BANCROFT NEUROHEALTH HEALTH AND WELFARE PLAN SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

Amended and restated July 1, 2024

This draft plan/SPD document, together with the incorporated documents, when adopted, will constitute a legal instrument with important tax and legal implications. Before you adopt it (in accordance with your standard business governance procedures), you should verify its accuracy and appropriateness for your benefit programs and your legal advisor(s) should review and approve it.

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Contents

This document incorporates by reference one or more specific booklets or plan summaries that describe in more detail certain of the benefit specific provisions governing the Bancroft Neurohealth Health and Welfare Plan.

Introduction

This combined Summary Plan Description and Plan Document (the "Document") describes the health and welfare benefits and programs available to eligible employees of Bancroft (the "Company") under the Bancroft Neurohealth Health and Welfare Plan (the "Plan") on or after their effective date(s) for participation.

Effective July 1, 2012, the Company combined plans 501 (Group Life and Disability), 503 (Health Major Medical), and 504 (Aflac Accident Cancer) into a single consolidated plan 504. Plan 504 was renamed the Bancroft Health and Welfare Plan. The Plan was amended and restated effective July 1, 2013; December 1, 2014; and July 1, 2015, respectively. The Plan was then amended, effective July 1, 2017, to make certain changes to the eligibility and termination of coverage sections (effective March 21, 2016) and to incorporate any legislative changes that were required since the last amendment and restatement through July 1, 2017. This Document comprises a complete amendment and restatement of the Plan effective as of July 1, 2024. This Document, along with the other related documents provided by the carriers and third party administrators (such as certificates of insurance and descriptive booklets, which are incorporated into this Document), is designed to be your primary source of health and welfare benefits information. Refer to it for information about your benefits and share it with your family members.

The Company maintains the Plan described herein for the exclusive benefit of its eligible employees and to provide various health and welfare group benefits (the component benefit programs), as described in Appendix A.

Certain benefits offered under the Plan are currently provided under insurance contracts and administrative agreements entered into between the Company and various insurance carriers and third party administrators. These benefits are described in this document and in the certificates of insurance and benefits booklets issued by the insurance companies and third party administrators, which are incorporated into this Document by reference.

This Document provides no guarantee that you are eligible to participate in every benefit or program described. Each benefit program may have its own eligibility requirements, so be sure to review individual eligibility requirements set forth in this Document and the booklets issued by the insurance companies and third party administrators carefully.

The Plan provides benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), Michelle's Law (when applicable), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), the Genetic Information Nondiscrimination Act (GINA), the Patient Protection and Affordable Care Act (PPACA) and its companion Health Care and Education Affordability Reconciliation Act (collectively referred to as Health Care Reform); the Coronavirus Aid, Relief, and Economic Security (CARES) Act; and the Consolidated Appropriations Act, 2021 (the "CAA").

The Plan, through this Document and referenced documents, is a plan document and a summary plan description and is intended to satisfy the written document requirements of section 402 of ERISA. The Plan is also intended to qualify as a "cafeteria plan" and to satisfy the requirements of sections 125, 129 and 105(e) of the Internal Revenue Code to provide employees health and dependent care flexible spending accounts (FSAs)] and the opportunity to make pre-tax contributions toward certain benefits. Each benefit program has a benefit booklet. Refer to each program's booklet for much of the information about a program's benefits and rules.

This Document is a “wrap” document. This wrap Document serves a dual purpose—it collects documents regarding more than one type of benefit together to form a single plan, ~~and also~~and provides the ERISA required language.

- It “wraps around” the carrier-provided documents and other written instruments (the summaries). This Document incorporates the terms of the summaries for each of the benefit programs. The summaries remain part of this Document (reflecting many of the Plan's most important terms and conditions), Together, this Document and the summaries also constitute the Summary Plan Description.
- For benefit programs that are insured, this Document “wraps around” the insurance policy. Together, the wrap document and the insurance policy constitute the plan document for insurance programs.
- For benefit programs that are self-funded, this Document combined with the benefit program booklet and any other governing documents constitute the plan document for the self-funded benefit programs.

This Document is also intended to supplement the documents described above with the necessary additional information required under ERISA, but not captured in the summaries, which together comprise the official Plan document. An amendment to this Document is considered an amendment to the official Plan document. You should receive separate summaries from each of the benefit programs in which you have enrolled or are automatically covered. In the separate summaries, you should find information about eligibility and benefits for each of the separate benefit programs. You are eligible to participate in this Plan if you are eligible to participate in one of the benefit programs. The benefit programs may require completion of application and administrative forms and may require annual elections. The details of the administrative requirements are provided in the attachments to Appendix A or in materials provided by the Company. In addition, in general, all benefits of this Plan are provided by the benefit programs mentioned above.

If you have any questions about this Document or certain provisions of the Plan, please call Human Resources.

Every effort has been made to ensure that the information in this Document is complete and accurate. However, if there is ever a conflict or a difference between what is written here and the related documents or insurance policies, the related documents or insurance policies will rule with respect to the specific benefits provided, unless otherwise provided by law. If there is ever a conflict or a difference between this Document and the related documents or insurance policies with respect to the legal compliance requirements under ERISA and any other federal law, this Document will rule, unless the provisions in the related documents are more generous for participants.

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, in its sole discretion and in accordance with the *Plan Amendment and Termination* section set forth below may amend or terminate any of the benefit programs or any provision of the Plan at any time. No amendment or termination will operate to reduce the amount of any benefit payment under the Plan for charges incurred prior to the effective date of such amendment or termination.

This Document is intended to comply with the requirements of ERISA and other applicable laws and regulations. It does not create a contract or guarantee of employment between the Company and any individual. Your employment is always on an at-will basis. The Company or you may terminate the employment relationship without notice at any time and for any reason.

Enrollment

Once you have been determined to be eligible for in accordance with the Eligibility Provisions of Appendix B, you may be required to enroll in benefits as provided in the section. In order to receive benefits under the Plan, some benefit programs require you to enroll, while for others, coverage is automatic.

Enrollment Is Required	Coverage is Automatic
- Medical Benefits (including prescription drug and telemedicine) - Prescription Drug (automatic w/medical) - Telemedicine (automatic w/medical) - Dental Benefits - Vision Benefits - Healthcare Flexible Spending Account (FSA) - Dependent Care FSA - Health Reimbursement Arrangement (HRA) - Voluntary Life Insurance Benefits - Voluntary Short-Term Disability (STD) Benefits - Accident Indemnity Insurance - Critical Illness Insurance - Medical Bridge Gap Insurance	- Basic Life Insurance Benefits (including Business Travel Accident (BTA)) - Basic Accidental Death and Dismemberment (AD&D) Benefits - Long-Term Disability (LTD) Benefits - Employee Assistance Plan (EAP)

When coverage is automatic

You do not need to enroll yourself or elect to participate under the automatic programs listed above. The Company automatically enrolls you in these programs for which you are eligible at no cost to you.

When enrollment is required

The following rules apply if you are required to enroll yourself and/or your spouse/partner and dependent children in a benefit program listed above.

You will be able to participate in the Plan when you meet the eligibility requirements of the component benefit programs, as long as you properly enroll by the communicated due date. You may enroll yourself and your spouse/partner and/or eligible dependents: 1) when you first become eligible for participation in the Plan, 2) during the annual open enrollment period, 3) as a result of certain special enrollment rights discussed below, or 4) within 31 days following a qualified change in status.

Initial eligibility

You can enroll, make elections, and direct the Company to make salary reduction or deduction contributions only by filing the appropriate completed and signed election forms or agreements with the Plan Administrator (including telephonic, e-mail, website, Internet, or any other type of electronic forms or agreements provided by the Plan Administrator).

Generally, your coverage under the benefits program begins on the first day of the calendar month that falls on or next following the date you are eligible for coverage (after the waiting period).

If you do not waive or enroll in coverage when you are first eligible, you will be considered to have elected not to participate in the Plan for purposes of the elective benefits for that plan year (which

means you would have to wait until the next open enrollment period or until you experience a "special enrollment event" or "change in status", as discussed below, to enroll).

Annual open enrollment

If you are a current employee qualified to receive benefits, you may enroll for, change your coverage level, or waive coverage during annual open enrollment. During annual open enrollment, you may change your elections for which enrollment is required without the normal restrictions that apply at other times of the year. Annual open enrollment elections will be effective the following July 1.

If you do not enroll during annual open enrollment, your coverage levels will continue from the previous year for medical (including prescription drug and telemedicine), vision, dental, indemnity insurances, life, voluntary short term disability and long term disability. You are required to enroll in the flexible spending account(s) during each annual open enrollment. If you do not elect each year to enroll in the flexible spending account(s), your participation in the flexible spending account(s) will terminate.

Special enrollment events under HIPAA

Under the Health Insurance Portability and Accountability Act ("HIPAA"), you have special enrollment rights under certain circumstances.

Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse/partner) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the other employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If the conditions for special enrollment are satisfied, coverage will be effective on the first of the month following your written or electronic request, as applicable, for enrollment is received by the Plan. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage/establishment of a domestic/civil union partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage/establishment of a domestic/civil union partnership, birth, adoption, or placement for adoption. If the conditions for special enrollment are satisfied, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your written or electronic request, as applicable, for enrollment is received by the Plan.

Loss of eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse/partner) are eligible, but not enrolled, for coverage under the Plan while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If the conditions for special enrollment are satisfied, coverage will be effective on the first of the month following your written or electronic request, as applicable, for enrollment is received by the Plan.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse/ partner) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If the conditions for special enrollment are satisfied, coverage will be effective on the first of the month following your written or electronic request, as applicable, for enrollment.

Questions should be directed to Bancroft NeuroHealth, Department of Human Resources, 425 Kings Highways East, Haddonfield, NJ 08033, 856-348-1149.

Qualified change in status

You may also enroll yourself, your spouse/ partner and/or your eligible dependents for coverage mid-year in certain circumstances. See the section titled *Making Changes during the Year*, for more information.

Cost of Coverage

The Company may pay the entire cost of certain benefit programs offered under the Plan and for some benefits, employees may pay the entire cost. For certain other benefit programs offered under the Plan, the employee and the Company may share the cost of coverage. Your portion of the cost for programs under the Plan will vary according to the benefits and coverage levels (i.e., single, family, etc.) you elect. You will receive information about your portion of the cost (including information on any wellness incentives integrated with the medical plans) for the benefit programs offered under the Plan during open enrollment or for new hires before you enroll. You may also obtain this information by contacting the Benefits Office.

Your costs for medical (including prescription drug and telemedicine), vision, dental, health and dependent care FSA are deducted from your pay on a pre-tax basis under the cafeteria plan option offered by the Company. This means your contributions come out of your pay before federal income and employment taxes are deducted. Pre-tax contributions reduce your gross salary, which lowers your taxable income and, therefore the amount of income tax you must pay. By paying lower taxes, you save money. Contributions may, however, be subject to state or local income taxes in some states. An employee can elect to have post-tax benefit contributions by completing and submitted to Human Resources a pre-tax contribution waiver form.

The chart below shows the different coverages available. It also shows which coverages the Company pays, which coverages you pay for on your own, which coverages you and the Company pay for together, and how you pay your share of the cost (pre- or after-tax).

Coverage	Company pays	You Pay	You and Company	You Pay Pre- or After-Tax
Medical (including prescription drug and telemedicine)			X	Pre-Tax
Prescription Drug (automatic w/medical)			X	Pre-Tax
Telemedicine (automatic w/medical)			X	Pre-Tax
Dental		X		Pre-Tax
Basic Employee Life and AD&D (including BTA)	X			N/A

Coverage	Company pays	You Pay	You and Company	You Pay Pre- or After-Tax
Voluntary Life and AD&D Insurance		X		After-Tax
Long Term Disability	X			N/A
Voluntary Short Term Disability		X		After-Tax
Health Reimbursement Account (HRA)	X			N/A
FSAs (Health & Dependent)		X		Pre-Tax
Accident Indemnity		X		After-Tax
Critical Illness		X		After-Tax
Medical Bridge Gap		X		After-Tax

Social Security taxes

Please note that you will not be paying Social Security taxes on any pre-tax contributions toward coverage under the benefit programs. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the benefit programs will normally be greater than any eventual reduction in Social Security benefits.

Contributions for domestic/civil union partner coverage

There may be important personal tax consequences that arise as a result of domestic partner coverage. In general, state income tax treatment of domestic/civil union partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic partner and his or her children, if any, qualify for the special state income tax treatment. If they do qualify, you must notify the Company immediately in writing of this special state income tax status.

Please see the ***Bancroft NeuroHealth's Policy on Domestic/Civil Union Partnership and Health Coverage*** for more information.

Making Changes during the Year

Federal rules and regulations govern when you can change certain benefit coverage elections outside of annual open enrollment. These rules apply to before-tax coverage elections you make for your medical (including prescription drug and telemedicine), vision, dental, accident and cancer indemnity and FSA coverages.

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the coverage period in which you are enrolled. Elections you make at annual enrollment generally remain in effect for the following coverage period. However, you may be able to change your medical (including prescription drug and telemedicine), vision, dental, and health care or dependent care FSA elections during the coverage period if you experience a change in status. You must make any status-related changes to your coverage within 30 days of the change in status. If the change involves a loss of your spouse's/ partner's or dependent's eligibility for medical or dental benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the change in election event, even if you do not request it within 30 days.

Please note that, to change your benefit elections due to a change in status, you may be required to show proof verifying that the event has occurred (for example, copy of marriage or birth certificate, or divorce decree, etc.).

Qualified changes in status

The following is a list of qualified changes in status that will allow you to make a change to your elections (as long as you meet the consistency requirements, as described below):

- **Legal marital status.** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment
- **Domestic partnership/civil union status**. You enter into or terminate a domestic partnership/civil union whereby your domestic/civil union partner is or was considered a tax dependent
- **Number of dependents.** Any event that changes your number of tax dependents, including birth, legal guardianship, death, adoption, and placement for adoption
- **Employment status.** Any event that changes your, your spouse's, or your other dependent's employment status and results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or terminating employment;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa (subject to any applicable waiting periods); and
  - A change in work location.
- **Dependent status.** Any event that causes your tax dependent to become eligible or ineligible for coverage under the Plan because of age, student status, tax dependent status, or similar circumstances
- **Residence.** A change in residence that causes an employee, spouse, or dependent to gain or lose eligibility for a plan or a different benefit option available under the plan (e.g., moving outside your medical or dental program's network service area)
- **COBRA.** Eligibility of an employee, spouse, or dependent for COBRA
- **HIPAA special enrollment events**: Events (such as the loss of other coverage) that qualify as special enrollment events under the Health Insurance Portability and Accountability Act (HIPAA) or an event that involves loss of group health coverage sponsored by a governmental or educational institution, such as a state health benefits risk pool, Medicaid or State Child Health Insurance Program (CHIP) coverage, or eligibility for state premium assistance.

Except as otherwise provided in an underlying benefit summary or booklet, other eligible individuals may also be added when a spouse or dependent gains eligibility because of a change in status event. This is referred to as the "tag-along" rule. Whenever a change in status event results in eligibility for any other dependent, it would be "consistent" to add dependents that were previously eligible for coverage.

