BIG 5 CORP. GROUP LIFE & HEALTH INSURANCE PLAN

SUMMARY PLAN DESCRIPTION SUPPLEMENT

PLAN NO.: 501

Amended and Restated Effective January 1, 2023

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SUMMARY PLAN DESCRIPTION SUPPLEMENT

This document, and the certificates, summaries, and other documents issued with respect to, and setting forth the terms of the welfare programs as identified in ***Appendix A*** ("Program Documents") together comprise the Summary Plan Description ("SPD") for the Big 5 Corp. Group Life & Health Insurance Plan (the "Plan"). The SPD summarizes each of the welfare program benefits in the Plan as identified in ***Appendix A*** (each a "Welfare Program").

In the event that the provisions of any Program Document conflict with the other provisions of this SPD Supplement or any other Program Document, the Plan Administrator (as defined in the Article of this SPD Supplement entitled "General Information") shall, in its discretion, interpret the terms and purpose of the Program Documents and this SPD Supplement so as to resolve any conflict; provided that if the terms of the Program Documents are inconsistent with applicable law, the terms of this SPD Supplement (disregarding the terms of the Program Documents) shall prevail. The terms of this SPD Supplement may not increase your rights (or your beneficiary's rights) to benefits available under any Welfare Program or any Program Document. In the case of any conflict between the terms of the Plan document and the terms of the SPD, the terms of the Plan document shall control. In the case of any conflict between the terms of any Program Document and the terms of this SPD Supplement, the terms of the Program Document shall control unless inconsistent with applicable law.

The SPD summarizes your rights and obligations as a participant (or beneficiary) in the Plan. It is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded to you by the Plan or any applicable state law not pre-empted by the Employee Retirement Income Security Act, as amended ("ERISA"), those legal rights supersede the rights set forth in the SPD.

GENERAL INFORMATION

NAME OF PLAN:

Big 5 Corp. Group Life & Health Insurance Plan

PLAN SPONSOR:

Big 5 Corp.
2525 East El Segundo Boulevard
El Segundo, CA 90245

Phone: (310) 536-0611

Collectively, the Plan Sponsor and any affiliated employers of the Plan Sponsor who participate in the Plan "***Participating Employers,***" as applicable, as set forth in ***Appendix B*** are referred to as the "***Employer***"; provided however that for purposes of the administrative provisions of the Plan and as the context otherwise requires, Employer shall only mean the Plan Sponsor. ***Appendix B*** may be amended from time to time by the Plan Sponsor without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

EMPLOYER IDENTIFICATION NUMBER:

95-1854273

PLAN NUMBER:

501

PLAN ADMINISTRATOR:

Group Life & Health Insurance Plan Administrative Committee
Big 5 Corp.
2525 East El Segundo Boulevard
El Segundo, CA 90245

Phone: (310) 536-0611

TYPE OF PLAN:

Welfare benefit plan including certain Welfare Program benefits as identified in *Appendix A*.

PLAN YEAR:

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The "Plan Year" begins on January 1 and ends on December 31.

CLAIMS ADMINISTRATION:

If you have a claim for benefits, such claim should be directed to the provider and address set forth in ***Appendix A***, which may be amended from time to time by the Employer without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

AGENT FOR SERVICE OF LEGAL PROCESS:

Plan Administrator of Big 5 Corp. Group Life & Health Insurance Plan
c/o CA Corporation Service
2710 Gateway Oaks Drive, Suite 150N
Sacramento, CA 95833-3505

You may also serve legal process on the Plan Administrator.

TYPE OF ADMINISTRATION:

Some benefits under the Plan are fully insured and are paid pursuant to the terms of insurance policies issued by insurance companies.

Other benefits are self-funded and are paid from the general assets of the Plan Sponsor. The Plan Sponsor has entered into contracts with third party vendors to assist the Plan Sponsor in administering self-funded benefits.

ELIGIBILITY:

An employee of the Employer ("Employee") is eligible to participate in the Plan if the following requirements are satisfied:

Except as provided below, you will be eligible to participate in the Plan if you are regularly scheduled to work at least 40 hours per week. You will enter the Plan on the first day of the month following 60 calendar days from your initial date of employment; provided, however that the combined waiting period and entry date will not exceed 90 days.

If you are regularly scheduled to work at least 30 hours but less than 40 hours per week, you will be eligible to participate in the medical and dental Welfare Programs under the Plan and enter the Plan on the first day of the month following 60 calendar days from your initial date of employment; provided, however that the combined waiting period and entry date will not exceed 90 days.

Variable Employee. If you are (i) classified as a "Variable Employee" (i.e., regularly scheduled to work less than 30 hours per week, or a variable hour or seasonal Employee (regardless of the number of hours worked)), and (ii) are determined by the Employer to have averaged at least 30 hours per week during a measurement period, you will be eligible to become a participant in the Plan for benefits under a medical Welfare Program subject to the Patient Protection and Affordable Care Act, as amended ("PPACA") (and for any additional Welfare Program) designated by the Employer for the immediately subsequent stability period. If, as a Variable Employee, you are determined by the Employer to be an eligible Employee for a given stability period, you will remain an eligible Employee for the entirety of such stability period, even if you are transferred during such stability period to a position in which you will work or are expected to work less than 30 hours per week, on average, on a regular basis, as long as you remain an Employee without a period of thirteen or more weeks during which you do not provide any hours of service to the Employer. As a Variable Employee, you will enter the Plan, with respect to the Welfare Programs for which you are eligible, on the first day of the applicable stability period following the date the Employer determines you, as a Variable Employee, have satisfied the Plan's eligibility requirements. The Employer adopted the "Patient Protection and Affordable Care Act Policy for Big 5 Corp Effective as of January 1, 2016", to implement and administer the provisions of the Plan relating to Variable Employees in a manner consistent with the PPACA ("Variable Employee Policy"). The Employer's Variable Employee Policy, and any successor(s) thereto, is hereby incorporated into this Plan by reference.

Effective March 1, 2020, if you are classified as a Self-Quarantined Employee, as that term is defined in ***Appendix C***, you shall remain eligible or become eligible, as applicable, to participate (or become eligible to make a new election) in those Welfare Programs consistent with the terms of ***Appendix C***.

The foregoing notwithstanding, the following individuals are not Eligible Employees:

- A leased Employee.
- A temporary Employee.
- A season Employee who does not meet the requirements as a Variable Employee.

- An Employee whose employment is governed by the terms of a collective bargaining agreement between Employee representatives and the Employer under which benefits were the subject of good faith bargaining between the parties, unless such agreement expressly provides for such coverage in the Plan.

