status as a Full-Time Employee for purposes of this policy is governed by the provisions of this policy regarding Ongoing Employees.

(b) **New Non-Full-Time Employees.** A New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee is not initially considered a Full-Time Employee and will have Hours of Service measured over an Initial Measurement Period and be treated as follows:

(1) **Full-Time After Initial Measurement Period.** If a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee is determined to be a Full-Time Employee during the Employee's Initial Measurement Period based on the Hours of Service credited during the Initial Measurement Period, the Employee will be considered a Full-Time Employee for purposes of this policy for each calendar month during the Employee's Initial Stability Period.

(2) **Not Full-Time After Initial Measurement Period.** If a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee is determined not to be a Full-Time Employee during the Employee's Initial Measurement Period based on the Hours of Service credited during the Initial Measurement Period, the Employee will not be considered a Full-Time Employee for purposes of this policy during the Employee's Initial Stability Period, except to the extent provided under the provisions of this policy regarding Ongoing Employees.

(3) **Change in Status During the Initial Measurement Period.** Notwithstanding the foregoing, if a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee experiences a change in employment status before the end of the Employee's Initial Measurement Period such that if the Employee had begun employment in that new status the Employee would have reasonably been expected to be a Full-Time Employee (and not a Seasonal Employee or Variable-Hour Employee), the Employee will be considered a Full-Time Employee for purposes of this policy beginning on the date of the change in the Employee's employment status or, if earlier, at the beginning of the Employee's Initial Stability Period, if the Employee is determined to be a Full-Time Employee during the Employee's Initial Measurement Period.

(4) **Transition to Ongoing Employee.** Once a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee has been employed for an entire Standard Measurement Period, the Employee becomes an Ongoing Employee, and the Employee's status as a Full-Time Employee for purposes of this policy is governed by the provisions of this policy regarding Ongoing Employees, but subject to the following:

(A) **Full-Time During the Initial Measurement Period but Not the First Standard Measurement Period.** If the Employee is determined not to be a Full-Time Employee for the Standard Measurement Period that overlaps or immediately follows the Employee's Initial Measurement Period, the Employee will continue to be considered a Full-Time Employee for purposes of this policy for each calendar month during the Initial Stability Period, if the Employee was determined to be a Full-Time Employee during the Employee's Initial Measurement Period.

(B) **Full-Time During the First Standard Measurement Period but Not During the Initial Measurement Period.** If the Employee is determined to be a Full-Time Employee for the Standard Measurement Period that overlaps or immediately follows the Employee's Initial Measurement Period, the Employee will be considered a Full-Time Employee for purposes of this policy for each calendar month during the entire Standard Stability Period associated with the Employee's first Standard Measurement Period, even though that Standard Stability Period may overlap an Initial Stability Period associated with an Initial Measurement Period during which the Employee was determined not to be a Full-Time Employee.

(C) **Full-Time During Both the Initial Measurement Period and the First Standard Measurement Period.** If the Employee is considered a Full-Time Employee for purposes of this policy during both the Employee's Initial Stability Period and the Employee's first Standard Stability Period, the Employee will be considered a Full-Time Employee for purposes of this policy during any period between the end of the Initial Stability Period and the beginning of the Employee's first Standard Stability Period.

3.3 Rehired Employees. An Employee who terminates employment and is rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer or any member of the Controlled or Affiliated Group for a period of at least 13 consecutive weeks immediately preceding the date of rehire or, if less, a period of consecutive weeks that exceeds the greater of (a) four weeks, or (b) the number of weeks of the Employee's immediately preceding Period of Employment. For purposes of applying these rehire rules, the duration of the Period of Employment immediately preceding a period during which an Employee was not credited with any Hours of Service is determined after application to that Period of Employment of the rules on Special Unpaid Leave, if and to the extent those rules are applicable.

3.4 Cessation of Full-Time Employee Status. An Employee who is a Full-Time Employee under this policy will cease to be a Full-Time Employee (and may, therefore, cease to be an Eligible Employee under the Plan, if they do not otherwise continue to qualify as an Eligible Employee) as of the earliest to occur of the following:

(a) The last day of any Stability Period after which the Employee ceases to be a Full-Time Employee.

(b) In the case of a New Employee who is a Full-Time Employee who has not reached the Employee's first Standard Stability Period, the last day of the month in which the Employee is last credited with at least 130 Hours of Service.

(c) In the case of an Employee who satisfies the following criteria, the last day of the third calendar month after the change in employment status described below:

(1) The Employer has offered the Employee minimum value coverage continuously during the period beginning on the first day of the calendar month following the Employee's initial three full calendar months of employment and ending on the last day of the calendar month in which the change in employment status described in this subsection occurs;

(2) The Employee has a change in employment status to a position or status in which the Employee would not have reasonably been expected to be a Full-Time Employee if the Employee had begun employment in that position or status; and

(3) The Employee actually is credited with less than 130 Hours of Service for each of the three full calendar months following such change in employment status.