Consistency requirements

Except for election changes due to a HIPAA and or Medicare/CHIP special enrollment, the changes you make must be "due to and consistent with" your qualified change in status. To satisfy the federally required "consistency rule," your qualified change in status and corresponding change in coverage must meet **both** of the following requirements.

- **Effect on eligibility.** Except for your dependent care FSA, the qualified change in status must affect eligibility for coverage under the Plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become

eligible (or ineligible) for coverage or if the qualified change in status results in an increase or decrease in the number of your dependents who may benefit from coverage under the Plan.

For your dependent care FSA, the qualified change in status must affect the amount of dependent care expenses eligible for reimbursement. For example, if your child reaches age 13, his or her dependent care expenses are no longer eligible for reimbursement.

- **Corresponding election change.** The election change must correspond with the qualified change in status. For example, if your dependent loses eligibility for coverage under the terms of the medical program, you may cancel medical coverage only for that dependent. When you experience a qualified change in status that is also a HIPAA special enrollment, the Plan will also allow you to change your coverage to another eligible medical option (for example, from a PPO to a HMO benefit option) if more than one medical option is available under the Plan. You and your dependents must be enrolled in the same medical option.

Additionally, you may increase, decrease or begin contributions to your health or dependent care FSA if you have or adopt a child or a child is placed with you for adoption. The Plan Administrator will determine whether a requested change is due to and consistent with a qualified change in status.

Coverage and cost events

In some instances, you can make changes to your benefits coverage for other reasons, such as mid-year events affecting the cost of coverage or the type of coverage provided, as described below. Note: *These rules do not apply for purposes of a healthcare FSA*. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

Coverage events

If the Company adds or eliminates a coverage option in the middle of the coverage year, or if coverage sponsored by the Company is significantly limited or ends, you and your eligible dependents may revoke your elections and elect coverage under another option that provides similar coverage. If no other similar coverage is available, you may revoke your existing election.

For example, if there is an overall reduction under a coverage option that reduces coverage to participants in general, participants enrolled in that coverage option may elect to enroll in another option providing similar coverage (if the other coverage option permits). Additionally, if the Company adds an HMO or other coverage option mid-year, participants can drop their existing coverage and enroll in the new coverage option (if the new coverage option permits). You or your eligible dependents may also enroll in the new coverage option even if not previously enrolled for coverage at all (if the new coverage option permits).

Also, if an election change is permitted during a different open enrollment period applicable to a plan of another employer (or, if applicable, to another plan sponsored by the Company), you may make a corresponding mid-year election change. This rule applies to the medical, vision, and dental programs, as well as the dependent care FSA.

If another employer's plan allows your spouse or other dependent to change his or her elections in accordance with IRS regulations, you may make a corresponding mid-year election change to your coverage.

Healthcare FSA. You may not increase, decrease or end healthcare FSA contributions or enroll for a healthcare FSA when your spouse becomes eligible for coverage under another plan. You may not end healthcare FSA contributions if you become eligible for coverage under another plan.

Dependent care FSA. You may make a change in your dependent care FSA if you make a change to your or your spouse's regular work schedule that increases or decreases your need for dependent care.

If your dependent care provider reduces or increases the number of hours worked, you may make a corresponding change to your dependent care FSA election. For example, if your child starts school, causing a reduction in the number of hours he or she is in the care of a dependent care provider, you may decrease your dependent care FSA election.

You may increase, decrease, or end contributions to your dependent care FSA if you gain coverage under another plan. Similarly, you may enroll for or increase contributions to a dependent care FSA if you lose coverage under another plan.

Cost events

You must contact the Plan Administrator within 30 days of a cost event. Otherwise, your next opportunity to make changes will be the next annual open enrollment period or when you have a qualified change in status or other applicable event, whichever occurs first.

Medical (including prescription drug and telemedicine), vision and dental coverage costs. If your cost for medical (including prescription drug and telemedicine), vision and dental coverage increases or decreases significantly during the year, you may make a corresponding election change. For example, you may elect another coverage option with similar coverage, or drop coverage if no similar coverage is available. Additionally, if there is a significant decrease in the cost of a coverage option during the year, you may enroll in that coverage option, even if you declined to enroll in that coverage option earlier.

Any change in the cost of your coverage option that is not significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Dependent care FSA. If you change your dependent care provider mid-year, you may change your dependent care FSA contributions to correspond with the new provider's charges. Similarly, if your dependent care provider (other than a provider who is your relative) raises or lowers its rates mid-year, you may increase or decrease your contributions.

Special note regarding domestic partner coverage: The events qualifying you to make a mid-year election change described in this section also apply to events related to a qualified domestic partner. However, IRS rules generally do not permit you to make a mid-year change "on a pre-tax basis" for such events unless they involve a tax dependent.

Other rules

Receipt of court orders and QMCSOs. You will be permitted to revoke an election for accident or health benefits during a period of coverage and make a new election if a judgment, decree, or order (collectively an "order") requires accident or health coverage for your child or for a foster child who is your dependent. The order must have resulted from a divorce, legal separation, annulment, or change in legal custody, and includes a qualified medical child support order (QMCSO). The plan may automatically change your benefit and contribution elections to provide coverage for your child if the order requires coverage under the plan.

You may also decrease your coverage for a child, if the order requires the child's other parent to provide coverage and your spouse's or former spouse's plan actually provides that coverage. You also may make other corresponding changes to your benefit elections under the Plan, to the extent permitted by the Code and the Plan.

Medicare or Medicaid entitlement. You may change an election for health coverage mid-year if you, your spouse, or your eligible dependent becomes entitled to, or loses entitlement to, coverage under Part A or Part B of Medicare, or under Medicaid. However, you are limited to reducing your health coverage only for the person who becomes entitled to Medicare or Medicaid, and you are limited to adding health coverage only for the person who loses eligibility for Medicare or Medicaid.

Reduction in hours. If you experience a change in employment status that results in you working less than 30 hours per week, you may prospectively drop your medical coverage under the Plan mid-year. In order to drop medical coverage under the Plan, you must enroll (and enroll any dependents whose medical coverage was dropped in connection with this event) in another medical plan that provides minimum essential coverage under Health Care Reform. The effective date of the new coverage can be no later than the first day of the second month following the month that includes the date the medical coverage under the Plan is revoked. You may not make changes to your healthcare FSA under this event.

Enrollment in a public Marketplace health plan. If you or a family member become eligible to enroll in public Marketplace coverage during a public Marketplace special or open enrollment period, you may prospectively drop medical coverage under the Plan for yourself and/or your family member, even if you and/or the family member remains eligible for coverage under this Plan. Your revocation of coverage must correspond to the intended enrollment of you or the family member in public Marketplace coverage that is effective beginning no later than the day after the last day coverage under this Plan is dropped. You may not make changes to your healthcare FSA under this event.

Family and Medical Leave Act

If you take a qualifying leave under the federal Family and Medical Leave Act (FMLA), you may continue your group health coverage for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. The Company may require that you continue all health benefits (including healthcare FSA), provided that participants on non-FMLA paid leave are required to continue coverage. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your group health and/or healthcare FSA benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pre-tax dollars to the extent that you receive compensation during the leave, or by prepaying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to prepay in advance, you must make a special election before such compensation normally would be available to you (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year)); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave). For purposes of subsection (b) above, pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year, in accordance with the cafeteria plan rules.

If the Company requires all participants to continue group health and healthcare FSA benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your coverage ceases while you are on FMLA leave (e.g., for nonpayment of required contributions), you will be permitted to re-enter such benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such benefits reinstated so long as coverage for employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to healthcare FSA benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the healthcare FSA benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which

you did not pay contributions. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated healthcare FSA benefits will equal the amount withheld before FMLA leave.

Non-health benefits during FMLA. If you take an FMLA leave, the entitlement to non-health benefits (such as dependent care FSA benefits) will be determined by the Company policy for providing such benefits when you are on non-FMLA leave. If the policy permits a participant to discontinue contributions while on leave, then you will, upon returning from leave, be required to repay the contributions not paid during the leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you do not return to work at the end of your FMLA leave, you may be entitled to purchase COBRA continuation coverage.

Deadline for making an election change

If you experience an event described above, your Plan Administrator must receive written notice of the election change within 30 days of the event. The Company reserves the right to request proof of a qualified change in status.

Change in election effective date

In general, your change in election will be effective as soon as administratively practicable, but no earlier than the first payroll period immediately following receipt of the completed election form by the Department of Human Resources. However, any election change made due to the birth, adoption or placement for adoption of a child and made within 30 days of such event will be effective retroactive to the date of the birth, adoption or placement for adoption and you will be permitted to pay for this retroactive coverage with pre-tax salary deductions.

Compliance with nondiscrimination requirements

The Plan and the various benefit programs are required to meet certain nondiscrimination provisions as outlined by the Code. The Company reserves the right to modify the amount of any benefit elections of the shareholders, officers, owners, and other highly compensated employees by the amount necessary to allow the Plan and its underlying benefit programs to satisfy these nondiscrimination requirements.

Benefits

The following pages contain a brief description of the various benefit options offered under the Plan. With respect to these options, you can find a more complete description of the level of benefits provided by consulting the benefit booklet issued by the applicable service provider or in the applicable certificates of insurance issued by the insurance companies, which are provided as attachments to Appendix A. The booklets and/or certificates will inform you of the following:

- any special eligibility requirements;
- any termination of coverage rules (that is, circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of any benefit that a Participant or beneficiary might otherwise reasonably expect the Plan to provide);
- any cost-sharing provisions, including premiums, deductibles, coinsurance and copayment amounts for which you or your beneficiary is responsible;
- any annual or lifetime caps or other limit of benefits;

- the extent to which preventive services are covered;
- whether, and under what circumstances, existing and new drugs are covered;
- whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
- provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services;
- any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- any conditions or limits applicable to obtaining emergency medical care;
- any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service; and
- other related provisions.

You may also obtain copies of the booklets and/or certificates applicable to all benefits by contacting the Plan Administrator.

Cafeteria Plan provisions

The Company offers its employees[1] a cafeteria plan intended to satisfy the requirements of Internal Revenue Code Sections 125, 129 and 105(e) and the regulations thereunder (referred to in this Document as the Cafeteria Plan), to provide employees health and dependent care FSAs and the opportunity to make pre-tax contributions toward certain other benefits.

Under the Cafeteria Plan, you may elect to have your cost for medical (including prescription drug and telemedicine), vision, dental, accident and cancer indemnity and the health and dependent care FSAs deducted from your pay on a pre-tax basis, pursuant to a salary reduction agreement. This means your contributions come out of your pay before federal income and employment taxes are deducted. Your contributions may, however, be subject to state or local income taxes. Pre-tax contributions reduce your gross salary, which lowers your taxable income and, therefore the amount of income tax you must pay. By paying lower taxes, you save money.

By electing one or more pre-tax premium payment benefits under the Cafeteria Plan, you convert a portion of your pay for the Plan Year (or other coverage period) into contributions to the Plan to pay premium payment benefits you have elected to receive. The Plan's terms, as set forth in this Document and as amended from time to time, govern a covered employee's rights and obligations under the Plan. Salary reductions are applied by the Company to pay your share of the contributions for the premium payment benefits and, for the purposes of this Plan and the Internal Revenue Code (the Code), are considered to be employer contributions.

Covered employees may elect one or more of the following pre-tax premium payment benefits:

Medical Premium Payment Benefit

If you are eligible for Company-sponsored medical benefits, you may elect any of the medical program options as the medical premium payment benefit. A description of the medical benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The medical benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

[1] Members of an LLC, partners, or more than 2% shareholders in an S corporation are not permitted to participate in pre-tax contributions for benefits offered under Code Section 125.

Dental Premium Payment Benefit

If you are eligible for Company-sponsored dental benefits, you may elect any of the dental program options as the dental premium payment benefit. A description of the dental benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The dental benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Prescription Drug Premium Payment Benefit

If you are eligible for Company-sponsored prescription drug benefits, you may elect the prescription drug program as the prescription drug premium payment benefit. A description of the prescription drug benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The prescription drug benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Healthcare FSA Premium Payment

If you are eligible to participate in the healthcare FSA, you may elect a contribution as the healthcare FSA premium payment benefit, subject to the minimum and maximum amounts for the applicable plan year as set forth in the plan summary materials provided at enrollment. A description of the healthcare FSA benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The healthcare FSA benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Dependent Care FSA Premium Payment

If you are eligible to participate in the dependent care FSA, you may elect a contribution as the dependent care FSA premium payment benefit, subject to the minimum and maximum amounts for the applicable plan year as set forth in the plan summary materials provided at enrollment. A description of the dependent care FSA benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions are set forth in the applicable attachment to Appendix A. The dependent care FSA benefits are subject to the terms, conditions and limitations set forth in the applicable attachment to Appendix A.

Notification of premium payment benefit amounts

The Company will provide you with written notification of the amount of the premium payment benefits for each program offered under the Plan that requires an employee contribution before your initial and annual enrollment/election periods. The amount of the premium payment benefits will be the contributions required of an employee to participate in the group health or welfare benefit program(s) for which a premium payment benefit is available through the Cafeteria Plan. The written notification is incorporated by reference and made a part of this Document.

Benefits other than premium payment benefits

Certain of the benefits are available for election on an after-tax contribution basis and may not be paid through the pre-tax premium payment benefit, such as voluntary life insurance and short-term disability.

Application of other plans

If you are electing one or more premium payment benefits under the Cafeteria Plan, you are subject to the provisions, conditions, limitations, and exclusions of the health and/or welfare benefit program(s) for the premium payment benefit which you elect.

Flexible spending account options

The healthcare FSA component of this Plan is intended to qualify as a "self-insured medical reimbursement plan" under Code section 105, and the medical care expenses reimbursed thereunder are intended to be eligible for exclusion from participating employees' gross income under Code section 105(b).

The dependent care FSA component of this Plan is intended to qualify as a "dependent care assistance program" under Code section 129, and the dependent care expenses reimbursed thereunder are intended to be eligible for exclusion from participating employees' gross income under Code section 129(a).

The healthcare FSA and the dependent care FSA components of this Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code sections 105 and 129. The healthcare FSA component is also a separate plan for purposes of applicable provisions of ERISA, HIPAA, and COBRA. The terms and provisions of the healthcare FSA and dependent care FSA benefits are more fully described in the applicable attachments to Appendix A.

Irrevocability of elections

Except as described in this Plan and the component documents, a participant's election under the Cafeteria Plan is irrevocable for the duration of the period of coverage to which it relates. In other words, unless an exception applies, the participant may not change any elections for the duration of the period of coverage regarding: (a) participation in this Plan; (b) salary reduction amounts; or (c) election of particular benefit package options.

Effect of mistakes

In the event of a mistake as to the eligibility or participation of an employee, the allocations made to the account of any participant, or the amount of benefits paid or to be paid to a participant or other person, the Plan Administrator will, to the extent that it deems administratively possible and otherwise permissible under Code section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such participant or other person the credits to the account or distributions to which he or she is properly entitled under the Cafeteria Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Company from compensation paid by the Company.