If you are an employee of an affiliated employer of the Employer set forth in ***Appendix B,*** you may participate in the Plan if you satisfy all eligibility requirements under the Plan. ***Appendix B*** may be amended from time to time by the Employer without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

Notwithstanding the foregoing, if you are eligible to participate in a Welfare Program, you will become a participant in such Welfare Program upon (1) meeting the eligibility requirements set forth in the applicable Policy or Welfare Program document, (2) enrolling in the Welfare Program at a time and in a manner set forth in the Welfare Program document and acceptable to the Plan Administrator, and (3) if applicable, satisfying any waiting period for initial enrollment as required by the Employer or the Welfare Program. If you are a new Employee who was acquired in an acquisition, merger or similar transaction by the Employer (or any affiliated employer) ("Acquisition"), your credited service for eligibility and entry into the Plan (and any underlying Welfare Program) may be altered as determined by the Employer or as set forth in a purchase agreement documenting such Acquisition. The Employer will communicate to you any change in credited service for eligibility and entry into the Plan (and any underlying Welfare Program) as soon as practicable after such Acquisition.

Except as required by law with respect to benefits subject to PPACA, if you are a rehired former participant, you will reenter the Plan when you again satisfy the eligibility requirements under the Plan.

Of course, if you were already a participant before this amendment and restatement, you will remain a participant in the Plan so long as you continue to be an eligible Employee meeting the above eligibility requirements. If you do not meet the above eligibility requirements, you are not eligible to participate in the Plan.

AMENDMENT AND TERMINATION:

The SPD contains a summary of the terms of the Plan and may be amended from time to time at its sole discretion by the Employer. The Plan and any Welfare Program may be terminated, modified or amended from time to time by the Employer, in its sole discretion and without notice. Any changes made shall be binding on you as a participant and any other covered persons referred to in the SPD.

The SPD will disclose Plan provisions governing your benefits, rights and obligations upon Plan termination or the amendment or elimination of benefits under the Plan.

NO CONTRACT OF EMPLOYMENT:

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

BENEFITS AND ADMINISTRATION:

The Plan provides certain Welfare Program benefits as identified in ***Appendix A*** for you, as an eligible Employee, and your covered dependents. The insurers' or third-party administrator's administrative functions include paying claims and determining medical necessity. These benefits are insured or administered by the companies listed in ***Appendix A*** and are generally described in the Program Documents.

Replacements for lost or misplaced copies of the Program Documents may be obtained by writing to the Plan Administrator. Notification will be given of changes in benefits that may occur from time to time.

Please refer to the Program Documents for a description of specific (or additional) eligibility and entry date requirements for you and your dependents under each Welfare Program, special enrollment rights, changes in status, termination of coverage provisions, coordination of coverage provisions, the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits.

SUMMARY OF PLAN BENEFITS

The Plan provides you and your eligible dependents with the coverages shown in the table set forth in ***Appendix A***. A summary of the benefits provided under the Plan is set forth in the Program Documents issued by the insurance companies or third party administrators who are shown in the table as set forth in ***Appendix A***.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT:

Any Welfare Program which is a group health plan 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, any Welfare Program under the Plan that is a group health program may not, under federal law, require that a provider obtain authorization from such Welfare Program for prescribing a length of stay not more than 48 hours (or 96 hours).

WOMEN'S HEALTH CANCER RIGHTS ACT:

If you or your covered dependent have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998, as amended. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

(a) All stages of reconstruction of the breast upon which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses; and

(d) Treatment of physical complications during all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical Welfare Program benefits under the Plan.

LOSS OF BENEFITS:

The provisions regarding termination of coverage and limitations and exclusions of benefits that may result in reduction or loss of benefits are explained in the Program Documents.

CONTRIBUTIONS:

Contributions to the Plan are provided as set forth in ***Appendix A***. The taxability of your contributions is also set forth in ***Appendix A***. The Plan Administrator provides a schedule of the applicable premiums during open enrollment periods and upon request.

HOW TO RECEIVE YOUR BENEFITS:

This information is explained in the section entitled "CLAIMS PROCEDURE."

BENEFIT-SPECIFIC INFORMATION:

Please refer to the Program Documents for the following information:

- A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which you or a beneficiary will be responsible;
- Any annual or lifetime caps or other limits on benefits under the Plan;
- The extent to which preventive services are covered under the Plan;
- Whether and under what circumstances existing and new drugs are covered under the Plan;
- 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; and
- Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

CLAIMS PROCEDURES

A Claim for benefits under a Welfare Program must be submitted to the party designated in the claims procedure prescribed under the terms of the applicable Welfare Program as provided in the Program Documents. To the extent that a claims procedure is not provided under a Welfare Program (or is deficient as determined by the Plan Administrator), the claims procedure described in this section shall apply with respect to such Welfare Program.

A "Claim" is defined as any request for a Plan or Welfare Program benefit made by a participant or beneficiary (hereinafter referred to as a "Claimant" (or by an authorized representative of a Claimant) that complies with the Plan procedures for making a benefit Claim. The times listed are maximum times only. A period of time begins at the time the Claim is filed. "Days" refers to calendar days, not business days.

A "Claims Supervisor" is the person responsible for benefits administration under a Welfare Program or the insurance company. For purposes of determining the amount of, and entitlement to, benefits of your insured Welfare Program, the respective insurance company described in ***Appendix A*** is the Claims Supervisor, with the full power to interpret and apply the terms of the Plan as they relate to your benefits. For purposes of determining the amount of, and entitlement to, benefits under your self-funded Welfare Program, the Plan Administrator is the Claims Supervisor (unless such power is delegated to another party as described in the Program Documents, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to your benefits.

There are different types of Claims (including disability, group health pre-service, group health concurrent and group health post-service), and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim.

CLAIMS PROCEDURES FOR WELFARE PROGRAMS OTHER THAN GROUP HEALTH OR DISABILITY

(a) **Time for Decision on a Claim**. A Claim shall be filed in writing with the Claims Supervisor and decided within 90 days by the Claims Supervisor unless the Claims Supervisor determines that special circumstances require an extension of time for processing the Claim. If the Claims Supervisor determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or Welfare Program expects to render the benefit determination.