For purposes of the foregoing, "minimum value coverage" means coverage described in Code Section 36B(c)(2)(C)(ii) and any regulations or other guidance thereunder, relating to coverage under a plan for which the plan's share of the total allowed costs of benefits provided under the plan is at least 60% of such costs.

4. Definitions and Interpretation

4.1 Definitions. For purposes of this policy, the following terms have the following meanings. Capitalized terms not specifically defined in this policy have the meanings set forth in the Plan.

(a) **"Administrative Period"** means a Standard Administrative Period or an Initial Administrative Period.

(b) **"Controlled or Affiliated Group"** means the group of organizations consisting of the Plan Sponsor and any other organization that is part of a controlled group or affiliated service group with the Plan Sponsor within the meaning of Code § 414(b), (c), (m), or (o).

(c) **"Employer"** means the Plan Sponsor and any other member of the Controlled or Affiliated Group that has adopted the Plan for the benefit of the Employer's employees.

(d) **"Full-Time Employee"** means an Employee of the Employer who is credited with an average of at least 30 Hours of Service per week during a Measurement Period. For this purpose, 130 Hours of Service in a calendar month is treated as the monthly equivalent of at least 30 Hours of Service per week.

(e) **"Hour of Service"** means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, and (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence (as defined in 29 CFR §2530.200b-2(a)).

(1) The term "Hour of Service" does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States, within the meaning of Code §§861 through 863 and the regulations thereunder.

(2) An Hour of Service for one organization is treated as an Hour of Service for all other organizations that are part of the same Controlled or Affiliated Group for all periods during which those organizations are part of the same Controlled or Affiliated Group.

(3) Hours of Service for all Employees are credited using actual Hours of Service from records of hours worked and hours for which payment is made or due.

(f) **"Initial Administrative Period"** means, with respect to a New Employee that is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the period described in Section 2.7 of this policy.

(g) **"Initial Measurement Period"** means, with respect to a New Employee that is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the period described in Section 2.5 of this policy.

(h) **"Initial Stability Period"** means, with respect to a New Employee that is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the period described in Section 2.6 of this policy.

(i) **"Look-Back Measurement Method"** means the method of identifying full-time employees for purposes of Code §4980H that is described in Treas. Reg. §54.4980H-3(d), as amended or supplemented.

(j) **"Measurement Period"** means an Initial Measurement Period or a Standard Measurement Period.

(k) **"New Employee"** means an Employee who has been employed for less than one complete Standard Measurement Period.

(l) **"Ongoing Employee"** means an Employee who has been employed for at least one complete Standard Measurement Period.

(m) **"Part-Time Employee"** means a New Employee whom the Employer reasonably expects to be employed on average less than 30 Hours of Service per week during the Employee's Initial Measurement Period, based on the facts and circumstances at the Employee's Start Date. Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee is a Part-Time Employee:

(1) Whether the Employee is replacing an Employee who was (or was not) a Full-Time Employee.

(2) The extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 30 hours of service per week during recent Measurement Periods.

(3) Whether the job was advertised or otherwise communicated to the new hire or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average 30 (or more) Hours of Service per week or less than 30 Hours of Service per week.

The anticipated length of the Employee's Period of Employment shall not be considered.

(n) **"Period of Employment"** means the period of time beginning on the first date for which an Employee is credited with an Hour of Service for an Employer or any member of the Controlled or Affiliated Group and ending on the last date on which the Employee is credited with an Hour of Service for that Employer or any member of the Controlled or Affiliated Group, both dates inclusive. An Employee may have one or more Periods of Employment with the same Employer.

(o) **"Plan"** means the IMA Group Health and Welfare Benefits Plan.

(p) **"Seasonal Employee"** means a New Employee who is hired into a position for which the customary annual employment is six months or less, occurring at approximately the same time each year.

(q) **"Special Unpaid Leave"** means unpaid leave that is subject to FMLA, subject to USERRA, or on account of jury duty.

(r) **"Stability Period"** means either a Standard Stability Period or an Initial Stability Period.

(s) **"Standard Administrative Period"** means the period described in Section 2.4 of this policy.

(t) **"Standard Measurement Period"** means the period described in Section 2.2 of this policy.

(u) **"Standard Stability Period"** means the period described in Section 2.3 of this policy.

(v) **"Start Date"** means the first date on which an Employee is credited with an Hour of Service with the Employer or a member of the Controlled or Affiliated Group.

(w) **"Variable-Hour Employee"** means a New Employee if, based on the facts and circumstances at the Employee's Start Date, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 Hours of Service per week during the Initial Measurement Period because the Employee's hours are variable or otherwise uncertain. For purposes of determining whether an Employee is a Variable-Hour Employee, the Employer may not take into account the likelihood that the Employee may terminate employment before the end of the Initial Measurement Period. Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee is a Variable-Hour Employee:

(1) Whether the Employee is replacing an Employee who was a Full-Time Employee or a Variable-Hour Employee.