No guarantee of tax consequences

Neither the Plan Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a participant under the Cafeteria Plan will be excludable from the participant's gross income for federal, state, or local income tax purposes. It will be the obligation of each participant to determine whether each payment under this Plan is excludable from the participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the participant has any reason to believe that such payment is not so excludable.

Limits for certain employees

Benefits payable under the Plan to each highly compensated participant, as defined in Code section 125(e)(1), or highly compensated individual, as defined in Code section 125(e)(2), will be limited to the extent necessary to avoid violating Code section 125(b)(1), as applicable.

Benefits payable under the Plan to each key employee, as defined in Code section 416(i)(1), will be limited to the extent necessary to avoid violating Code section 125(b)(2), as applicable; and with respect to any life insurance benefits for which the participant contributes on a pre-tax basis, Code section 79(d).

Benefits payable under the Plan to each highly compensated employee, as defined in Code section 414(q), are limited to the extent necessary to avoid violating Code section 129(d)(8). The Company may determine prior to, or during, a Plan Year that the salary reduction contributions of a highly compensated employee must be reduced to avoid violating Code section 129(d)(8). Any amounts that are in excess of the Code section 129(d)(8) limit may be returned to the highly compensated employee in the form of taxable compensation.

Indemnification of Company

If any participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such participant will indemnify and reimburse the Company for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Medical

The Company's health benefits program provides eligible employees with the opportunity to elect medical benefits for themselves and their covered spouses and dependents and to certain eligible retirees.

The medical benefits available under the health benefits program are either self-insured by the Company and provided through contracts with the service providers and/or are insured and provided through insurance contracts with the insurance carriers, as listed in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, required deductibles, co-payments, maximums, limitations, coordination of benefits and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the medical plan. You may automatically access the online provider directory at your medical plan website or by calling your medical plan (see the *Plan Administration and Other General Information* section of this Document for websites and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

The terms and provisions of the health benefits are more fully described in the applicable attachments to Appendix A. For additional information regarding the medical benefits provided under the health benefits program, please contact the Plan Administrator.

The Company may also premium incentives if you participate in certain wellness programs, as described in your enrollment materials.

The Company may also offer telemedicine benefits, if any, as described in your enrollment materials.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

Women's Health and Cancer Rights Act

The health benefits program will provide certain benefits related to benefits received in connection with a mastectomy. The health benefits program will include reconstructive surgery following a mastectomy.

If you or your dependent(s) (including your spouse) are receiving medical benefits under the health benefits program in connection with a mastectomy and you or your dependent(s) (including your spouse) elect breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas.

Reconstructive benefits are subject to annual health benefits program deductibles and coinsurance provisions like other medical and surgical benefits covered under the health benefits program.

Genetic Information Nondiscrimination Act

The Plan will comply with the requirements of the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the guidance issued pursuant to GINA that is applicable to the Plan. The Plan will not request or require you to undergo genetic tests and will not collect genetic information prior to or in connection with enrollment, or for underwriting purposes.

No Surprises Act

The No Surprises Act (NSA) applies for Plan Years beginning on or after January 1, 2022. Under the NSA, you will be entitled to pay any applicable cost-sharing as if you received services from an in-network provider for any "protected services" you receive from a non-network provider. For this purpose, "protected services" include: (1) emergency services, as defined by applicable regulations under the NSA, (2) non-emergency services provided by a non-network provider at an in-network facility (unless you have expressly waived this right), and (3) covered non-network air ambulance services.

Mental Health and Substance Use Disorder Parity

To the extent that the Plan provides mental health and substance use disorder benefits, such benefits will be provided in a manner that complies with the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008.

Patient Protections

The Patient Protection and Affordable Care Act (PPACA) applies to the benefits under the Plan that are "Group Health Plans" under HIPAA and not otherwise subject to an exception under PPACA. PPACA does not apply to limited scope dental and vision benefits provided under the Plan. Each of the benefits subject to PPACA will comply with its applicable rules. In the event of a conflict between an underlying incorporated documents referenced in Appendix A and this section; the terms of the underlying incorporated documents will control so long as its terms comply with PPACA.

Prohibition on Pre-Existing Condition Exclusions

No limitations or exclusions from benefits (including a denial of coverage) will be based on the fact that a condition was present before the effective date of coverage (or if coverage is denied, the date of the denial).

Limitation on Waiting Periods

The period of time that must pass before coverage begins for an otherwise eligible employee or dependent will not exceed 90 days.

Cost-Sharing Limit

The total cost-sharing obligation on participants, including deductibles, co-insurance, co-payments and other similar charges, for essential health benefits will not exceed the annual (indexed) limit on cost-sharing established under Section 1302(c)(1) of PPACA.

Clinical Trials

The component benefits program will not deny any qualified individual the right to participate in a clinical trial; deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in a clinical trial; or discriminate against any qualified individual who participates in a clinical trial. For this purpose, a "clinical trial" is a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is (1) federally approved or funded (by an agency listed under PPACA), (2) conducted under an investigational new drug application reviewed by the FDA, or (3) a drug trial that is exempt from filing an investigational new drug application.

First Dollar Coverage for Preventive Care

No cost-sharing requirements will apply to preventive care services (as defined by PPACA).

Designation of Primary Care Provider/Pediatrician

If a medical benefit program generally requires/allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the medical benefit component program network and who is available to accept you or your family members. For any dependent who is a child, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator.

Designation of OB/GYN

You do not need prior authorization from the medical benefit component program or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our 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 procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at (856) 348-1149.

Coverage for Emergency Services

Coverage for emergency services will 1) not require pre-authorization, including for services provided out-of-network; 2) be available whether the provider is in- or out-of-network; 3) not be subject to any administrative requirement or coverage limitation that is more restrictive than those that apply to in-network emergency services; 4) not apply higher co-payments or co-insurance rates for out-of-network emergency services than apply to in-network emergency services; and 5) comply with the provisions of the No Surprises Act and its related regulations regarding the coverage of emergency services and all related prohibitions on balanced billing for out-of-network services.

Coverage of Adult Children Through Age 26
Where dependent coverage is available, the adult children of eligible employees will be eligible for that coverage until they turn age 26.

No Annual or Lifetime Limits
No annual or lifetime limits will be applied to essential health benefits.

No Rescission
Your coverage under the Plan will only be retroactively cancelled in the event of a failure to pay premiums or in the case of fraud or a misrepresentation of a material fact. You will be provided with prior written notice at least 30 days before coverage is cancelled as a result of fraud or a misrepresentation of material fact. For purposes of this rule, enrolling an ineligible individual or otherwise failing to comply with the Plan's eligibility requirements constitutes fraud or an intentional misrepresentation of a material fact. If your coverage is rescinded, you will be liable for any benefits paid by the Plan on your behalf prior to the date of rescission.

HIPAA Privacy and Security Rights
A group health plan generally cannot use or disclose your individually identifiable health information (i.e., Protected Health Information or PHI) or that of your dependents, except as authorized by you or by the regulations issued by the Department of Health and Human Services (HHS). However, de-identified health information (e.g., health information from which the name, Social Security Number, and similar identifying information have been removed) is not protected. In addition, the health privacy regulations broadly authorize claims administrators and other health plan vendors to routinely use and disclose protected health information for treatment, payment, or health care operations. In contrast, employers can use PHI only under very strict conditions.

A complete description of your privacy rights under HIPAA can be found in the Notice of Privacy Practices distributed to Plan participants.

Employee Assistance Plan

The Company's health benefits program provides confidential counseling and referral services at no cost to eligible employees and their covered spouses and dependents through an Employee Assistance Plan (EAP). The EAP benefits are provided through contracts with the service providers and/or are provided through insurance contracts with the insurance carriers, as listed in the *Plan Administration and Other General Information* section below. Any contact you have with the EAP is strictly confidential. Benefits offered under the EAP (including information about who is eligible to receive benefits, limitations, and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

The terms and provisions of the EAP benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the EAP, please contact the Plan Administrator.

Telemedicine

The Plan provides telemedicine benefits to eligible employees who elect certain medical coverage, as described in the applicable attachment to Appendix A.

These benefits (including information about who is eligible to receive benefits, the amount of benefits payable, required deductibles, co-payments, limitations, exclusions, etc.) are summarized in the

description attached at the *Summary Plan Description Attachments and Additional Benefits* section of this Document. The description is also available from the Plan Administrator.

For more information regarding the severance benefits, please contact the Plan Administrator.

Prescription Drug Benefits

The Plan provides prescription drug benefits to eligible employees who elect medical coverage.

The prescription drug benefits are either self-insured by the Company and provided through contracts with the service providers and/or insured and provided through insurance contracts with certain insurance carriers, as listed in the *Plan Administration and Other General Information* section below. These benefits (including information about the amount payable, required deductibles, co-payments, maximums, limitations, coordination of benefits and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the plan. You may automatically access the online provider directory at your prescription drug vendor website or by calling your prescription drug vendor (see the *Plan Administration and Other General Information* section of this Document for websites and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

The terms and provisions of the prescription drug benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the prescription benefits provided under the plan, please contact the Plan Administrator.

Health Reimbursement Arrangement

The Plan provides health reimbursement arrangement benefits to eligible employees. Health reimbursement arrangements (HRAs) are employer-funded plans that reimburse employees on a tax-free basis for their eligible health care expenses. The HRA is offered in conjunction with a consumer-directed high-deductible health plan (HDHP).

Bancroft NeuroHealth will reimburse the following amounts toward the annual deductible for participants in the high deductible health plan:

- Single coverage up to the first $500
- Family coverage up to the first $1,000

Balances from previous plan years will not carry over to the new plan year.

Note: If you elect healthcare FSA benefits, special “ordering” rules apply. Generally, you generally must take payments first from the HRA and second (after the HRA limits are exhausted) from the healthcare FSA. Please see the applicable HRA attachment to Appendix A for more information on the ordering of payments of HRA benefits.

The HRA is currently administered under service contracts with the service providers described in the Plan Administration and Other General Information section of this Document. These benefits (including information about who is eligible to receive benefits, the amount of contributions, maximums, limitations, and reimbursable expenses) are summarized in the descriptions attached at the Summary Plan Description Attachments and Additional Benefits section of this Document. The descriptions are also available from the Plan Administrator.

The terms and provisions of the HRA benefits are more fully described in the applicable attachment to Appendix A. For more information regarding the benefits offered under the HRA program, please contact the Department of Human Resources.

Dental

The benefits program provides eligible employees with the opportunity to elect dental benefits for themselves and their covered spouses and dependents.

The dental benefits available are either self-insured by the Company and provided through contracts with the service providers and/or are insured and provided through insurance contracts with the insurance carriers, as listed in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, required deductibles, co-payments, maximums, limitations, and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the dental plan. You may automatically access the online provider directory at your dental plan website or by calling your dental plan (see the *Plan Administration and Other General Information* section of this Document for websites and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

The terms and provisions of the dental benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the dental benefits provided under the plan, please contact the Plan Administrator.

Vision

The benefits program provides eligible employees with the opportunity to elect vision benefits for themselves and their covered spouses and dependents.

The vision benefits are either self-insured by the Company and provided through contracts with the service providers, and/or are insured and provided through insurance contracts with the insurance providers, as listed in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, required deductibles, co-payments, maximums, limitations, and exclusions) are summarized in the applicable benefit booklet(s) issued by the service provider(s) or in the applicable certificate(s) of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the vision plan. You may automatically access the online provider directory at your vision plan website or by calling your vision plan (see the *Plan Administration and Other General Information* section of this Document for websites and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

The terms and provisions of the vision benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the vision benefits provided under the plan, please contact the Plan Administrator.

Life Insurance

The life insurance benefits program provides eligible employees with life insurance benefit protection. Basic life and accidental death and dismemberment (AD&D) benefits are provided to employees, and voluntary life, AD&D, and dependent insurance benefits are also available. The life insurance benefits are provided through insurance contracts with the insurance provider(s) described in the *Plan Administration and Other General Information* section below.

These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are summarized in the applicable descriptions provided by the insurance provider(s). The descriptions are also available from the Plan Administrator.

Taxes on imputed income

In some cases, an additional amount of taxable pay, known as imputed income, may be added to your W-2 earnings. Imputed income is the amount the Internal Revenue Service (IRS) requires to be added to your taxable pay for the "value" of the Company-provided life insurance in excess of $50,000. The value of your insurance is not the face amount of your life insurance coverage over $50,000. Instead, the IRS assigns a dollar amount (premium) of taxable income for each $1,000 of life insurance over $50,000. The IRS determines this premium according to a formula using IRS Table I Rates. This excess cost is considered "imputed income" by the IRS and is subject to federal income taxes and Social Security and Medicare taxes.

The terms and provisions of the life insurance benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the life insurance benefits offered under the life insurance benefits program, please contact the Plan Administrator.

Short-Term Disability (STD)

New Jersey Temporary Disability Benefit (TDB) - Short-term disability (STD) benefits are provided to eligible employees through the New Jersey Temporary Disability Benefit (TDB) state plan. Eligibility for New Jersey TDB is determined by the state of New Jersey. For more information, please visit the NJ Temporary Disability website at: https://www.nj.gov/labor/myleavebenefits/worker/tdi/

Voluntary STD - The STD program provides eligible employees with an opportunity to elect STD benefits. The fully insured STD benefits are provided through insurance contracts with the provider(s) described in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are summarized in the applicable descriptions provided by the provider(s). The descriptions are also available from the Plan Administrator.

The terms and provisions of the STD benefits are more fully described in the applicable attachment to Appendix A. For more information regarding the benefits offered under the STD program, please contact the Plan Administrator.

Long-Term Disability (LTD)

The long-term disability (LTD) program provides automatic benefit protection to eligible employees. The LTD program provides an eligible employee with salary continuation in the event that illness or injury prevents an eligible employee from working for an extended period of time.

The LTD benefits are provided through insurance contracts with the insurance providers described in the *Plan Administration and Other General Information* section below.

These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are summarized in the applicable certificate(s) of insurance provided by the insurance companies. The certificates are also available from the Plan Administrator.

The terms and provisions of the LTD benefits are more fully described in the applicable attachment to Appendix A. For more information regarding the benefits offered under the LTD program, please contact the Plan Administrator.

Accident Insurance

The Plan provides eligible employees with an opportunity to elect accident insurance benefits. The accident insurance benefits are provided under an insurance contract with an insurance company described in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are detailed in the accident insurance summary of benefits.

The terms and provisions of the accident insurance benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the accident insurance benefits offered under the Plan, please contact the Plan Administrator.

Critical Illness Insurance

The Plan provides eligible employees with an opportunity to elect critical illness insurance benefits. The critical illness insurance benefits are provided under an insurance contract with an insurance company described in the *Plan Administration and Other General Information* section below. These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are detailed in the critical illness insurance summary of benefits.

The terms and provisions of the critical illness insurance benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the critical illness insurance benefits offered under the Plan, please contact the Plan Administrator.

Medical Bridge Gap

Eligible employees may enroll in the medical bridge gap benefit. The medical bridge gap benefits are provided under an insurance contract with an insurance company described in the Plan Administration and Other General Information section below. These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are detailed in the medical bridge gap summary of benefits.

The terms and provisions of the medical bridge gap benefits are more fully described in the applicable attachment to Appendix A. For additional information regarding the medical bridge gap benefits, please contact the Plan Administrator.