(b) **Notification of Adverse Determination**. Notice of the decision on such Claim shall be furnished promptly to the Claimant. Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan or Welfare Program provisions on which the determination is based; (iii) a description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary; and (iv) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's

right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

(c) **Right to Review**. A Claimant may review all pertinent documents and may request a review by the Claims Supervisor of such decision denying the Claim. Any such request must be filed in writing with the Claims Supervisor within 60 days after receipt by the Claimant of written notice of the decision. A failure to file a request for review within 60 days will constitute a waiver of the Claimant's right to request a review of the denial of the Claim. Such written request for review shall contain all additional information that the Claimant wishes the Claims Supervisor to consider.

(d) **Review Procedures**. During the review process, the Claims Supervisor will provide: (i) the Claimant the opportunity to submit written comments, documents, records, and other information relating to the Claim for benefits; (ii) that a Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits; and (iii) for a review that takes 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.

(e) **Time for Decision on Review**. Written notice of the decision on review shall be furnished to the Claimant within 60 days unless the Claims Supervisor determines that special circumstances require an extension of time for processing the Claim. If the Claims Supervisor determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice will describe the special circumstances requiring an extension of time and the date by which the Plan or Welfare Program expects to render the determination on review.

(f) **Notification of Determination on Review**. Notice of the decision on such Claim shall be furnished promptly to the Claimant. Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan or Welfare Program provisions on which the benefit determination is based; (iii) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits; and (iv) a statement describing any voluntary appeal procedures, if any, offered by the Plan or Welfare Program and the Claimant's right to obtain additional information about those voluntary review procedures, if any, and a statement of the Claimant's right to bring an action under ERISA Section 502(a).

(g) **Legal Remedies**. Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in the Program Documents for a particular Welfare Program, such later date with respect to a Claim arising out of that Welfare Program.

DISABILITY CLAIMS PROCEDURES

(a) **Time for Decision on a Claim**. A Claim shall be filed in writing with the Claims Supervisor and decided within 45 days after receipt of the Claim by the Claims Supervisor. If the Claims Supervisor determines that an extension is necessary due to matters beyond the control of the Plan or Welfare Program, a maximum of two 30-day extensions will be permitted. A Claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A Claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the Claim, and any additional information needed to resolve those issues. If additional information is required from a Claimant, such Claimant will have 45 days to provide such information. The deadline for making a decision on the Claim will then be extended for 45 days or, if shorter, for the length of time it takes the Claimant to provide the additional information.

(b) **Notification of Adverse Determination**. Notice of the decision on such Claim shall be furnished to the Claimant within the applicable time periods set forth in subsection (a) above and shall contain the following information:

(i) Every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary; (4) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the Claimant to the Plan or Welfare Program of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan or Welfare Program in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the Claimant presented by the Claimant to the Plan or Welfare Program made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the Claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program do not exist; and (8) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access

to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits.

"Adverse benefit determination" also means any rescission of disability coverage with respect to a Claimant (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(c) **Right to Review**. A Claimant may review all pertinent documents and may request a review by the Claims Supervisor of such decision denying the Claim. Any such request must be filed in writing with the Claims Supervisor within 180 days after receipt by the Claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the Claimant's right to request a review of the denial of the Claim. Such written request for review shall contain all additional information that the Claimant wishes the Claims Supervisor to consider.

(d) **Review Procedures**. During the review process, the Claims Supervisor will provide: (i) Claimants the opportunity to submit written comments, documents, records, and other information relating to the Claim for benefits; (ii) that a Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits; (iii) for a review that takes 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; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan or Welfare Program who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vi) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan or Welfare Program in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; (vii) that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and (viii) the Claimant shall be provided, free of charge and as soon as possible and sufficiently in advance of the date on which notice of the adverse benefit determination on review must be provided to the Claimant to give the Claimant reasonable opportunity to respond prior to the deadline, (A) any new or additional evidence considered relied upon, or generated by the Plan, Welfare Program, insurer, or other person making the benefit determination (or at the direction of the Plan, Welfare Program, insurer of such other person) in connection with the Claim; and (B) any new or additional rationale that the disability benefit Claim is based on.

(e) **Time for Decision on Review**. Written notice of the decision on review shall be furnished to the Claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the Claimant will be given a written notice of the required extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Claims Supervisor expects to render a decision. The extension may be for up to 45 additional days from the end of the initial period.

(f) **Notification of Determination on Review**. Notice of the decision on such Claim shall be furnished to the Claimant within the applicable time periods set forth in subsection (e) above and shall contain the following information:

(i) Every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the benefit determination is based; (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan or Welfare Program and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA Section 502(a), which statement shall also describe any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the Claim; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the Claimant to the Plan or Welfare Program of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan or Welfare Program in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the Claimant presented by the Claimant to the Plan or Welfare Program made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program do not exist.

If ten percent or more of the population residing in the county (in which a Claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary of the Department of Labor ("Secretary"), the Employer must: (i) provide oral language services that include answering questions in the non-English language and provide assistance with filing Claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the Claimant;

and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan or Welfare Program.

(g) **Legal Remedies**.

(i) Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in the Program Documents for a particular Welfare Program, such later date with respect to a Claim arising out of that Welfare Program.

(ii) If the Plan (or Welfare Program) fails to strictly adhere to these Claims review procedure requirements, the Claimant is deemed to have exhausted the administrative remedies available under the Plan (or Welfare Program), except as provided in the paragraph below. Accordingly, the Claimant is entitled to pursue any available remedies under ERISA Section 502(a) on the basis that the Plan (or Welfare Program) failed to provide a reasonable Claims procedure that would yield a decision on the merits of the Claim. If a Claimant chooses to pursue remedies under ERISA Section 502(a) under such circumstances, the Claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(iii) Except as provided in the paragraph above, the administrative remedies available under the Plan (or Welfare Program), will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan (or Welfare Program) demonstrates that the violation was for good cause or due to matters beyond the control of the Plan (or Welfare Program) and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan (or Welfare Program) and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan (or Welfare Program). The Claimant may request a written explanation of the violation from the Plan (or Welfare Program), and the Plan (or Welfare Program) must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan (or Welfare Program) to be deemed exhausted. If a court rejects the Claimant's request for immediate review under the preceding paragraph on the basis that the Plan (or Welfare Program) met the standards for the exception under this paragraph, the Claim shall be considered as re-filed on appeal upon the Plan's (or Welfare Program's) receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan (or Welfare Program) shall provide the Claimant with notice of the resubmission.

GROUP HEALTH CLAIMS PROCEDURES

(a) **Time for Decision on a Claim**.