(2) The extent to which the Hours of Service of employees in the same or comparable positions have actually varied above and below an average of 30 hours of service per week during recent Measurement Periods.

(3) Whether the job was advertised or otherwise communicated to the new Employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average at least 30 hours of service per week, average less than 30 hours of service per week, or might vary above and below an average of 30 hours of service per week.

4.2 **Interpretation of Terms.** Whenever the context may require, (a) any pronoun used in this policy includes the corresponding masculine, feminine, or neuter forms, and (b) the singular form of nouns, pronouns, and verbs includes the plural and vice versa. In the event of any ambiguity in the application of this policy, it will be interpreted in accordance with Code Section 4980H and the regulations and other guidance issued thereunder.

Exhibit C
Health Savings Account Contributions

The Cafeteria Plan permits you to make pre-tax contributions to a health savings account ("HSA") that you establish and maintain outside the Plan with an HSA trustee or custodian. For purposes of the Cafeteria Plan, HSA-related benefits consist solely of the ability to make such pre-tax contributions under the Cafeteria Plan.

Eligibility to Contribute to an HSA

To make HSA contributions under the Cafeteria Plan, you must be an HSA-eligible individual. This means that you must be eligible to contribute to an HSA under the requirements of Internal Revenue Code ("Code") Section 223. A key requirement is that you have elected qualifying high deductible health plan ("HDHP") coverage and have not elected any disqualifying non-HDHP coverage. You should be aware that disqualifying coverage can include coverage under a spouse's plan, including a spouse's health FSA. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

Relationship to Health FSA Benefits

If you have coverage under a general purpose health flexible spending account plan, you cannot also elect to make HSA contributions. If an expense is eligible for reimbursement under both a health flexible spending account plan and your HSA, you may seek reimbursement from either the health flexible spending account plan or your HSA, but not both.

HSA Is Not a Benefit Plan

An HSA is not an employer-sponsored employee benefit plan. It is an individual trust or custodial account that you open with an HSA trustee or custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code Section 223. Consequently, an HSA trustee or custodian, not the Employer, will establish and maintain your HSA. The HSA trustee or custodian will be chosen by you and not by the Employer. Your Employer may, however, limit the number of HSA providers to whom it will forward pre-tax salary reduction contributions, a list of which will be provided upon request. Any such list of HSA trustees or custodians, however, will be maintained for administrative purposes only and will not be an endorsement of any particular HSA trustee or custodian. Your HSA is administered by your HSA trustee or custodian. The Employer's role is limited to allowing you to contribute to your HSA on a pre-tax basis. The Employer has no authority or control over the funds deposited in your HSA. Neither your HSA nor the ability to contribute to an HSA through the Cafeteria Plan on a pre-tax basis is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan Administrator will maintain records to keep track of HSA contributions that you make via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

Maximum Annual Contribution

The amount you elect to contribute to an HSA must not exceed the statutory maximum amount for HSA contributions applicable to your HDHP coverage option (i.e., single or family) for the calendar year in which the contribution is made. The statutory maximums are indexed for inflation and can change from

year to year. The current statutory maximums are:

	Single	Family
2023	$3,850	$7,750
2024	$4,150	$8,300
2025	$4,300	$8,550
2026	$4,400	$8,750

Refer to IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans) for information about the specific statutory maximum in effect for any future year.

An additional catch-up contribution of $1,000 may be made if you are age 55 or older. In addition, the maximum annual contribution will be: (a) reduced by any matching (or other) Employer contribution to the HSA made on your behalf; and (b) pro-rated for the number of months in which you are an HSA-eligible individual.

Note that if you are an HSA-eligible individual for only part of the year but you meet all of the requirements under Code Section 223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family). However, any contributions in excess of your annual contribution under the Cafeteria Plan for HSA benefits (as described above), but not in excess of the applicable full statutory maximum amount, must be made outside of the Cafeteria Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of Code Section 223 during the following year, the portion of the HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 10% penalty. Exceptions apply in the event of death or disability.

Tax Treatment of HSA Benefits

You may save both federal income taxes and FICA (Social Security) taxes by participating in the Cafeteria Plan. However, very different rules apply with respect to taxability of HSA benefits than for other benefits offered under the Cafeteria Plan. For more information regarding the tax ramifications of participating in an HSA, as well as the terms and conditions of your HSA, see the communications materials provided by your HSA trustee or custodian and see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

The Employer cannot guarantee that specific tax consequences will flow from your participation in the Cafeteria Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA benefits.

Changing Your HSA Contribution

You may increase, decrease, or revoke your HSA contribution election at any time during the plan year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective following submission your election change in accordance with uniform rules established by the Plan Administrator. Your ability to make pre-tax contributions under the Cafeteria Plan to an HSA ends on the date that you cease to meet the eligibility requirements.

Additional Information

For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying HDHP, contributions to the HSA, and distributions from the HSA), please refer to your HSA trust or custodial agreement and other documentation associated with your HSA and provided to you by your HSA trustee or custodian. You may also want to review IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

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