Flexible Spending Accounts (FSA)

Healthcare flexible spending account

The Plan provides healthcare flexible spending account (FSA) benefits to eligible employees. Healthcare FSA benefits offer you the opportunity to save tax dollars on your eligible out-of-pocket health care costs. Here's how the account works: you make contributions to the healthcare FSA on a

pre-tax basis. You are then reimbursed from your account tax free. Because of the tax advantages that this account offers, it is subject to certain IRS restrictions.

HRA benefits note: If you also have HRA benefits, special "ordering" rules apply. Generally, you generally must take payments first from the HRA and second (after the HRA limits are exhausted) from the healthcare FSA. Please see the applicable HRA attachment to Appendix A for more information on the ordering of payments of HRA and healthcare FSA benefits.

The healthcare FSA is currently administered under service contracts with the service providers described in Appendix A.

These benefits (including information about who is eligible to receive benefits, the amount of contributions, maximums, limitations, and reimbursable expenses) are more fully described in the applicable attachment to Appendix A. For more information regarding the benefits offered under the healthcare FSA program, please contact the Plan Administrator.

Dependent care flexible spending account

The Plan provides dependent care FSA benefits to eligible employees. Dependent care FSA benefits offer you the opportunity to save tax dollars on your eligible out-of-pocket dependent care costs. Here's how the account works: you make contributions to a dependent care FSA on a pre-tax basis. You are then reimbursed from your account tax free. Because of the tax advantages that this account offers, it is subject to certain IRS restrictions.

The dependent care FSA is currently administered under service contracts with the service providers described in Appendix A.

These benefits (including information about who is eligible to receive benefits, the amount of contributions, maximums, limitations, and eligible expenses) are more fully described in the applicable attachment to Appendix A. For more information regarding the benefits offered under the dependent care FSA program, please contact the Plan Administrator.

Covered and Non-Covered Services

See the certificates of insurance and benefits booklets attached at Appendix A for a specific listing of covered and non-covered services for your benefits.

Claims and Appeal Process

In general, any participant or beneficiary or his/her duly authorized representative (the "claimant") may file a written claim for benefits using the proper form and procedure. A benefit plan has a specific amount of time, by law, to evaluate and process claims for benefits covered by ERISA. The length of time the benefit plan has to evaluate and process a claim begins on the date the claim is first filed.

If you have any questions regarding how to file or appeal the initial claim, contact the appropriate Claims Administrator. (See the *Plan Administration and Other General Information* section for the Claims Administrators' contact information.)

Following an adverse benefit determination on review, and after exhausting the applicable plan appeal process described below, you are entitled to bring a civil action in a federal or state court of competent jurisdiction in accordance with Section 502(a) of the Employee Retirement Income Security Act of 1974.

The general rules under ERISA are described in this section. These rules generally do not apply to any plans that are not subject to ERISA. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply.

The Plan intends to comply with the many changes that are required by new standards for internal claims and appeals and external reviews as required by the Affordable Care Act. If the Plan existed prior to enactment of the Affordable Care Act, and the Plan is a grandfathered health plan, the new external review provisions do not apply to the Plan. If the Plan is not a grandfathered health plan and it is self-insured, see the applicable certificates and descriptive booklets for more information on the full claims and appeals process.

Filing a claim

For information on how to file your initial claim, see the claim filing procedures in the insurance contract or associated documents that describe the benefit program. **[**Notwithstanding the foregoing, claims filed under a self-insured medical or prescription drug plan offered herein must be filed within 12 (twelve) months of the date of service, or such longer time as may be provided in an underlying booklet.**]** In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrator or Plan Administrator.

Claim-related definitions

Urgent care claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for medical benefits is urgent.

Pre-service claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-service claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent care claims

"Concurrent care claims" are claims in which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim", "pre-service claim", or "post-service claim", depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

In addition, in an urgent care situation in which the Plan previously approved a course of treatment and you wish to extend such treatments past the time period or number of treatments previously approved, you may request an extension to the course of treatments at least 24 hours prior to the time the treatments are scheduled to expire. The Plan must notify you of its determination of whether to grant the request within 24 hours of receipt of the claim.

Claim review procedures

The Claims Administrator listed in the *Plan Administration and Other General Information* section below will process the payment of claims under the Plan and handle the related recordkeeping. The Company may act as the Claims Administrator for purposes of reviewing claims and claim denials under the Plan, or may designate other organizations or persons to act as the Claims Administrator for claims review and denials. With respect to fully insured benefits, the Claims Administrator is the insurance company. For more information on the Claims Administrator for purposes of claims review and denials under the self-insured benefits offered under the Plan, see the claim filing procedures described in the associated documents that describe the benefit program. The Company or other designated Claims Administrator has full discretion and authority to determine all claims under the benefit programs. Any action or determination in the review procedure will be final, conclusive and binding on the Claims Administrator, the Plan Administrator, the Company, you and your family members.

If you, your beneficiary or your authorized representative feel that any of the benefit programs have made an error concerning your benefits, you, your beneficiary or your authorized representative has the right to request reconsideration under the Plan in accordance with the applicable procedures. All requests for reconsideration will be submitted in writing to the Claims Administrator listed in the *Plan Administration and Other General Information* section below.

Initial claim determination

Pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), for each of the Plan options, except for the cafeteria plan option, the health reimbursement account, and the dependent care FSA, the Plan has a specific amount of time, by law, to evaluate and respond to a claim for benefits. The period of time the Plan has to evaluate and respond to a claim begins on the date the claim is first filed. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

The following timeframes apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

Timeframes for initial claims decisions

Timeframes generally start when the Plan receives a claim. (But see the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally should be provided through in-hand delivery, mailed, or sent by electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Healthcare FSA claims are considered non-urgent "post-service" claims.

	Medical, Dental and Vision Plans — urgent care claims	Medical, Dental and Vision Plans — non-urgent "pre-service" claims	Medical, Dental, Vision and Healthcare FSA Plans non-urgent "post-service" claims	Medical, Dental and Vision Plans "concurrent care" decision to reduce benefits	Disability Plans	Life Insurance and Accidental Death & Dismemberment Plans
Timeframe for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, no later than 72 hours. If you request in advance to extend ongoing treatments, provide notice of determination as soon as possible taking into account medical exigencies, but no later than 24 hours.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan sufficiently in advance to give you an opportunity to appeal and obtain decision before benefit is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.
Extensions	The Plan has up to 48 hours (subject to decision being made as soon as possible) for missing claim information; this period measured from when information is received or extension period expires.	The Plan has up to 15 days if necessary due to matters beyond the plan's control and must provide extension notice before period ends.*	The Plan has up to 15 days if necessary due to matters beyond the Plan's control and must provide extension notice before period ends.*	N/A	The Plan has up to 30 days if necessary due to matters beyond the Plan's control. A second 30 day extension may also be permitted. The Plan must provide the extension notice before period(s) end.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours).	You have at least 45 days to provide any missing information.	Give claimant at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	Notice that claim is improperly filed or missing information must be provided by the Plan as soon as possible (no later than 24 hours).	Notice that claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days).	N/A	N/A	N/A	N/A

***** 15 or 30-day extension period (whichever is applicable) is "tolled" until the claimant responds to the notice.

Adverse benefit determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" – a denial, reduction or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- an individual being ineligible to participate in the Plan;
- utilization review;
- a service being characterized as experimental or investigational or not medically necessary;
- a concurrent care decision; and/or
- certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at the time.

An adverse benefit determination for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. An adverse benefit determination for disability claims (including life waiver of premium claims), includes a rescission of coverage, including retroactive cancellations of coverage due to alleged misrepresentation of fact (for example, errors in the application for coverage). Rescissions for nonpayment of disability premiums are not considered adverse benefit determinations.

In the event of an adverse benefit determination, you will receive notice of the determination. The notice will include:

- the specific reasons for the adverse determination;
- the specific Plan provisions on which the determination is based;
- a description of any additional information needed to reconsider the claim and the reason this information is needed;
- a description of the Plan's review procedures and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- if any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- for adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- for adverse determinations involving urgent care, a description of the expedited review process for such claims (this notice may be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice).

For medical claims, the notice will include information sufficient to identify the claim involved. This includes:

- the date of service;
- the health care provider;
- the claim amount (if applicable); and
- the denial code.

For medical claims, the notice will also include:

- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;

- a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For disability claims, the notice must include:

- a complete description of the Plan's standard used in denying the claim;
- a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents;
- include the internal rules, guidelines, protocols, standards or other similar criteria of the Plan that were used in denying a claim, or a statement that none were used; and
- information in a culturally and linguistically appropriate manner in certain situations.

Appealing a claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the timeframes described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator set forth in the *Plan Administration and Other General Information* section of this Document.

Any appeal will be decided in accordance with reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you will lose your right to later object to the decision and your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan).

Timeframes for appeals process

Timeframes for filing an appeal start when you receive written notice of the adverse benefit determination. The timeframes for providing notice of benefit determination on review start when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision should be provided through in-hand delivery, mailed, or sent by electronic delivery before the period expires, though urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days.

	Medical, Dental and Vision Plans — urgent care claims*	**Medical, Dental and Vision Plans — non-urgent care pre-service claims***	**Medical, Dental, Vision and Healthcare FSA Plans — non-urgent care post-service claims***	**Disability Plans**	**Life Insurance and Accidental Death & Dismemberment Plans**
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 60 days.
Timeframe for Providing Notice	As soon as possible taking into account medical exigencies, but not later than 72 hours. Maximum 2 levels of mandatory review.	Within reasonable period of time appropriate to medical circumstances, but not later than 30 days. Maximum 2 levels of mandatory review. If 2 levels are used, notice must be provided within 15 days of each appeal.	Within reasonable period of time, but not later than 60 days. Maximum 2 levels of mandatory review. If 2 levels are used, notice must be provided within 30 days of each appeal.	Within reasonable period of time, but not later than 45 days. Maximum 2 levels of mandatory review.	Within reasonable period, but not later than 60 days.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request).	Additional 60 days if special circumstances require extension.
Quarterly Meeting Rule Alternative to Above Time Limits	None.	None.	None.	None.	Available.

*****An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service or post-service claim, depending on the facts.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination which is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable DOL regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

For medical and disability claims (including life waiver of premium claims), the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, but rather based on the professional's qualifications.

Prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the medical or disability plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical and/or disability claim (including life waiver of premium claims), you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimus, if the error does not cause harm to the claimant, if the error was due to a good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an urgent care claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the timeframes described above. For urgent care, all necessary information, including

the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- the specific reason for the adverse determination on review;
- reference to the specific provisions of the Plan on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a description of your right to bring a civil action under ERISA following an adverse determination on review;
- if any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- for adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- a description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For medical claims adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- the date of service;
- the health care provider;
- the claim amount (if applicable); and
- the denial code.

For medical claims, the notice will also include:

- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For disability claims, the notice must include:

- a complete description of the Plan's standard used in denying the claim;
- a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents;
- include the internal rules, guidelines, protocols, standards or other similar criteria of the Plan that were used in denying a claim, or a statement that none were used; and
- information in a culturally and linguistically appropriate manner in certain situations.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Legal remedies

You will not be able to bring a legal or equitable action for benefits under the Plan or any benefit program unless and until you have:

- submitted a claim for benefits in accordance with the foregoing applicable description of the claims process;
- you have been notified by the Claims Administrator that the claim has been denied; and
- you have filed a written request for a review of the claim in accordance with the foregoing applicable description of claims appeal procedures and the denial of the claim has been affirmed.

However, you will be entitled to bring a legal action on any claim if the Claims Administrator has failed to take any action on the claim within the time permitted for reviewing the claim as discussed in the chart above.

Unclaimed benefits

The Plan Administrator will take reasonable steps to ascertain the whereabouts of a claimant so as to affect delivery of benefits payable under the Plan. If a claimant has not collected benefits payable to him or her within 12 months from the date the claim was filed, the Plan Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Plan Administrator, deem the claimant's right to such benefit waived. Upon such waiver, the Plan will have no liability for payment of the benefit otherwise payable. If the unclaimed benefits provisions in this Document conflict with the unclaimed benefits provisions in an insurance contract governing benefits at issue, the unclaimed benefits provisions in the insurance contract will govern.

Coordination of Benefits

Coordination of benefits provisions apply to the health plans only and, to the extent that these provisions are not described in the applicable certificates or descriptive booklets, are described in this section. To the extent that the descriptive booklet(s) provided by the third party administrator or insurance carrier includes coordination of benefit provisions, the provisions of the descriptive booklet(s) will govern.

All payments under the plans described in this Document will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication and works to the advantage of all members of the group.

When you or your dependent(s) are eligible for benefits under another group plan, the eligible expenses under this plan will be determined as follows. One of the plans involved will pay benefits first — the Primary Plan — and the other plan(s) will pay benefits next — the Secondary Plan(s), as defined below.

Definitions

Allowable Expense: Includes any necessary, reasonable, and customary expense that would be covered in full or in part under the Plan. When a plan provides benefits in the form of furnishing services or supplies rather than cash payments, the service or supply will not be considered an allowable expense or a benefit paid.

Plan: Most plans under which group health benefits are provided, including group insurance closed panel or other forms of group or group-type coverage (whether insured or uninsured) or provides benefits on a prepaid or managed care basis (for example, PPO or HMO) or an indemnity basis, medical care components of group long-term care contracts (such as skilled nursing care), medical benefits under group or individual automobile contracts, Workers' Compensation, and Medicare or

other governmental benefits, as permitted by law. Also included are plans that provide coverage for students that are sponsored by, or provided through, a school or other educational institution, except for accident-type coverage for grammar and high school students.

Primary Plan: A benefit plan that has primary liability for a claim.

Secondary Plan: A benefit plan that adjusts its benefits by the amount payable under the Primary Plan.

This Plan will be the Primary Plan on claims:

- for you, if you are not covered as an employee by another plan;
- for your spouse**/**domestic partner, if your spouse/domestic partner is not covered as an employee by another plan; and
- for your dependent children, the birthdays of the parents are used to determine which coverage is primary. This is the case if the parents are married to each other or not separated (whether or not they were ever married), or if a court decree awarding joint custody does not stipulate that one parent is responsible for the child's health care. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered primary coverage (For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is the primary plan for your children). If both parents have the same birthday, then the coverage that has been in effect the longest is primary.

When a child is claimed as a dependent by parents who are separated or divorced, the Primary Plan is the plan of the parent who has court-ordered financial responsibility for the dependent child's health care expenses. If there is no court-ordered financial responsibility for the dependent child's health care expenses, the Plan will be Secondary. When a child's parents are separated or divorced and there is no court decree, then the Primary Plan will be determined in the following order:

- the plan of the parent with custody of the child;
- the plan of the spouse of the parent with custody of the child; and
- the plan of the parent not having custody of the child.

The "birthday rule" described above applies if a court decree awarding joint custody does not stipulate that one parent is responsible for the child's health care.

If the Plan is the Primary Plan, it will pay benefits first. Benefits will be calculated according to the terms of the Plan and will not be reduced due to benefits payable under other plans.