(i) **Pre-Service Claim Determinations**. When a Claimant requests a medical necessity determination prior to receiving care, the Claims Supervisor will notify the Claimant of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Supervisor's

control, the Claims Supervisor will notify the Claimant prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time. This notice will include the date a determination may be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Claimant must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the date the Claimant responds to the notice. The Claims Supervisor will provide a determination of the Claim within 15 days following the receipt of the additional information.

If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the Claimant's health condition, would cause severe pain which may not be managed without the requested services, the Claims Supervisor will make the pre-service determination on an expedited basis. The Claims Supervisor will notify the Claimant of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Supervisor will notify the Claimant within 24 hours after receiving the request to specify what information is needed. The Claimant must provide the specified information to the Claims Supervisor within a reasonable amount of time (at least 48 hours), taking into account the circumstances. The Claims Supervisor will notify the Claimant of the expedited benefit determination within 48 hours after the earlier of the date the Claimant responds to the notice or the end of the period given to the Claimant to provide the specified additional information. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If the Claimant fails to follow the Claims Supervisor's procedures for requesting a pre-service medical necessity determination, the Claims Supervisor will notify the Claimant of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the Claimant requests written notification.

The prior approval of the pre-service Claim does not guarantee payment or assure coverage; it means only that the information furnished to the Claims Supervisor at the time indicates that the requested service, supply, prescription drug, equipment or treatment is medically necessary and not experimental or investigational. A pre-service Claim receiving prior approval as a pre-service Claim must still meet all other coverage terms, conditions and limitations. Coverage for any such pre-service Claim receiving prior approval may still be limited or denied if, when, after the requested service, supply, prescription drug, equipment or treatment is completed and the Claims Supervisor receives post-service Claim(s), investigation shows that a benefit exclusion or limitation applies, that the Claimant ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of employee contributions, that out-of-network limitations apply, or any other basis specified in the Plan (or Welfare Program) applies to limit or exclude the Claim.

(ii) **Concurrent Claim Determinations**. When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a Claimant and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Supervisor shall notify the Claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a Claimant and the Claimant requests to extend the course of treatment, such a request is a Claim involving urgent care. The Claimant must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the Claimant requests such a determination, the Claims Supervisor will notify the Claimant of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

(iii) **Post-Service Claim Determinations**. When a Claimant requests a Claim determination after services have been rendered, the Claims Supervisor will notify the Claimant of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Supervisor's control, this period may be extended up to an additional fifteen (15) days, if the Claims Supervisor notifies the Claimant prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Claims Supervisor expects to render its decision. If such extension is necessary due to the failure of the Claimant to submit information necessary to render a decision, the extension notice will also specify what information is needed, and the Claimant must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the date the Claimant responds to the notice. The Claims Supervisor will provide a determination of the Claim within 15 days following the receipt of the additional information.

(b) **Notice of Adverse Determination**.

(i) To the extent that the Welfare Program is not subject to PPACA, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary; (4) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination,

either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) in the case of a Claim involving urgent care, a description of the expedited review process applicable to such Claim.

(ii) To the extent that the Welfare Program is subject to PPACA, every notice of an adverse benefit determination will be provided in writing or electronically in a culturally and linguistically appropriate manner calculated to be understood by the Claimant, and will include all of the following that pertain to the determination: (1) information sufficient to identify the Claim involved, including the date of service, the health care provider, the Claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meaning of these codes); (2) the specific reason or reasons for the adverse determination (including the denial code and its corresponding meaning, as well as a description of the Plan's (or Welfare Program's) standard, if any, that was used in denying the Claim; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the Claim and an explanation of why such material or information is necessary; (5) a description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the Claimant's right to bring a civil action under ERISA Section 502 following a final appeal; (6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; (7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; (8) in the case of a Claim involving urgent care, a description of the expedited review process applicable to such Claim; and (9) the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

If ten percent or more of the population residing in the county (in which a Claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing Claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the Claimant; and (iii) include a non-English statement in the English

version of the notice on how to access the non-English language services provided by the Plan or Welfare Program.

(c) **Right to Review**. A Claimant may review all pertinent documents and may request a review by the Claims Supervisor of such decision denying the Claim. Any such request must be filed in writing with the Claims Supervisor as set forth in subsection (e) below after receipt by the Claimant of written notice of the decision. A failure to file a request for review within the deadline set forth in subsection (e) will constitute a waiver of the Claimant's right to request a review of the denial of the Claim. Such written request for review shall contain all additional information that the Claimant wishes the Claims Supervisor to consider.

(d) **Review Procedures**. During the review process, the Claims Supervisor will provide: (i) the Claimant the opportunity to submit written comments, documents, records, and other information relating to the Claim for benefits; (ii) that a Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits; and (iii) for a review that takes 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.

(e) **Time for Decision on Review**.

(i) **First Level of Appeal**. If a Claimant's Claim is denied in whole or in part, then the Claimant may appeal that decision directly to the Claims Supervisor. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a Claimant 's circumstance warrants an expedited appeals procedure, then the Claimant should contact the Claims Supervisor immediately. The Claimant will be asked to explain, in writing, why he or she believes the Claim should have been processed differently and to provide any additional material or information necessary to support the Claim. Following review, the Claims Supervisor will issue a decision on review.

The Claims Supervisor's review will be processed in accordance with the following time frames: (a) 72 hours in the case of an urgent care Claim; (b) 15 days in the case of a pre-service Claim; (c) before a treatment ends or is reduced in the case of a concurrent care Claim involving a reduced or terminated course of treatment; (d) 24 hours in the case of a concurrent care Claim that is a request for extension involving urgent care; or (e) 30 days in the case of a post-service Claim.

(ii) **Second Level of Appeal**. If, after exhausting the first level appeal with the Claims Supervisor, a Claimant is still not satisfied with the result, the Claimant (or the Claimant's designee) may appeal the Claim directly to the Employer (or another fiduciary named by the Plan Administrator in writing, which writing is incorporated herein by reference). Appeals will not be considered by the Employer unless and until the Claimant has first exhausted the Claims procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Supervisor's final decision on review. As part of the appeal process, a Claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the Claim.

In the normal case, the Employer will make a determination on the basis of the supporting file documents and written statement as submitted. However, the Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

The Employer's decision on appeal will be conclusive and binding on the Claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth in subsection (e)(i) above.

To the extent that the Welfare Program is subject to PPACA, after exhaustion of the Claims procedures provided under the Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available.

(f) **Notice of Determination on Review**.

(i) To the extent that the Welfare Program is not subject to PPACA, every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information (as defined below); (4) a statement describing any voluntary appeal procedures offered by the Plan or Welfare Program, the Claimant's right to obtain the information about such procedures, and any Claimant's right to bring an action under ERISA Section 502(a); (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(ii) To the extent that the Welfare Program is subject to PPACA, every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the Claim involved, including the date of service, the health care provider, the Claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meaning of these codes); (2) the specific reason or reasons for the adverse determination (including the denial code and its corresponding meaning, as well as a description of the Plan's (or Welfare Program's) standard, if any, that was used in denying the Claim; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (5) a

statement describing any voluntary appeal procedures offered by the Plan or Welfare Program, the Claimant's right to obtain the information about such procedures, and any Claimant's right to bring an action under ERISA Section 502(a); (6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; and (7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(iii) Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(g) **Review Procedures on Appeal**. In the conduct of any review, the following will apply:

(i) No deference will be afforded to the initial adverse determination;

(ii) The review will be conducted by an appropriate named fiduciary who is neither the Claimant who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such Claimant;

(iii) In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

(v) Any health care professional consulted in making a medical judgment shall be an Claimant who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such Claimant; and

(vi) In the case of a Claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the Claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan

and the Claimant by telephone, facsimile or other available similarly expeditious method.

(vii) To the extent that the Welfare Program is subject to PPACA, the Claimant will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for denial. The Claimant will have a reasonable opportunity to respond to such new evidence or rationale.

(h) **Deemed Exhaustion of Internal Claims and Appeals Processes**. To the extent that the Welfare Program is subject to PPACA, if the Plan fails to strictly adhere to the internal Claims and appeals requirements of 29 CFR 2590.715-2719(b)(2), the Claimant may initiate an external review or may bring an action under ERISA Section 502(a). A deemed exhaustion, however, does not occur if violations of the Claims review process are de minimis violations that do not cause, and are not likely to cause prejudice or harm to the Claimant so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between the Claimant and the Plan Administrator, Claims Supervisor, claims administrator or Named Fiduciary. The Claimant may request a written explanation of the violation from the Plan Administrator, which must be provided within 10 days, including the basis for asserting that the violation should not cause the internal Claims and appeals process to be deemed exhausted. In case there is a deemed exhaustion, the Claimant may also be entitled to remedies under ERISA Section 502 by filing a case in court. Unless otherwise specified herein, the Claimant is required to exhaust the internal Claim and appeal process before filing a request for external review or filing a lawsuit.

(i) **External Claims Procedure**. To the extent that the Welfare Program is subject to PPACA, after receiving notice of an adverse benefit determination or a final internal adverse benefit determination (or been deemed to have exhausted the internal appeal process), a Claimant may file with the Plan a request for an external review, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the Plan is not eligible for the external review process. A Claimant may request from the Claims Supervisor additional information describing the Plan's external review procedure.

(j) (j) **Legal Remedies**. Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in the Program Documents for a particular Welfare Program, such later date with respect to a Claim arising out of that Welfare Program.

WHEN COVERAGE MAY BE CONTINUED

You and your covered dependents may continue your group health coverage under the Plan under certain circumstances, according to the terms of your Employer's leave of absence policy, the Family and Medical Leave Act of 1993, as amended ("FMLA"), the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), and the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). Group health coverage for yourself and your covered dependents may be continued if you cease active work

because of an approved medical, family, personal, or military leave of absence or if your employment with the Employer ends.

CONTINUATION OF COVERAGE UNDER COBRA:

To the extent a description of COBRA rights is not provided in the Program Documents, the following applies:

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Employees (as defined below) and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that a Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries). When a Covered Employee becomes eligible for COBRA, a Covered Employee may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace ("Marketplace"), Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". For example, a Covered Employee may be eligible to buy an individual plan through the Marketplace. By enrolling in coverage through the Marketplace, a Covered Employee may qualify for lower costs on the Covered Employee's monthly premiums and lower out-of-pocket costs. Additionally, a Covered Employee may qualify for a special enrollment period for another group health plan for which the Covered Employee is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Please note that certain excepted benefits such as health flexible spending accounts, integrated health reimbursement arrangements, or standalone vision or dental plans will not be offered under the Marketplace. Some of these options may cost less than COBRA continuation coverage. For more information about health insurance options available through the Marketplace, and to locate an assister in your area who you may talk to about the different options, visit www.HealthCare.gov.

Who may become a Qualified Beneficiary?

In general, a Qualified Beneficiary may be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a Covered Employee, the spouse of a Covered Employee, or a dependent child of a Covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "Covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with the Plan's eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a Covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. Generally, a Covered Employee's domestic partner or civil union partner is not considered to be a Qualified Beneficiary unless that individual is eligible for COBRA coverage due to qualifying as a Covered Employee's tax dependent upon losing coverage under the Plan. However, the Plan may provide continuation coverage on an after-tax basis to (i) a domestic partner or civil union partner but only in circumstances where a Covered Employee is also entitled to COBRA for the same Qualifying Event or (ii) a domestic partner or civil union partner of a Covered Employee as required by any applicable state insurance laws with respect to insured group health plan Welfare Program benefits.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

<u>What is a Qualifying Event?</u>

A Qualifying Event is any of the following if the Plan provided that the Covered Employee would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a Covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a Covered Employee's employment.

(c) The divorce or legal separation of a Covered Employee from the Employee's spouse. If the Employee reduces or eliminates the Employee's spouse's Plan 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 even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.

(d) A Covered Employee's entitlement to any part of Medicare.

(e) A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the Covered Employee, or the covered spouse or a dependent child of the Covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a Covered Employee, or the spouse, or a dependent child of the Covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under FMLA does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

Premiums. The Plan may charge up to 102% of total group health plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

Provider Networks. If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. A Qualified Beneficiary may want to check to see if such Qualified Beneficiary's current health care providers participate in a network in considering options for health coverage.

Drug Formularies. For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

Severance Payments. If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This may affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

Medicare Eligibility. A Qualified Beneficiary should be aware of how COBRA coverage coordinates with Medicare eligibility. If a Qualified Beneficiary is eligible for Medicare at the time

of the Qualifying Event, or if a covered individual will become eligible soon after the Qualifying Event, such individual should know such individual has 8 months to enroll in Medicare after employment–related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.

Service Areas. If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

Other Cost-Sharing. In addition to premiums or contributions for health coverage, the Plan requires Covered Employees to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified Beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a Covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as amended ("Trade Act"), and the Employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information. More information about the Trade Act is also available at www.doleta.gov/tradeact.