If the Plan is the Secondary Plan, benefits under the Plan may be reduced. The Claims Administrator will determine the amount the Plan normally would pay. Then the amount payable under the Primary Plan for the same expenses will be subtracted from the amount the Plan would have normally paid. The Plan will pay the difference. If the Plan is Secondary, you will never be paid more for the same expenses under both the Plan and the Primary Plan than the Plan would have paid alone.

When the Plan is the Secondary Plan and the patient is covered under an HMO, benefits under the Plan will be limited to the copayment, if any, for which you would have been responsible under the HMO, whether or not the services provided, are rendered by the HMO.

In the event that a legal conflict exists between two plans as to which is the Primary Plan and which is the Secondary Plan, the plan that has covered the patient for the longer time will be considered the Primary Plan. When a plan does not have a coordination of benefits provision, the rules in this provision are not applicable and such plan's coverage is automatically considered the Primary Plan.

Even if the Plan is your Primary Plan or Secondary Plan, in states with no-fault automobile insurance, the automobile insurance carrier is the primary insurance for injuries resulting from an automobile accident. In no fault states, all medical expenses related to an automobile accident should be submitted to the automobile insurance carrier first. The Plan will pay covered expenses not payable

under the no-fault automobile insurance according to the coordination of benefit rules discussed above. Then, you can submit claims under another plan, such as your spouse's employer's plan, for any expenses not paid by the Plan. Depending on the coordination of benefit provisions of the other plan, you may or may not receive additional benefits.

Coordination with Medicare

When you or your eligible dependents are entitled to Medicare and you elect coverage under the Plan, the Plan continues to be the Primary Plan as long as you are an active employee. The Plan is Primary Plan for the following situations:

- eligible active employees age 65 and over and who are entitled to Medicare benefits;
- dependent spouses age 65 and over who participate in the Plan on the basis of current employment status of the employee and who are entitled to Medicare benefits;
- Social Security disabled participants who are covered by the Plan on the basis of your active employment status with Company and who are entitled to Medicare benefits; and
- for the first 30 months of Medicare entitlement, certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD), unless applicable federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

If you or your eligible dependents who are entitled to Medicare coverage decline coverage under the Plan, benefits listed herein will not be payable even as secondary coverage to Medicare.

If you or a covered family member becomes covered by Medicare after a COBRA election is made, your COBRA coverage will end.

There are some circumstances under which Medicare would be required to pay its benefits first and, to the extent required by federal regulations, the Plan will pay after any Medicare benefits. In these cases, benefits under the Plan will be calculated as Secondary Plan (as described in this section). You or your eligible dependents entitled to Medicare will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not you or your eligible dependents have enrolled for the full coverage. If the provider accepts assignment with Medicare, covered expenses will not exceed the Medicare-approved expenses.

Facility of payment

When benefit payments that would have been made under a Company plan have been made under another plan, the Plan has the right to pay the other plan the amount that satisfies the intent of the provision. Any payment made will be considered payment of benefits under the Plan and, to the extent of such payment, the Plan's obligation to pay benefits will be satisfied. The Company will not have to pay that amount again. The term "payment made" also includes providing benefits in the form of services; in which case "payment made" means a reasonable cash value of the benefits provided in the form of services.

Right of recovery

The Plan has the right to recover any payment made in excess of the maximum amount payable under this provision. The Plan may recover from one or more of the following entities in an effort to make the plan whole:

- any persons it paid or for whom payment was made;
- any insurer, and any other organization; or
- any entity that was thereby enriched.

The "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Release of information

Certain facts are needed to apply the rules of this provision. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may get the needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. At the time a claim for benefits is made, the Claims Administrator will determine the information necessary to operate this provision.

Recovery Provisions

The descriptive booklet(s) provided by the third party administrator or insurance carrier may include subrogation, acts of third party, and right of recovery provisions applicable to the health plan benefits offered under this Plan. See the component plan documents for more information. To the extent that these provisions are not described in the applicable certificates or descriptive booklets, they are described in this section.

Right of the plan to recover improperly paid benefits

The Company has the right to recover an amount paid in error. For example, if you receive benefits for a service under the Plan in error, and you also receive benefits from another plan for the same service, the Company and the Plan vendor have the right to recover the amount paid to you by the other plan. You are not permitted to receive total benefits above the cost of the service provided. The same is true if payment is made in excess of what should have been paid under the Plan.

Refund of overpayments

If benefits are paid under the Plan for expenses incurred, you or any other person or organization that was paid must make a refund to the Plan if:

- all or some of the expenses were not paid by you or did not legally have to be paid by you, or
- all or some of the payment made under the Plan exceeded the benefits available under the Plan.

The refund equals the amount of benefits paid in excess of the amount that should have been paid under the Plan.

If the refund is due from another person or organization, then you agree to assist the Company in obtaining the refund when requested.

If you, or any other person or organization that was paid, do not promptly refund the full amount, the amount owed may be deducted from any future claim reimbursements.

Acts of third parties

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- has an equitable lien on any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- may appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- may bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment, however characterized, from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds (without reduction for attorney's fees or otherwise) in a separate, identifiable account and that the plan has an equitable lien on the funds, and you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must reimburse the Plan first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must reimburse Plan up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must reimburse the Plan regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds. The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid (or payable) to you, your guardian or other representatives.

As a Plan participant, you are required to:

- cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Document.
- notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of third party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of third party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

Continuation Coverage

There are several types of continuation coverage that may apply to particular component benefit programs, as highlighted below. For more information, see the attachments to Appendix A for the particular component benefit programs.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires that the Company provide you and/or your spouse and covered dependents who are qualified beneficiaries under COBRA with the opportunity to continue medical (including prescription drug and telemedicine), dental, vision and EAP coverage for a temporary period at group plan premium rates in certain instances where your coverage under the plans would otherwise end.

The descriptive booklet(s) provided by the third party administrator or insurance carrier include a complete explanation of your COBRA rights and responsibilities. These descriptive booklet(s) may also describe any state continuation of coverage laws that may provide additional protection to participants under insured arrangements and if so, those rules will apply. If you have any questions about your COBRA rights, please read your Initial COBRA Notice, a copy of which has been previously furnished to you and your spouse (if covered). Please contact the Plan Administrator if you need another copy.

As a qualified beneficiary, you can elect to continue the health coverage (that is, medical, dental, vision, prescription drug) in effect on the date your coverage would otherwise end. You may also, under certain circumstances, be eligible to continue your participation in the healthcare FSA. In general, healthcare FSA continuation under COBRA is available only for the remainder of the year in which you terminate employment. You may not continue your dependent care FSA under COBRA. COBRA does not apply to the other non-health benefits offered under the Plan (for example, life insurance, AD&D, LTD, STD, group legal).

Qualified beneficiaries include you, your spouse, and dependent children who were covered under the Plan immediately before coverage ends. A qualified beneficiary also includes a child born to or placed for adoption with you, the employee, while enrolled in COBRA continuation coverage, provided you provide timely and proper notification of the birth or adoption.

Note that you may have options other than COBRA 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. For more information about the Marketplace, visit www.HealthCare.gov. 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.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The Company reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the health plans.

You will have 60 days from the date of the qualifying event to elect COBRA continuation coverage, or, if later, 60 days from the date the COBRA Administrator or its agent sends a COBRA election notice to you. If you do not choose COBRA coverage within that time, you will not be eligible for COBRA coverage. See the *Electing COBRA* section below for more information.

You will have to pay the entire premium (subject to any applicable government subsidy) plus a 2% administrative fee for your continuation coverage. There is a grace period of at least 30 days for the payment of the regularly scheduled premium. Your first premium payment is due within 45 days of the date of your election. See the *Cost of Coverage* section below for more information.

Contact information

If you have any questions about your COBRA rights, please read your Initial COBRA Notice, a copy of which has been previously furnished to you and your spouse (if covered). Please contact the Plan Administrator if you need another copy. COBRA continuation is administered by Flores & Associates, 2013 W Morehead Street, Suite B, Charlotte, NC 28208, 800.532.3327, herein referred to as the "COBRA Administrator".

Who is covered

Employees

If you are an employee covered by a Company-sponsored group health plan, you have a right to elect COBRA coverage if you lose your group health coverage under the Plan because of either of the following qualifying events:

- a reduction in your hours of employment with the Company; or
- the termination of your employment (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee and are covered by a Company-sponsored plan on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose group health coverage under a Company-sponsored group health plan for any of the following four reasons:

- the death of your spouse;
- the termination of your spouse's employment (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment;
- divorce or legal separation from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation; or
- your spouse becomes entitled to (that is, covered by) Medicare.

Federal law does not recognize your domestic partner as your spouse and a domestic partner is not recognized as a COBRA qualified beneficiary. As such, a domestic partner has no independent right to continue group health plan coverage under COBRA. Domestic partners and their eligible dependent children are not considered qualified beneficiaries for purposes of legal entitlement to COBRA continuation coverage. But a former employee has a COBRA right to retain a domestic partner's coverage and to elect domestic partner coverage during open enrollment, if similarly situated active employees can do so.

Dependent Children

If you are a covered dependent child of an employee covered by a Company-sponsored plan on the day before the qualifying event, you also are a qualified beneficiary and have the right to continuation coverage if group health coverage under such plan is lost for any of the following five reasons:

- the death of the parent-employee;
- the termination of the parent-employee's employment (for reasons other than his/her gross misconduct) or reduction in his/her hours of employment;
- the parent-employee's divorce or in some cases legal separation;
- the parent-employee becomes entitled to (that is, covered by) Medicare; or
- the dependent ceases to be a "dependent child" under the Company-sponsored plan.

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

Your duties

Under the law, the employee or a family member has the responsibility to provide notice of a divorce, termination of domestic partnership, legal separation or a child losing dependent status under the Company-sponsored group health plan. The notice must include the following information:

- the name of the employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- the qualifying event giving rise to COBRA coverage;
- the date of the qualifying event; and
- the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if it is requested. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s) or driver's license(s).

You must mail or hand-deliver this notice to the COBRA Administrator at the address listed in the *Contact Information* section above. This notice must be provided within 60 days from the date of the divorce, legal separation or child losing dependent status (or if later the date coverage would normally be lost because of the event). When the COBRA Administrator is notified that one of these events has happened, the COBRA Administrator in turn will notify you that you have the right to elect continuation coverage. See the *Electing COBRA* section below for more information.

If you or your family member fails to provide notice of the qualifying event to the COBRA Administrator during this 60-day notice period, any family member who loses coverage will not be offered the option to elect continuation coverage. If you or your family member fails to notify the COBRA Administrator and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation, or a child losing dependent status, then the employee and family members will be required to reimburse the employer-sponsored group health plans for any claims mistakenly paid.

Company's duties

Qualified beneficiaries will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage. The employee's:

- death;
- termination (for reasons other than gross misconduct);
- reduction in hours of employment; or
- Medicare entitlement.

The Company will notify the Plan Administrator of a qualifying event within 30 days of the date of the qualifying event or, if later, date of the loss of coverage. If notice of the qualifying event is sent to the Plan Administrator within 30 days of the date of the loss of coverage, the duration of COBRA will be counted from the date that coverage ceases (not the date of the qualifying event). See Duration of COBRA section below for more information regarding the period of COBRA coverage.

Electing COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice. You must mail or hand-deliver this completed notice to the COBRA Administrator. An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described earlier, or, if later, 60 days after the COBRA Administrator provides you with notice of your right to elect continuation coverage. Your election must be postmarked within the 60-day election period. If you (or a family member) do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you choose continuation coverage, the Company is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the health plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. "Similarly situated" refers to a current employee or dependent who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

If you do not choose continuation coverage within the 60-day election period, your group health coverage will end as of the date of the qualifying event. If you return your election form waiving your rights to COBRA and change your mind within the 60-day period, you may revoke your waiver and still elect COBRA coverage as long as it is within the 60-day window. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Newly eligible child: If you, the former employee of the Company, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary with his own rights to COBRA. If your dependent who is a qualified beneficiary elects COBRA coverage and then has a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is eligible for COBRA coverage as a dependent of the qualified beneficiary, but will NOT become a qualified beneficiary with his own rights to COBRA. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these children can be added to COBRA coverage by providing the COBRA Administrator with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and a copy of the birth certificate or adoption decree.

If you fail to notify the COBRA Administrator within the 30 days, you will not be offered the option to elect COBRA coverage for the newly acquired child. Other newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

Separate elections: Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or domestic partner or dependent child is entitled to elect COBRA coverage even if the covered employee does

not make that election. Similarly, a spouse/domestic partner or dependent child may elect different coverage than the employee elects. A covered employee or spouse/domestic partner can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. And at subsequent open enrollments, a spouse/domestic partner or dependent child may elect a different coverage from the coverage the employee elects. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

The Trade Act of 2002: The Trade Act of 2002 created a tax credit (the Health Coverage Tax Credit or "HCTC") for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). The HCTC has expired and been reinstated and changed over time. Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of a portion of premiums paid for qualified health insurance, including COBRA continuation coverage. The IRS will provide ongoing guidance on the HCTC, including guidance for taxpayers who also qualify for premium assistance under the Affordable Care Act. More information about the HCTC is available at https://www.irs.gov/credits-deductions/individuals/hctc. More information about the Trade Act is available at https://www.dol.gov/agencies/eta/Tradeact.

Medicare and other coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. When you complete the election form, you must notify the Company if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. The 18-month COBRA coverage period begins on the later of the date of the qualifying event or the date coverage is lost. For all other qualifying events (an employee's death, divorce, legal separation, or a child losing dependent status), the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

Additional qualifying events, which are an employee's death, divorce, legal separation, or Medicare entitlement or a child losing dependent status may occur while COBRA continuation coverage is in effect due to an employee's termination of employment or reduction in hours ("Second Qualifying Events"). Second Qualifying Events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage or the date coverage would have been lost due to the initial qualifying event.

The maximum COBRA coverage period for the healthcare FSA ends on the last day of the plan year in which the qualifying event occurred, but claims incurred during any grace period are eligible for reimbursement.

Medicare: When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits within 18 months BEFORE termination or reduction of hours, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement.

COBRA coverage can end before any of the above maximum periods for several reasons. See the *Early Termination of COBRA* section below for more information.

Your duties upon a second qualifying event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension described below, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18 months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you (or a representative acting on your behalf) notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- the name(s) and addresses of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the second qualifying event;
- the date of the second qualifying event;
- the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. You must mail or hand-deliver this notice to the COBRA Administrator at the address listed under the *Contact Information* section above.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Special rules for disability: If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. A qualified beneficiary must be determined, under the Social Security Act, to have been disabled and the disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally, 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary become disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand-deliver this notice to the COBRA Administrator at the address listed under the *Contact Information* section above.

If, during the extended continued coverage period, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this redetermination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner and include the same information required for a notice of disability as described above.

Early termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- the Company no longer provides group health coverage to any of its employees;
- the premium for continuation coverage is not paid on time (within the applicable grace period);
- the qualified beneficiary becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee);
- the qualified beneficiary first becomes entitled to (covered by) Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- coverage has been extended for up to 29 months due to disability, and there has been a final determination under the Social Security Act that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security Administration determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate the coverage of a participant not receiving COBRA coverage (such as fraud). In addition, the Company reserves the right to terminate your coverage retroactively, in the event it determines you are not eligible for COBRA.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. The Company, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See the *Special Rules for Disability* section above.