The Trade Act also created a tax credit for certain TAA-eligible individuals and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under these tax provisions, eligible individuals may either take a tax credit or get advance payment of a significant portion of the premiums for qualified health insurance, including continuation coverage. Individual coverage purchased through the Marketplace is excluded from the list of qualified health insurance. A Covered Employee may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282 if a Covered Employee has questions about these new tax provisions. TTD/TTY callers may call toll-free at 1-866-626-4282.

Is a Covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment or reduction of hours of employment,

(b) death of the Covered Employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the Covered Employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Covered Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the Covered Employee or covered dependent or someone on their behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60 day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. A Covered Employee must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that a Covered Employee (or covered dependent) provides must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. A Covered Employee (or covered dependent) must mail, fax or hand-deliver notice to the person, department or firm listed below, at the following address:

Big 5 Corp.
2525 East El Segundo Boulevard
El Segundo, CA 90245

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state:

- the **name of the plan or plans** under which the Covered Employee lost or are losing coverage,
- the **name and address of the Covered Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, a Qualified Beneficiary may be required to provide **a copy of the divorce decree, the legal separation agreement** or other relevant documentation as required by the Plan Administrator.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If a Covered Employee, covered spouse or covered dependent children do not elect continuation coverage within the 60 day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver may be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment (as defined below) is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan.

(e) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either Part A or Part B, whichever occurs earlier).

(f) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) 29 months after the date of the Qualifying Event or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan may terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a Covered Employee's entitlement to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of:

(1) 36 months after the date the Covered Employee becomes entitled to Medicare; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the Covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving

rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances may the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18 month or 29 month maximum coverage period is followed, within that 18 or 29 month period, by a second Qualifying Event that gives rise to a 36 months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance may the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the Covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a Covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan Administrator will inform the Qualified Beneficiary of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for COBRA continuation coverage?

"Timely Payment" means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the

Employer is allowed until that later date to pay for coverage of similarly situated non COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180 day period that ends on that expiration date, provide a Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Is State COBRA coverage available?

With respect to benefits under an insured group health Welfare Program under the Plan which are subject to state continuation coverage laws, a Covered Employee (or covered dependent) may be able to continue coverage beyond the eighteen (18) months of continuation coverage allowable under federal COBRA laws but only if a Covered Employee (or covered dependent) meet certain eligibility, notice or residency requirements, if applicable, or any other requirements set forth by such state continuation coverage law.

For more information

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under (ERISA), including COBRA, PPACA, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you may talk to about the different options, visit www.HealthCare.gov.

Keep the Plan Administrator informed of address changes.

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

CONTINUATION OF COVERAGE UNDER THE EMPLOYER'S LEAVE POLICY:

In addition to FMLA and USERRA leaves of absence described below, you may continue to receive benefits under specified Welfare Programs for your approved disability leave to the extent and for the period described in the Employer's leave policy. Any such leave policy adopted by the Employer, and any successor(s) thereto, are hereby incorporated into this SPD Supplement by reference. For more information about approved disability leaves of absence, please contact the Plan Administrator.

CONTINUATION OF COVERAGE UNDER FMLA:

Except to the extent otherwise provided in the Program Documents, the provisions provided in this SPD Supplement with respect to the FMLA will apply. If you meet certain service requirements, you may be entitled to take a maximum of 12 weeks of unpaid leave each year for certain specified family and medical reasons under the FMLA. Upon your return to work after FMLA leave, you will be entitled to the position that you held when your FMLA leave began or an equivalent position with equivalent pay, benefits and other terms and conditions of employment.

Under certain circumstances, when restoration of employment would cause substantial and grievous economic injury to the Employer's operations, certain highly paid "key" Employees may not be reinstated after FMLA leave.

You must notify the Plan Administrator at least 30 days before the beginning of your leave if the leave is foreseeable. If the leave is not foreseeable, you must provide such notification as soon as possible. Please contact the Plan Administrator to determine whether you qualify for FMLA leave.

If you take leave under FMLA, you will be entitled during your leave to continue your benefits at the same coverage level in effect at the time of your leave. If you marry or have or adopt a child (or you otherwise acquire a new dependent) during your leave, your new spouse or dependent will also be eligible for coverage during your leave (if you continued your coverage under the Plan and such spouse or dependent meets the plan's eligibility requirements). You will be responsible for paying your portion of these benefits at active Employee rates while you are on leave. You will be required to pay your contributions for your benefits on a monthly basis (with after-tax dollars) in the manner required by the Plan Sponsor. Please contact the Plan Administrator for more information.

You will be eligible for new benefits that are offered by the Plan Sponsor during your leave. Your coverage will also be affected by any changes that the Plan Sponsor makes to the benefit plans and programs during your leave. If the costs for providing new or changed benefits increase during your leave, your contributions may increase accordingly.

When you return from your FMLA leave, you will continue your benefits in accordance with your coverage elections that were in effect immediately before your leave. You will be able to make coverage elections that differ from those that were in effect before your leave only if there is an annual open enrollment period at that time or you have a life change event.

FMLA and leave to care for a servicemember.

If you need to care for a family member who was injured or became ill while on active military duty, you may be entitled to up to 26 weeks of FMLA leave. Additionally, unpaid active duty leave

may also be available. Any leave related to military duty or military illness or injury will be administered in compliance with applicable federal requirements.

(a) **Caregiver leave**. Caregiver leave, which is unpaid, will be granted to you in the event that you are needed to care for a family member who is an Armed Forces servicemember recovering from a serious illness or injury. If you are the spouse, son, daughter, parent, or nearest blood relative of a servicemember who is medically unfit to perform the duties of his office, grade, rank or rating, and the servicemember is undergoing medical treatment, recuperation, or therapy, is in an outpatient status, or is on the temporary disability retired list, you may take job-protected leave in order to care for the servicemember.

Caregiver leave will not be provided in addition to FMLA leave taken for other reasons, and the 26-week caregiver leave may only be taken in a single 12-month period.

(b) **Active Duty leave**. If you are eligible for FMLA leave, active duty unpaid leave (when required by the government), will be granted if your family member has been called up to or engaged in active military duty. Under the active duty leave provision, the Employer will grant up to 12 weeks of FMLA leave. This leave will be granted for events outlined in applicable law, and the leave will be available if your spouse, son, daughter, or parent is on or is called into active duty against another military force. If you request this leave you must provide the Employer with notice as soon as it is "reasonable and practicable" and you may be required to provide certification supporting the active duty of the affected family member.