COBRA and FMLA

If you take a leave of absence that qualifies under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- you lose group health coverage under the Plan because you do not return to work at the end of the FMLA leave.

COBRA coverage will begin on the earliest of the following to occur:

- when you definitively inform the Company that you are not returning at the end of the leave; or
- the end of the leave, assuming you do not return to work.

The Company will notify the Plan Administrator of your qualifying event within 30 days of the last day of FMLA leave, or if later, the date coverage terminates. Your maximum coverage period starts the later of the last day of FMLA leave or the date coverage terminates.

Healthcare flexible spending account COBRA coverage

You may also, under certain circumstances, be eligible to continue your participation in the healthcare FSA. (You may not continue your dependent care FSA under COBRA.) COBRA coverage under the healthcare FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the healthcare FSA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for healthcare FSA COBRA coverage that will be charged for the remainder of the plan year. In general, healthcare FSA continuation under COBRA is available only for the remainder of the year in which you terminate employment. COBRA coverage for the healthcare FSA, if elected, will consist of the healthcare FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply. All qualified beneficiaries who were covered under the healthcare FSA will be covered together for healthcare FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate healthcare FSA annual coverage limit and a separate COBRA premium.

Cost of coverage

You do not have to show that you are insurable to choose COBRA coverage. You will be required to pay the full cost of COBRA coverage. The amount you may be required to pay may not exceed 102% 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 COBRA coverage). If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the cost of covering an employee and any eligible dependents, if applicable. This cost increase begins with the 19th month of COBRA coverage, provided that the disabled individual is one of the individuals who elected the disability extension. The cost of group health coverage periodically changes. If you elect COBRA coverage, you will be notified by the COBRA Administrator of any cost changes.

You will have to pay the entire premium (subject to any applicable government subsidy) plus a 2% administrative fee for your continuation coverage. There is a grace period of at least 30 days for the payment of the regularly scheduled premium.

COBRA coverage is not effective until you elect it and make the required payment. Your first premium payment is due within 45 days after you elect COBRA coverage. Claims for reimbursement will not be

processed and paid until you have elected COBRA and made the first payment for it. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payments. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you pay part but not all the premium, and the amount you paid is not significantly less than the full amount due, you will have 30 days from the end of the initial 30-day grace period to pay the outstanding amount due.

All COBRA premiums must be paid by check, money order, ACH debit or on-line credit card payment, as permitted by the COBRA Administrator. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the COBRA Administrator. If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

If you do not make timely payments, your COBRA coverage will be terminated as of the last day of the month for which you made timely payment.

For more information

If you have any questions about COBRA coverage or the application of the law, please contact the Plan 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.

Keep the Plan informed of address changes

In order to protect your and your family's rights, you should keep the Company informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to the Company. Notices should be sent to the Plan Administrator.

Insured plans - continuation of coverage

If you participate in a fully insured health plan, then you may also have special continuing coverage rights. Further, your spouse and dependents may also have special continuation rights. Please see your insured plan insurance certificate for details.

Converting Coverage after Termination

Contact your insured plan for information on converting to an individual policy. Many PPOs, HMOs, and other insured plans will permit you to continue membership or equivalent coverage on an individual policy. Conversion rights may also be available to your spouse and/or dependents when their coverage may not otherwise qualify for health insurance under normal circumstances. Due to this fact, however, the cost of the coverage is usually high and the conversion plans, prescribed by the state insurance regulations, will not offer the same comprehensive coverage as the Company health benefits program. For that reason, you should also contact other insurance companies so you can be sure you are getting the best coverage for your money.

For more information about conversion rights, contact the Plan Administrator.

Individual coverage after termination

You may be able to obtain coverage under an individual insurance policy issued by an insurance company. The opportunity to buy an individual insurance policy is the same whether the individual is laid off, is fired or quits his or her job. For information on individual insurance policies you should contact your State Insurance Commissioner's Office.

For information on individual plan options that might be available through the Health Insurance Marketplace, visit www.HealthCare.gov.

Coverage during Leave of Absence

If you go on an approved leave of absence, then entitlement to benefits will be determined by the Company policy for providing benefits during leave of absence. See below for benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, contact the Plan Administrator.

If you go on a paid leave of absence that does not affect eligibility for pre-tax elections under the Plan, then you will continue to participate in these benefits and your contributions due will continue to be paid on a pre-tax basis during your leave, as may be determined by the Plan Administrator. The Company will continue its contributions at the same level and under the same conditions as if you had continued to work.

If you go on an unpaid leave that does not affect eligibility for pre-tax elections under the Plan, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be prepaid before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. The Company will continue its contributions at the same level and under the same conditions as if you had continued to work.

If you go on an unpaid leave that affects eligibility for pre-tax elections under the Plan, then the election change rules described in the *Making Changes during the Year* section of this Document will apply.

This section describes benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, contact the Plan Administrator.

Family and medical leave

The federal Family and Medical Leave Act ("FMLA") allows eligible employees to take a specific amount of unpaid leave for certain reasons, including for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. This leave is also for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty.

See the Family and Medical Leave Act discussions in the *Making Changes during the Year* section and the *Continuation Coverage* section of this Document for more information on continuation of benefits during FMLA leave.

Military leave

If you take a military leave, whether for active duty or for training, you are entitled to extend your health coverage for up to 24 months (or the day you fail to return to work after the end of the leave, if sooner) as long as you give the Company advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Your total leave, when added to any prior periods of military leave from the Company, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit – including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after you uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee who is not on military leave (including any amount for dependent coverage).

COBRA continuation coverage will run concurrently with USERRA coverage, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period.

If you take a military leave, but your coverage under the health benefits program is terminated – for instance, because you do not elect the extended coverage – when you return to work at the Company, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies.

All other coverages will continue during your military leave.

Participation in the dependent care FSA will terminate. If you are called to perform military service for more than 179 days, you will be able to take your unused healthcare FSA balance as a taxable cash distribution by the last day of the FSA Plan Year, extended for any 2 ½ month grace period.

Funding

The Company's contributions

The Company will contribute to the cost of benefits provided under the Plan in whole or in part. Contributions made by the Company will be made at the times and in the manner determined by the Company. All contributions made by the Company will be for the exclusive purpose of providing benefits to you and other participants in the Plan. In no event will the Company have any obligation to fund self-insured benefits provided under the Plan in advance of the date that such benefits are payable or pre-pay the premiums or other fees required in order to provide insured benefits under the Plan. The Company will determine the method for funding benefits under the Plan. The method may include the purchase of insurance, contracting with HMOs or PPOs, payments from general assets, or through any combination of these methods or otherwise.

Your contributions

The amount of contributions that you will be required to make with respect to each program requiring an employee contribution will be set forth in the enrollment forms and/or benefit booklets. In

determining required contributions, the Company may take into account such factors as the projected cost of insurance premiums, administrative fees and benefits under the Plan, the prior claims experience under the various benefits offered by the Plan, and the amount of the Company's contributions to the Plan. The Company's objective in determining the amount of required contributions will be to provide sufficient funds to cover the projected cost of benefits available under the Plan equal to the combined total of the contributions required and the amount that the Company has agreed from time to time to contribute toward the cost of benefits. The Company will deduct contributions from your wages in accordance with the Company policies and the salary reduction or deduction agreements between the Company and you.

Source of benefit funding

The Company's general assets will be the sole source of self-insured benefits under the Plan. No assets will be set aside for the purpose of providing benefits under the Plan. The Company will pay benefits (including any insurance premiums necessary for the purchase of benefits) required under the Plan out of the general assets of the Company, and benefits will be deemed to come first from amounts contributed by employees and then from amounts contributed by the Company.

Unless otherwise required by applicable law, the Company assumes no liability or responsibility for payment of such benefits beyond that which is provided in the Plan, and each participant or other person who claims the right to any payment with respect to such benefits under the Plan will not have any right, claim or demand therefore against the Company or any employee, officer or director of the Company.

With respect to insured benefits, you (or in the case of your death your beneficiary as that term is defined in the applicable insurance contract or booklet) will be entitled to receive only the insured benefit for which provision is actually made under the insurance contract or booklet. The Company does not assume liability or responsibility for any insured benefit and you will only be able to look to the insurance contracts for payment of any benefits. You will not have any claim for insured benefits against the Company, the Plan Administrator or any employee, officer or director of the Company. To the maximum extent that is consistent with ERISA or other applicable law, in the event of a conflict between the terms of an insurance contract and this Document, the terms of the insurance contract will govern.

Policy dividends and refunds

To the fullest extent permitted by applicable law, the Company will be entitled to retain any policy dividend or refund, or portion thereof, it receives from any insurance company, or other organizations, or any individual, that exceeds the amount necessary to fund the benefits provided by any particular benefit program offered under the Plan. Under ERISA, the Plan Administrator of the group health plan may have fiduciary responsibilities regarding distribution of dividends, demutualization and use of the Medical Loss Ratio rebates from group health insurers. Some or all of any rebate may be an asset of the Plan, which must be used for the benefit of the participants covered by the policy. Participants should contact the Plan Administrator directly for information on how the rebate will be used.

Experience gains

All amounts paid to and held by the Plan, as well as any policy dividends and refunds not belonging to the Company, will be available to fund the benefits provided by any benefit program. The Plan Administrator, in its exclusive discretion, may use funds accumulated under the Plan or any benefit program (whether insurance contract reserves, participant or Company contributions, or administrative fees) to reduce the level of contributions or payments of expenses or benefits that the Company would otherwise make to the Plan or any benefit program.

No right to assets

No participant or beneficiary will have any right to, interest in, or claim for, any assets of the Company, the Plan, any benefit program, or any underlying contract, trust or other vehicle for purposes of satisfying any benefits due such individual.

ERISA

Note that the pre-tax salary reduction elections under Code section 125 (the cafeteria plan), the dependent care FSA, state-mandated or self-insured short-term disability component benefit programs are not covered by ERISA and this ERISA rights statement does not apply to these programs.

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

Receive information about your plan and benefits

You can review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plans with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

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

Receive a summary of the plans' annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue group medical plan coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the medical plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary and the other documents governing the plans 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 on the people who are responsible for the operation of the 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 plan participants and beneficiaries. No one, including your company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare plan benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plans 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. In addition, if you disagree with the plans' decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that fiduciaries misuse the plans' assets, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, 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 plans, 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 nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

Plan Administration and Other General Information

The Company is responsible for the general administration of the Plan and will be the fiduciary to the extent not otherwise specified in this Document or in an insurance or administrative contract. The Company has the authority to appoint the Plan Administrator, as described below. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make certain amendments to the Plan to comply with law, to make determinations regarding issues that relate to eligibility for benefits, to decide disputes that may arise relative to a Plan Participant's or any other person's rights or obligations, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and the Company will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor the Company will be liable in any manner for any determination made in good faith.

The Plan Administrator has the necessary discretionary authority and control over the Plan to require deferential judicial review pursuant to the U.S. Supreme Court's 1989 decision in *Firestone Tire & Rubber Co. v. Bruch*.

The Company may designate other organizations or persons to carry out specific fiduciary responsibilities of the Company in administering the Plan including, but not limited to, the following:

- pursuant to an administrative_–services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,
- the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and

- the responsibility to act as a Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

The Company will administer the Plan on a reasonable and nondiscriminatory basis and will apply uniform rules to all persons similarly situated.

Power and authority of the insurance company

Certain benefits under these Plans are fully insured. Benefits may be provided under a group insurance contract entered into between the Company and an insurance company. With respect to fully insured benefits, claims for benefits should be sent to the insurance company. The insurance company is responsible for paying claims, not the Company.

The insurance company is responsible for:

- determining eligibility for and the amount of any benefits payable under the applicable benefit coverage.
- prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to the applicable benefit coverage.

The insurance company also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the applicable benefit coverage.

The Plan Administrator hereby delegates to each insurance company the discretionary authority to construe and interpret the terms and provisions of the insurance benefits they are contracted to provide as listed herein. Any such interpretation or determination is final and binding subject only to the arbitrary and capricious standard of judicial review.

Questions

If you have any general questions regarding the Plan, or any benefit program offered under the plan, please contact the Plan Administrator.

Plan Information	
Plan Sponsor	Bancroft 1255 Caldwell Road Cherry Hill, NJ 08034 856-348-1139
Employer Identification Number	21-0672770
Plan Administrator	Bancroft 1255 Caldwell Road Cherry Hill, NJ 08034 856-348-1139
COBRA Administrator	Flores & Associates 2013 W Morehead Street, Suite B Charlotte, NC 28208 800.532.3327
Member Advocacy	Bancroft Benefits Helpline 844-577-2616 cssteam@connerstrong.com SENA Health 609-503-4707 www.senahealth.com

Population Health	Wellworks for You 800-425-4657 www.wellworksforyoulogin.com Livongo/Teladoc Health 800-945-4355 https://hello.livongo.com/WPGEN
Claims Administrators	See charts below
Agent for Service of Legal Process	Plan Administrator
Plan Year	The Plan Year is each July 1 through June 30

Plan Types, Names and Numbers	

- Medical (including prescription drug and telemedicine)
- Employee Assistance Program
- Health Reimbursement Arrangement (HRA)
- Dental
- Vision
- Life Insurance Benefits
  • Basic Life
  • Voluntary Term Life
  • Dependent Life
- Accidental Death and Dismemberment (AD&D)
  • Basic AD&D
  • Voluntary AD&D
- Long-Term Disability (LTD)
- Short-Term Disability (STD)
- Accident Insurance
- Critical Illness Insurance
- Medical Bridge GAP Insurance
- Health Care FSA
- Dependent Care FSA
	Bancroft Neurohealth Health and Welfare Plan
	
	Plan Number 504

Claims Administrators	
Self-Insured Plans: *The following benefits are self-insured by the Company through contributions made by the Company, or contributions made jointly by the Company and participating employees. These benefits are paid directly out of the general assets of the Company. There is no special fund or trust from which benefits are paid. The Company has engaged the services of the following third-party administrators who are responsible for processing claims for these self-insured benefits. The ERISA fiduciary responsibility under the Plan to make a final decision on denied claims for self-funded benefits may be retained by the Company or delegated to the Claims Administrator. Any such delegation of this ERISA fiduciary responsibility to the Claims Administrator will be set forth in the associated documents which describe the benefit program:*	
Medical (including prescription drug and telemedicine)	Imagine360 800-903-4360 https://mibenefits.imagine360.com
Telemedicine (automatic w/medical)	UCM Digital Health 844-484-7362 www.GoSeeSam.com
Prescription Drug (automatic w/medical)	Express Scripts 800-282-2881 www.express-scripts.com
Healthcare FSA Dependent Care FSA Commuter Benefits	Flores & Associates 704-335-8211 www.Flores247.com
Health Reimbursement Arrangement (HRA)	Flores & Associates 704-335-8211 www.Flores247.com

Insured Plans: *The following benefits are insured through contracts with insurance companies who also administer claims for these benefits and are solely responsible for providing benefits. The ERISA fiduciary responsibility under the Plan to make a final decision on denied claims for fully insured benefits is delegated to the insurance companies:*	
Vision	EyeMed 844-873-7853 www.eyemed.com
Dental	Delta Dental 800-452-9310 www.deltadentalnj.com
Long-Term Disability	New York Life 888-842-4426 www.myNYLGB.com
Basic Life and Accidental Death & Dismemberment (AD&D) Voluntary Life and AD&D	New York Life 888-842-4462 www.myNYLGB.com

Employee Assistance Plan (EAP)	Carebridge 800-437-0911 www.myliferesource.com Register with Access Code: MRTXF
Voluntary Benefits: Accident Insurance Critical Illness Insurance Short-Term Disability Insurance	Aflac 800-433-3036 www.aflacatwork.com/enroll
Medical Bridge GAP Insurance	Colonial Life 856-983-9600

The dependent care FSA, and state-mandated or self-insured short-term disability benefit and the pre-tax salary reduction elections under Code section125 (the cafeteria plan)] described herein are not subject to ERISA. Contact information is provided for your convenience.