If you have any questions regarding whether FMLA leave applies to you, you should contact your human resources office.

CONTINUATION OF COVERAGE UNDER USERRA:

USERRA provides for continuation of health care coverage if you are called for active duty military service.

Except to the extent greater benefits are provided under the terms of the Program Documents, the maximum length of extended coverage under USERRA is the lesser of:

- 24 months beginning on the date that the military leave begins; or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee.

If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

Your COBRA continuation coverage and USERRA continuation coverage are concurrent.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan. A QMCSO may apply to coverage under a group health plan Welfare Programs under the Plan. Once the Plan Administrator determines that the order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Plan Administrator receives a QMCSO, you and the affected child will be notified by the Plan Administrator before benefits are assigned pursuant to the order.

SUBROGATION AND RIGHT OF REIMBURSEMENT

The provisions of this section pertaining to subrogation shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to subrogation, or (ii) a court, arbitrator, mediator or other judicial body determines that the subrogation provisions of a Welfare Program are not enforceable. The provisions of this section pertaining to a right of reimbursement shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to a right of reimbursement, or (ii) a court, arbitrator, mediator or other judicial body determines that the right of reimbursement provisions of a Welfare Program are not enforceable.

If you or your dependents (as covered persons) become sick or injured you have the right to receive benefits under the Plan, but you or your dependents (as covered persons) also have the right to receive compensation for the sickness or injury from a third party (such as an insurance company, for example), the Plan, or the Plan's designee, has a right of recovery.

The Plan's right of recovery includes the right to be reimbursed from any payment by the third party for your sickness or injury, for Plan benefits paid with respect to the sickness or injury. The Plan's right of recovery also includes the right of subrogation which means that the Plan may choose to assert your right of recovery against the third party. The Plan's right of recovery extends to any right of recovery your estate, your spouse, your dependents, your (or your dependent's) guardian or other representative may have against the third party.

The Plan will have a first priority lien on any full or partial recovery by or on your behalf from the third party. You (and your personal representative, beneficiary, or estate) shall agree to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the sickness or injury. You (or your personal representative, beneficiary, or estate) shall serve as a constructive trustee over the funds due and owed to the Plan and hold such funds in trust.

The Plan's right of recovery will apply regardless of whether you are made whole from the recovery against the third party, and will not be reduced or prorated by or on account of your attorneys' fees and costs. Any full or partial recovery by you against a third party shall be deemed to be recovery for Plan benefits incurred with respect to the injury or sickness for which the third party is liable, regardless of whether or not the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically limited to certain kinds of damages or payments.

The Plan's right of recovery may be from the third party, any liability or other insurance covering the third party, malpractice insurance; your own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal injury protection (PIP); or, any other first or third party insurance coverages which are paid or payable.

If the Plan takes legal action to enforce its recovery rights, the Plan shall be entitled to recover its attorneys' fees and costs from you.

You shall not do anything to hinder the Plan's right of recovery. You shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the third party or any insurance coverages to which you may be entitled. The Plan is not obligated to pay Plan benefits incurred with respect to your injury or sickness until you, or someone legally qualified and authorized to act for you, enters into a written agreement with the Plan regarding its right of recovery. Also, the Plan may suspend payment of Plan benefits if you do not execute such an agreement or does not comply with the terms of such an agreement. Payment of Plan benefits by the Plan before such a written agreement is obtained, or while you are not in compliance with the terms of such a written agreement, shall not constitute a waiver by the Plan of its right of recovery.

The Plan Administrator, in its sole discretion, may waive the Plan's right of recovery. Waivers may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan or for any other reason as determined by the Plan Administrator. The Plan's waiver of its right of recovery with respect to one claim shall not constitute a waiver of its right of recovery with respect to another claim; and the Plan's waiver of its right of recovery with respect to one covered person shall not constitute a waiver of its right of recovery with respect to another covered person.

INSURANCE REFUNDS OR REBATES:

You and any beneficiaries are not entitled to any refunds, rebates, discounts or other arrangements based on the actual cost of providing benefits under the Plan or Welfare Program. The Employer has complete discretion to apply any payments received from an insurer, including premium rebates based on experience, dividends, and proceeds from demutualization, to reduce its contributions to any Welfare Program offered under the Plan.

PPACA COMPLIANCE

Applicability. This section will apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.

Pre-Existing Conditions. Notwithstanding anything contained in the Plan to the contrary, the Plan does not place any limitation or exclusion on coverage of pre-existing conditions for individuals.

Lifetime/Annual Limits. Notwithstanding anything contained in the Plan to the contrary, the Plan does not place any lifetime or annual limits on the dollar value of essential benefits for any individual under a group health plan. "Essential benefits" are those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

Cost Sharing Requirements for Preventive Care Expenses. With regard to non-grandfathered benefits under the Plan, there will be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.

Dependent Definition. The term "dependent" includes any child of a participant who is covered under a Welfare Program, as defined in the Program Document, as allowed by reason of PPACA and the regulations and guidance issued thereunder.

No Rescission of Coverage. The Plan and each Welfare Program that is "group health plan" subject to ERISA Section 715 and 29 CFR 2590.715-2712 shall not rescind your coverage under the Plan or such Welfare Program unless you or your covered dependent performs an act, practice, or omission that constitutes fraud, or unless you or your covered dependent make an intentional misrepresentation of material fact, as prohibited by the terms of the Plan or such Welfare Program. The Plan will provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded under 29 CFR § 2590.715-2712(a)(1). For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

Selection of Providers. If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. The plan or issuer must also permit the participant to designate an in-network pediatrician who is available to accept the participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the participant, beneficiary, or enrollee.

Emergency Services. With respect to non-grandfathered benefits under the Plan, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services.

Cost Sharing Limits. With respect to non-grandfathered benefits under the Plan, the Plan does not impose cost sharing amounts (i.e., copayments, coinsurance, and deductibles, but not premiums) that are more than the maximum allowed by law.

Clinical Trials. With respect to non-grandfathered benefits under the Plan, the Plan will not deny any "qualified individual," as set forth in Public Health Service Act §2709, participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan also will not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. Finally, the Plan will not discriminate against the individual on the basis of the individual's participation in such trial.

Provider Discrimination. With respect to non-grandfathered benefits under the Plan, the Plan shall not discriminate with respect to participation under the Plan against any health care provider that is acting within the scope of that provider's license or certification under the laws of the state issuing such license or certification, as required by Public Health Service Act §2706(a).