Plan amendment and termination

The Company reserves the right to amend the Plan, as set forth in this Document, in whole or in part, to completely discontinue any of the benefit programs, and to terminate the Plan in its entirety, at any time. For example, the Company reserves the right to amend or terminate covered expenses, benefit co-pays, lifetime maximums, and reserves the right to amend the plans to require or increase employee contributions. The Company also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable. An amendment to this Document is considered an amendment to the official plan document.

Any amendment, termination or other action by the Company with respect to the Plan will be by a duly adopted resolution of the Board of Directors or may be made by any person duly authorized to take such action on behalf of the Board of Directors. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination will reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of the Company, the Plan will terminate unless the Plan is continued by a successor to the Company.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus will revert to the Company to the extent permitted under applicable law, unless otherwise stated in the insurance or administrative contract or otherwise determined by the Board of Directors of the Company.

Participating employers

Any Affiliated Company may, with the consent of the Company, become a Participating Employer under the Plan, provided the Participating Employer agrees to be bound by all of the provisions of the Plan and any amendments in the manner set forth herein, agrees to pay its share of the expenses of the Plan as they may be determined from time to time; and agrees to provide the Company with full, complete, and timely information on all matters necessary for the operation of the Plan. "Affiliated Company" means all corporations and other entities which are members of the Company's controlled group or are under common control with the Company (within the meaning of Section 414 of the Code), but only during the period any such corporation or other entity is a member of such controlled group or under such common control.

In the event of the adoption of the Plan by an Affiliated Company, the Affiliated Company will become a Participating Employer and all the terms and conditions of the Plan as set forth hereunder will apply to the participation under the Plan of such Affiliated Company and its Employees. Notwithstanding the above, the Company reserves the right to designate a Participating Employer and the right to amend

the Plan, as set forth herein. These rights are specifically reserved to the Company so long as the Participating Employer participates under the Plan; and any such amendment, unless otherwise specified therein, will be fully binding with respect to such participation by any Participating Employer; provided that this reservation will in no event be construed to prevent any Participating Employer from terminating at any time its participation as a Participating Employer under the Plan.

The Company, in its sole and absolute discretion, may allow any Participating Employer at any time to terminate its participation under the Plan; provided that, if the Company will terminate its participation in the Plan, or disassociate itself, then each remaining Participating Employer will make such arrangements and take such action as may be necessary to assume the duties of the Company in providing for the operation and continued administration of the Plan.

Other Important Information

SPD/Plan Document

This Document constitutes the Bancroft Health and Welfare Plan and is an amendment and restatement of the Plan, effective as of July 1, 2024. Participants should always refer to their most recent enrollment materials and the descriptive booklets provided in Appendix A for current plan offerings. The Company maintains the Plan for the exclusive benefit of its eligible employees and their eligible spouses and dependents. The original effective date of the Plan was July 1, 2008. The Plan provides benefits through the component benefit programs described herein. Each of these component programs is described in a contract, certificate or booklet issued by an insurance company, a plan summary, or another governing document prepared by the Company or vendor for the benefits listed herein. A copy of each applicable component document is attached to this Plan. This Document should be read in combination with the certificates of insurance and benefit booklets, which are incorporated by reference into this Document. The Plan, through this Document and referenced documents, is a plan document and a summary plan description and is intended to satisfy the written document requirements of section 402 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and is also intended to satisfy the written document requirements of section 125 and other applicable provisions of the Internal Revenue Code (the "Code") for the cafeteria plan and flexible spending account features of the Plan.

No assignment of benefits

Except as may otherwise be required by applicable law, or as otherwise specifically provided in the Plan or by certificates of insurance and benefit booklets, you will not be entitled to assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any amount payable to you, your spouse or any dependents at any time under the Plan. Any attempt to assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void. If you, your spouse or dependent attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or any part thereof, then the Plan Administrator, if it so elects, may direct that such amount be withheld and that the same or any part thereof be paid or applied to or for the benefit of you, your spouse or your dependents, or any of them in such manner and proportion as the Plan Administrator may deem proper.

Notwithstanding the foregoing provisions of this *No assignment of benefits* section, you may request and authorize the Plan Administrator or the appropriate insurance company or service provider, in writing, to pay benefits directly to the hospital, physician, dentist or other person furnishing services or supplies covered under the applicable benefit program and any such payment, if made, will constitute a complete discharge of the liability of the plan therefore. No payment by the Plan pursuant to such request will be considered as recognition by the Plan of a duty or obligation to pay such provider, except to the extent the Plan chooses to do so. Benefits also may be assigned to an alternate recipient pursuant to a QMCSO.

Medicaid eligibility and assignment of rights

The Plan will not take into account whether an individual is eligible for, or is currently receiving medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a participant or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid Plan pursuant to §1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law which provides that the State has acquired the rights with respect to such individual to payment for such items and services under the Plan. If a benefit program available under this Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such benefit program will govern unless the language fails to comply with applicable state laws and regulations.

Important legal notice

The Plan Administrator will be responsible for the general administration of the Plan. The Plan Administrator and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, will have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including component benefit programs), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including component benefit programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator will be final and binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

Waiver of terms

No term, condition or provision of the Plan will be deemed waived, and the provisions of the Plan will be enforced, unless the Company or you specifically waive, in writing, the condition or provision. The written waiver will not be deemed a continuing waiver unless stated specifically in the waiver, and each waiver will operate only as to the specific term or condition waived.

Excess payments

If the Plan has made an erroneous or excess payment to or on behalf of you, your spouse or dependents, the Plan Administrator will be entitled to take action to correct the error, including recovering the excess from you, your spouse or dependents. To the extent permitted by applicable law, the recovery of the overpayment may be made by offsetting the amount of any other benefit or amount payable to or on behalf of you, your spouse or dependents by the amount of the overpayment.

Limitation of rights

This Document will not be held or construed to give any person any legal or equitable right against the Company, the Plan Administrator, or any other person connected with the Company or the Plan, except as expressly provided in this Document or as provided by applicable law; or to give any person any legal or equitable right to any assets of the Plan.

Severability

If any provision of this Document or the application of a provision of the Plan to any person, entity or circumstance is held invalid or unenforceable under governing law by a court of competent jurisdiction, its invalidity or unenforceability will not affect any other provision of this Document, or the application of this provision of the Plan to any person, entity or circumstance. The Document will be construed and enforced as if such provision had not been included in this Document.

Tax consequences

The Company does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in the Plan. You should consult with professional tax advisors to determine the tax consequences of participation.

Misrepresentation or fraud

If you receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and you may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator will decide such matters on a case by case basis. You may be asked to provide proof of eligibility for your dependents. False or misrepresented eligibility information could cause both your and your dependents coverage to terminate irrevocably (retroactively, to the extent permitted by law), and could be grounds for disciplinary action, up to and including your termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. Notwithstanding the foregoing, the Plan will not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

Legal action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan.

Applicable law

This Document will be construed in accordance with the laws of the State of New Jersey, except to the extent such laws are pre-empted by the law of any other state or by federal law.

Paperless communications

Notwithstanding anything contained in this Document to the contrary, the Company may from time to time establish uniform procedures whereby with respect to any or all instances in this Document where a writing is required, including but not limited to any required written notice, election, consent, authorization, instruction, direction, designation, request or claim communication may be made by any other means designated by the Company, including paperless communication, and such alternative communication will be deemed to constitute a writing to the extent permitted by applicable law, provided that such alternative communication is carried out in accordance with such procedures in effect at such time.

HIPAA Privacy and Security

This section describes the manner in which the Plan will protect certain health information used or maintained by the Plan.

The Company sponsors and maintains certain group health plans that are subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations, as are described more fully

in this Document. Under the privacy and security rules of HIPAA, and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), and as HIPAA and the HIPAA regulations were amended by the American Recovery and Reinvestment Act of 2009 ("ARRA"), a group health plan must: (i) restrict the use and disclosure of protected health information ("PHI"), (ii) ensure the confidentiality, integrity, and availability of all electronic protected health information ("e-PHI") the plan creates, receives, maintains, or transmits, (iii) protect against any reasonably anticipated threats or hazards to the security and integrity of such information, (iv) protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA privacy rules set forth in 45 CFR Part 164, Subpart E, and (v) ensure compliance with the HIPAA security rules set forth in 45 CFR Part 164, Subpart C by its workforce.

1. **Sharing PHI with the Company.** The Plan and the Company may disclose a Plan participant's PHI to the Company (or to the Company's agent) for the Plan administration functions described under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations.

2. **Certification from the Company.** Neither the Plan nor any of its Business Associates, health insurance issuers, or HMOs, will disclose PHI to the Company except upon the Plan's receipt of the Company certification that the Plan has been amended to incorporate the agreements of the Company under paragraph 3, except as otherwise permitted or required by law.

3. **Safeguarding PHI Shared with the Company.** As a condition for obtaining PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

   a. Not use or further disclose such PHI other than as permitted by paragraph 1 of this section, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

   b. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Company with respect to such information;

   c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company, and not use or disclose PHI that is genetic information for underwriting purposes;

   d. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Company becomes aware;

   e. Make the PHI of a particular member available for purposes of the member's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

   f. Make the PHI of a particular member available for purposes of required accounting of disclosures by the Company pursuant to the member's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

   g. Make the Company's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

   h. If feasible, return or destroy all PHI received from the Plan that the Company 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, the Company agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

4. **Ensuring Adequate Separations Between the Plan and the Company.** Ensure that there is adequate separation between the Plan and the Company by implementing the terms of subparagraphs (1) through (3), below:

1. **Employees with access to PHI:** Only those employees or classes of employees identified in the Plan's privacy policies and procedures may have access to and use and disclose PHI for plan administration functions that the Company performs for the health plan. If such individuals do not comply with this Document, the Company shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

2. **Use limited to plan administration**: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Company for the Plan.

3. **Mechanism for resolving noncompliance.** If the Company or any other person(s) responsible for monitoring compliance determines that any person described in (1), above, has violated any of the restrictions of this section, then such individual will be disciplined in accordance with the policies of the Company established for purposes of privacy compliance, up to and including dismissal from employment. The Company will arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

5. **Breach Reporting**. Notify a member or members of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:

   a. the names of the individuals whose PHI was involved in the Breach;

   b. the circumstances surrounding the Breach;

   c. the date of the Breach and the date of its discovery;

   d. the information Breached;

   e. any steps the impacted individuals should take to protect themselves;

   f. the steps the Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and

   g. a contact person who can provide additional information about the Breach.

   The Company will cooperate with the member in the investigation of, and response to, the Breaches it reports to the member.

6. **Security Standards for Electronic PHI**. As a condition for obtaining e-PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

   b. Ensure that the adequate separation between the Plan and the Company as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

   c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

   d. Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, "Security Incident" will mean successful unauthorized access to, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

   e. Upon request from the Plan, the Company agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Company.

7. **Other Permitted Disclosures to the Company**. Notwithstanding the foregoing, the terms of this section will not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504 (f)(l)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations; provided however that paragraph 6 above will apply if and only if e-PHI beyond enrollment, disenrollment, summary health information, and authorized disclosures is obtained by the Company, and the Company adopts the literal interpretation of 45 CFR 164.314(b)(1).

8. **Definitions**. All capitalized terms within this section not otherwise defined by the provisions of this section will have the meaning given them in the respective Plan or, if no other meaning is provided in the Plan, the term will have the meaning provided under HIPAA.

Appendix A
Benefit Booklets

This Appendix is considered a part of the Plan and may be amended by the Company at any time for any reason without consent of any person except as otherwise provided by applicable law. Formal amendment of the Plan is not necessary to amend this Appendix. It may be amended by adding a new Appendix with the current date and current listing of incorporated documents.

The following benefits are further described in summaries and booklets provided to participants as attachments to this Document. The terms, conditions and limitations of the benefits are set forth in the Plan and the underlying incorporated documents referenced herein. Certain documents are incorporated by reference in this Appendix, including any written document pursuant to which the applicable benefit is provided under the Plan (e.g., written plans, vendor contracts, insurance policies, coverage certificates, summary plan descriptions, or other materials describing benefits provided thereunder).

As of July 1, 2024, the following Plan benefits are further described in summaries and booklets attached to this Document:

- Medical
- Health Reimbursement Arrangement (HRA)
- Prescription Drug
- Telemedicine
- Employee Assistance Plan (EAP)
- Vision
- Dental
- Life and Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D Insurance
- Long-Term Disability (LTD)
- Short-Term Disability (STD)
- Accident Insurance
- Critical Illness
- Medical Bridge Gap
- Healthcare Flexible Spending Account (FSA)
- Dependent Care FSA

Please refer to the Benefit Booklets for details [add hyperlink or more information as to location].

Appendix B
Eligibility Provisions

This Appendix B is considered a part of the Plan and may be amended by the Company at any time for any reason without consent of any person except as otherwise provided by applicable law. Formal amendment of the Plan is not necessary to amend this Appendix. It may be amended by adding a new Appendix with the current date and current eligibility listing.

Certain individuals or groups are included in, or excluded from, participation in certain or all of the benefits offered under the Plan as determined by the Company and as described herein. This Document provides no guarantee that you are eligible to participate in every benefit or program described herein. The terms, conditions and limitations of the benefits are set forth in the Plan and the underlying incorporated documents attached under Appendix A. Insurance carriers sometimes impose requirements for certain types of insurance (for example, life and disability). Therefore, your participation in those benefits may be delayed or otherwise affected. Requirements would be reflected in your Certificate (or Evidence) of Coverage.

Additionally, any employee who is not otherwise eligible to participate under the medical benefit, but who meets the definition of full-time employee under Section 4980H of the Internal Revenue Code as determined based on the administrative policies of the Company, may be offered coverage under a component medical benefit subject to the Patient Protection and Affordable Care Act (PPACA). Any individual eligible for medical benefits under this provision will be notified by the Company. This eligibility information is available upon request to the Plan Administrator or as described below.

For additional information regarding eligibility under the programs, please contact the Plan Administrator.

Eligibility for Benefits

An eligible employee with respect to the programs described in this Document is any individual who is designated as eligible to participate in and receive benefits under one or more of the component benefit programs described herein. You must satisfy the eligibility and participation requirements under a particular component benefit program, which may vary depending on the particular component program, in order to receive benefits under that program. Other individuals, such as an eligible employee's spouse, children, or other family members, may be eligible to participate in and receive benefits under one or more of the component benefit programs due to their relationship to an eligible employee. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility and coverage information found in Appendix B and the respective attachments to Appendix A.

An eligible employee begins participating in the Plan upon his or her 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. Eligibility for benefits will also be made available as required by any applicable state insurance law.

Eligibility

Employee[1] coverage

Benefit Program	Eligibility Requirements*
- Medical (including prescription drug and telemedicine) - Prescription Drug (must be enrolled in medical benefit) - Basic Life Insurance Benefits (including Business Travel Accident (BTA)) - Basic Accidental Death and Dismemberment (AD&D) - Voluntary Short Term Disability (STD) - Long Term Disability (LTD) - Health Reimbursement Arrangement (HRA) - Healthcare Flexible Spending Account (FSA) - Dependent Care FSA - Cancer Indemnity - Accident Indemnity - Medical Bridge Gap - Critical Illness	Eligible full time education and non-education employees working an average of 30 hours or more per week who have completed 60 days of service are eligible to participate in the Plan. Grandfathered part-time employee working less than 32 hours per week are also eligible for benefits. Benefits will begin the first of the month coinciding with or the following first of the month after eligibility requirements met.

*Except as required by any state law for employees enrolled in insured plans with policies issued in that state.

Credit for part-time status employment

Effective March 21, 2016, an education and non-education part-time non-benefits eligible employee who averages less than 30 hours per week and who becomes full-time benefits eligible employee at any time after their first day of employment will be credited with part-time service performed for the Company.

A part-time non-benefits eligible employee who was employed for 60 days or more at the time of the transfer to full-time benefits eligible status will be eligible to participate in the Plan on the first of the month following the transfer. A part-time non-benefits eligible employee who was employed for less than 60 days at the time of the transfer to full-time benefits eligible status will be eligible to participate in the Plan on the first of the month following 60 days of employment.

*Members of an LLC, partners, or more than 2% shareholders in an S corporation are not permitted to participate in the Code Section 125 plan.

[8] *Employee means a common law employee of the Company. The term employee does not mean any of the following persons, even if determined retroactively by a court or governmental agency to be a common law employee: a self employed individual as defined in Code section 401(c)(1)(A), a member of the Board of Directors who is not otherwise an employee, a person the Plan Administrator determines is an independent contractor for the Company, and a person the Plan Administrator determines is engaged by the Company as a consultant or advisor on a retainer or fee basis. A person the Plan Administrator determines is not an "employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters.*

Retiree coverage

Benefit Program	Eligibility Requirements
Medical (including prescription drug) Dental	The following individuals are eligible for Retirement Benefits: Full-time and/or part-time employees who retired prior to July 1, 2012 who meet the following requirements: • between the ages of 55 and 65 • have at least 10 years of cumulative service. **Note:** Retirement benefits are offered to a closed class of employees. Please see *Early Retirement Policy and Procedure* for additional information regarding retiree benefits and cost.

Excluded individuals

Certain individuals or groups are included in participation or excluded from participation in certain or all of the benefits offered under the Plan as determined by the Company. For example, individuals who are characterized by the Company as an independent contractor or a contract employee are excluded from participation. This summary provides no guarantee that you are eligible to participate in every benefit or program described herein. For additional information regarding eligibility under the programs, please contact the Plan Administrator.

The following individuals may not participate in the Plan:

- those covered by a collective bargaining agreement that does not provide for eligibility to participate in the Plan,
- part-time employees working less than 32 hours per week, excluding part-time grandfathered employees,
- those characterized by the Company as independent contractors,
- non-resident aliens who received no income (within the meaning of Code Section 911(d)(2)) from an employer that constitutes income from sources within the United States, as defined in code Section 861(a)(3),
- leased workers as defined in Code Section 414(n),
- temporary or seasonal employees and defined in the Employee Handbook.

Eligible dependents

If you are eligible to receive benefits under the Plan, your eligible dependents may also be eligible to receive these benefits, if coverage is elected and as provided in the underlying incorporated documents attached under Appendix A. Your eligible dependents on the date you become eligible for coverage under the Plan will become eligible on the same date for dependent coverages then applicable.

An individual who first becomes an eligible dependent after your initial eligibility will become eligible for coverage under the Plan on the date such individual first becomes an eligible dependent (for example, date of marriage, birth, or adoption), however, coverage for such new eligible dependent may become effective on the first day of the month on or following the eligibility date.

Your or your spouse's newborn Children will be temporarily covered for benefits for 31 days immediately following the birth. During that 31-day period, you must contact the Plan and complete the necessary enrollment forms to enroll such dependent in the Plan.

Spousal coverage

If you are eligible to receive medical (including prescription drug and telemedicine), vision, and dental benefits under the Plan, your spouse will also be eligible to receive these benefits if coverage is elected. For purposes of these benefits programs your eligible spouse means your spouse under a legally valid existing marriage. Divorced spouses and legally separated spouses are not eligible for continued coverage under the plan. Common law spouses of any state are not eligible for coverage under the plan.

Domestic, civil union partner coverage

If you are eligible to receive medical (including prescription drug and telemedicine), vision, and dental benefits under the Plan, your partner, who is your civil union partner, domestic partner or other "state sanctioned life partners" recognized under state law in the state in which you reside, will also be eligible to receive these benefits where available.

If you reside in a state that legally recognizes domestic, civil union, or other "state sanctioned" partners, you must have a state issued certificate of your partnership in order for your partner to be eligible for medical (including prescription drug and telemedicine), vision, and dental benefits under the Plan.

If you do not reside in a state that legally recognizes domestic, civil union or other "state sanctioned" partners, your partner must meet the following requirements to be eligible for coverage under the Plan.

- Be at least 18 years old,
- Not married to anyone, having dissolved any prior marriages or partnerships through death or divorce,
- Not be related by blood in a way that would prohibit legal marriage,
- Have entered into the civil union/domestic partnership voluntarily and without reservation,
- Share joint responsible for each other's common welfare and financial obligations, and
- Intend to continue the Domestic Partnership relationship indefinitely, with the understanding that the relationship can be terminated at any time by either partner.

Please see ***Bancroft NeuroHealth's Policy on Domestic/Civil Union Partnership and Health Coverage*** for more information regarding registering and covering domestic/civil union partners under the Plan.

Please Note: There may be important personal tax consequences that arise as a result of domestic/civil union partner coverage. For example, you may be subject to imputed income for tax purposes. Contact your personal tax advisor for more information. Note too that in general, state income tax treatment of domestic partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic/civil union partner and his or her children, if any, qualify for the special state income tax treatment. If they do qualify, you must notify the Company immediately in writing of this special state income tax status.

Note too that if your relationship ends with your civil union/domestic partner either through death, separation or divorce, you must notify the Company within 30 days. You will be asked to complete and submit forms regarding the termination of the civil union/domestic partnership. The partner's coverage will terminate the date the relationship ends through divorce, separation or death provided coverage has not otherwise terminated due to standard policy provisions.

An employee's failure to notify the Benefits Office within 30 days of this change or any other change that would affect a covered dependent's eligibility for continued coverage under the Bancroft

NeuroHealth Health and Welfare Plan may result in termination of the dependent's health coverage, retroactive to the date of the coverage, and may result in a civil action to recover any losses for all benefits paid while your civil union/domestic partner was ineligible for coverage, and you may be subject to disciplinary action (including possible termination of employment).

Note too that the definition of covered spouse may vary under certain fully-insured programs offered in certain states - refer to the certificates to identify a "spouse" covered under a particular insured contract. If any coverage is insured and/or otherwise required to comply with applicable state or other law and such applicable law requires recognizing such individuals as spouses (such as domestic/civil union partners or other “state sanctioned life partners”) or individuals who are eligible for coverage, the plan will provide coverage to the minimum extent required by applicable law, notwithstanding the above exclusions. Benefits for any “state sanctioned life partner”) may require an affidavit confirming the relationship as well as documenting proof of such relationship.

Dependent children

If you are eligible to receive coverage under the medical (including prescription drug and telemedicine) prescription drug and dental benefits your dependent child(ren) may also be eligible to receive these benefits if coverage is elected. For purposes of these benefits, your dependent child(ren) is:

- Your natural born child or the natural born child of your domestic/civil union partner regardless of where or with whom the child lives
- Your stepchild so long as you and the child’s natural parent remain married;
- Your foster child;
- A child who is: (a) legally adopted by you, or your spouse, domestic/civil union partner, regardless of where or with whom such child lives or (b) placed with you, or your spouse, domestic/civil union partner for adoption. Upon request, you are required to provide proof of such adoption or placement;
- Your or your spouse's, civil union partner's legal ward who: (a) resides with you in a regular parent-child relationship; (b) is chiefly dependent on you for support and maintenance; and (c) is unmarried. Upon request, you are required to provide proof of such guardianship;
- A child that the Plan is required to cover under the terms of a Qualified Medical Child Support Order (“QMCSO”).

It is also possible for you to cover your unmarried natural born child or step child, foster child or adopted child on the plan who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. For your handicapped dependent child to remain covered, they must be legally or financially dependent primarily on you. You must submit proof of the child’s inability to engage in self-sustaining employment by reason of mental retardation or physical handicap within 31 days of the child’s attainment of age 26. The proof must be in a form that meets plan approval. In the event of a change in insurance carriers, you may be required to re-submit proof of the child’s mental or physical disability.

Note: Please review your fully-insured program materials for each benefit carefully. These fully-insured programs may have different eligibility requirements for dependents. For example, some insured coverages may have different age limits or requirements or limitations for insuring dependent children.

No Dual Coverage Permitted

If you are married to another employee of the Company or in a domestic/civil union partnership with another employee of the Company, you may enroll as an employee or as a dependent, but you cannot be covered as both. Dependent children may be covered under one employee’s coverage only.

Definition of dependent under the cafeteria plan

Dependent means: (a) for purposes of accident or health coverage (to the extent funded under the premium payment component, and for purposes of the healthcare FSA component), (1) a dependent as defined as in Code section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code section 152(f)(1)) of a participant who as of the end of the taxable year has not attained age 27, and (3) any child of a participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the dependent care FSA component, a "Qualifying Individual" as defined below. Notwithstanding the foregoing, the healthcare FSA component will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order, even if the child does not meet the definition of "dependent" as defined in this section.

"Qualifying Individual" for purposes of the dependent care FSA means (a) a tax dependent of the participant as defined in Code section 152 who is under the age of 13 and who is the participant's qualifying child as defined in Code section 152(a)(1); (b) a tax dependent of the participant as defined in Code section 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the participant for more than half of the year; or (c) a participant's Spouse (as defined below) who is physically or mentally incapable of self-care, and who has the same principal place of abode as the participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code section 21(e)(5)), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code section 152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

"Spouse" for purposes of the dependent care FSA means an individual who is legally married to a participant as determined under applicable state law and who is treated as a spouse under the Code. Notwithstanding the above, Spouse shall not include (a) an individual legally separated from the participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the participant, files a separate federal income tax return, maintains a principal residence separate from the participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the participant.

Documentation of dependents

If you elect coverage for yourself and your eligible dependents, you must certify in writing that your eligible dependents meet all Plan eligibility requirements. You must also provide social security numbers for your dependents as requested in order to cover dependents under the plan. The Company maintains the right to request documentation from you at any time to ensure that your dependents meet the eligibility criteria. In the event you provide a false certification or false or misleading information, you will be required to reimburse the Company for all amounts paid by the Company on your behalf. Any fraudulent attempt to secure or maintain coverage for a non-eligible person may lead to disciplinary action, up to and including termination of employment.

Qualified medical child support orders (QMCSOs)

For purposes of the Plan, the term "QMCSO" shall mean a qualified medical child support order. A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law.

If a QMCSO requires the Plan to provide health coverage, dependent children may also include your children who do not live with you and for whom you do not provide financial support. In general,

QMCSOs are orders under state law requiring a parent to provide health care support to a child – for example, in case of separation or divorce. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who do not reside with you. However, children who are no longer eligible, due to their age for example, cannot be added under a QMCSO.

You may obtain a copy of the Company's procedures governing QMCSO determinations, free of charge, by contacting the Plan Administrator.

Notification

You are responsible for notifying the Department of Human Resources and the COBRA Administrator in writing within 60 days in the event of divorce or legal separation, or in the event your child ceases to meet the eligibility requirements for benefit coverage. For more information about your duty to notify Bancroft NeuroHealth in such an event, see the *Continuation Coverage* section of this Document. Please note that Bancroft NeuroHealth does not treat the termination of a domestic/civil union partnership as a COBRA qualifying event.

Additional information

Additional information regarding how and when you, your spouse and dependent children become eligible to participate in the benefit programs and any conditions and limitations to eligibility are provided in Appendix B and in the certificates of insurance and benefits booklets provided by the applicable insurance companies and/or service providers, provided as attachments to Appendix A.

When coverage ends

Benefits under all component programs (for all covered persons) will cease upon termination of the Plan.
Other circumstances can result in the termination of individual benefits under the Plan. The insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the applicable attachments provide additional information.

Except as otherwise, provided under a plan specific summary or evidence of coverage booklet, your coverage under the Plan automatically will terminate on the earliest of the following dates:

- The date the Plan terminates;
- The date a particular benefit program terminates (for that benefit program only);
- The last day for which the necessary contributions are made;
- For life, AD&D and disability coverage, the day on which you retire, you die or you otherwise cease to be eligible for coverage; or
- For all other coverage, the last day of the month in which your employment terminates.

Except as otherwise provided under a plan specific summary or evidence of coverage booklet, your eligible dependent's coverage automatically will terminate on the earliest of the following dates:

- The date the Plan terminates;
- The date a particular benefit program terminates (for that benefit program only);
- The date on which your coverage terminates;
- The date you elect to terminate your eligible dependent's coverage;
- The last day for which the necessary contributions are made;
- The last day of the month in which the eligible dependent(s) ceases to be eligible for coverage;
- The date the eligible dependent(s) is covered as an employee under the Plan;

- The date the eligible dependent(s) is covered as the dependent of another employee under the Plan;
- The date the eligible dependent(s) enters the armed forces of any country or international organization; or
- The date the dependent is no longer eligible for coverage under a qualified medical child support order (QMCSO).

When an eligible employee's participation in the Plan terminates, benefits under the Plan for the eligible employee and covered persons covered through that eligible employee will cease. When an eligible employee's participation in a component benefit program terminates, benefits under that component benefit program for the eligible employee and covered persons covered through that eligible employee will cease. Termination of participation in a component benefit program occurs in accordance with the terms and conditions established for that program.

Employment termination

If you terminate employment, you will no longer be eligible to participate in the Plan. Typically, your pre-tax contributions will continue through your last regular payroll period. If you terminate employment and are rehired within 30 days, you will re-enter the Plan with the same election you had before you left. If you are rehired after 30 days, you may make a new benefit election for the remainder of the coverage year. Please contact your Plan Administrator for more information on the options available to you.

Termination of participation in the Plan will not affect any rights you may have to continue participation in certain group health plans. Your Plan Administrator will give you information on how to continue coverage under COBRA, if this is appropriate.