COVID-19 OUTBREAK NATIONAL EMERGENCY

As described in the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak and the Robert T. Stafford Disaster Relief and

Emergency Assistance Act, a nationwide national emergency began March 1, 2020 (the "National Emergency"). As a result, and pursuant to additional guidance issued by the Internal Revenue Service and the U.S. Department of Labor, effective March 1, 2020, group health Welfare Programs under the Plan will pause, on an individual by individual basis, the periods and dates described below ("COVID Tolled Deadlines") and will not commence or recommence such periods and dates until the earlier of (i) sixty (60) days after the announced end of the National Emergency or, (ii) one year from the date that tolling of the COVID Tolled Deadline commenced ("COVID Extended Period").

- The 30-day period (or 60-day period, if applicable) to request special enrollment,
- The 60-day election period for COBRA continuation coverage,
- The date for making COBRA premium payments,
- The date for individuals to notify the Plan of a Qualifying Event or determination of disability,
- The date within which individuals may file a benefit claim under the Plan's claims procedure,
- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure,
- The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination, and
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

CONSOLIDATED APPROPRIATIONS ACT

Notwithstanding anything in the Plan to the contrary, and solely to the extent of the Welfare Programs to which it applies, the Plan will comply with the Consolidated Appropriations Act of 2021, as amended, including, but not limited to the applicable provisions of the No Surprises Act. The No Surprises Act protects you from surprise billing or balance billing when you receive emergency medical care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center. If you have any questions about your rights and obligations under this law, please contact the Plan Administrator.

ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS:

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

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE:

You may continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this SPD Supplement and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES:

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

ENFORCE YOUR RIGHTS:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you may take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that 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 Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

APPENDIX A
WELFARE PROGRAMS AND CLAIMS ADDRESSES

Welfare Program:	**Funding:**	**Paid by:**	**Payroll deduction**	**Insurer or Third Party Administrator /Claims Administrator and Address**	**Policy Number**
Fully-Insured HMO Medical	Fully Insured	Employee/ Employer	Pre-tax	Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004	231485
Self-Funded CDHP Medical	Self-funded	Employee/ Employer	Pre-tax	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156	469718
Self-Funded CPOSII Medical	Self-funded	Employee/ Employer	Pre-tax	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156	469718
Self-Funded EPO Medical	Self-funded	Employee/ Employer	Pre-tax	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156	469718
Fully-Insured DHMO Dental	Fully-insured	Employee/ Employer	Pre-tax	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156	469718
Self-Funded PPO Dental	Self-funded	Employee/ Employer	Pre-tax	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156	469718
Fully-Insured Voluntary Vision	Fully-insured	Employee	Pre-tax	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156	469718
Fully-Insured Vision	Fully-insured	Employee/ Employer	Pre-tax	Vision Service Plan P.O. Box 997105 Sacramento, CA 95899-7105	12164038
Group Term Life	Fully-insured	Employer	N/A	The Lincoln National Life Insurance Company	000010062581
Voluntary Life (including Employee Assistance Program)	Fully-insured	Employee	Post-tax	The Lincoln National Life Insurance Company	000400001000-03816
Voluntary Short-term Disability	Fully-insured	Employee	Post-tax	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066	000010168128
Voluntary Long-term Disability	Fully-insured	Employee	Post-tax	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066	000010062583

This ***Appendix A*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person. To the extent that this ***Appendix A*** is modified, such modified ***Appendix A*** shall replace and supersede the prior version of ***Appendix A*** upon the effective date of the modified appendix.

This ***Appendix A*** is effective on and after: **January 1, 2023**.

APPENDIX B
PARTICIPATING EMPLOYERS

This ***Appendix B*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person. To the extent that this ***Appendix B*** is modified, such modified ***Appendix B*** shall replace and supersede the prior version of ***Appendix B*** upon the effective date of the modified appendix.

- As of January 1, 2023, there are no Participating Employers who participate in the Plan or any Welfare Programs.

This ***Appendix B*** is effective on and after: **January 1, 2023**.

APPENDIX C
SPECIAL ELIGIBILITY – COVID-19

Self-Quarantined Employee: You are considered to be a Self-Quarantined Employee if you are an Employee who has met all eligibility requirements of a particular Welfare Program, including the waiting period, and you voluntarily elect to self-quarantine or shelter-in-place in response to the COVID-19 (Coronavirus) pandemic ("***Self-Quarantine Election***"), and you either: (i) were actively participating in a Welfare Program under the Plan immediately before your Self-Quarantine Election or (ii) experienced a qualifying status change or special enrollment event ("***Mid-Year Enrollment Event***") such that you would, but for your Self-Quarantine Election, be eligible to elect coverage or otherwise make a Welfare Program election change under the Welfare Program mid-year.

Special Eligibility Rules Self-Quarantined Employees: Effective on or after March 1, 2020, if you are determined to be a Self-Quarantined Employee, you and your eligible dependents will (a) remain eligible for coverage under each Welfare Program under the Plan in which you were enrolled immediately before your Self-Quarantine Election, or, (b) be permitted to make a new election based on a Mid-Year Enrollment Event consistent with the terms of the applicable Welfare Program. This special eligibility shall continue until the earlier of (i) the end of the month coinciding with the announced end of the National Emergency; (ii) a 12 month cumulative period during which you choose to self-quarantine or shelter-in-place; or (iii) such other termination date determined by the Employer, in its sole discretion ("***Extended Coverage Period***"); provided, however, that to the extent the Employer elects to shorten such Extended Coverage Period, it will do so only after providing you prior written notice. In the event of a change in the Extended Coverage Period expiration date, you will be provided a new Summary of Material Modifications with the information indicated below completed.

Note, if you are a Self-Quarantined Employee who was not actively participating in a particular Welfare Program as of March 1, 2020, and you become eligible to elect coverage mid-year due to a Mid-Year Enrollment Event, you are required to timely make an active election to enroll in each Welfare Program for which you wish to participate at a time and in the manner set forth in the Welfare Program document and that is acceptable to the Plan Administrator.

You are also required to continue paying your portion of all applicable Welfare Program premiums during the Extended Coverage Period in order to maintain your coverage under the Plan. Failure to timely pay the applicable premiums will result in the termination of coverage under the Plan. Importantly, please note that if your coverage is terminated for failure to timely pay premiums, you will not be eligible for COBRA continuation coverage under the Plan.

This ***Appendix C*** is effective on and after: March 1, 2020.

* This ***Appendix C*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person by completion of the below information:

New Extended Coverage Period expiration: _____

_____

_____

_____

Approved by: _____

Date approved: _____