

Summary Plan Description of Employee Health & Welfare Benefits



2026

CBRE Government & Defense Services

Preferred Provider – Employee Health & Welfare Plan

Dear Participant:

We are proud to present to you this booklet, the purpose of which is to describe those features of the Plan which may not be addressed in the Summary Plan Description (SPD) issued by your Plan's insurance carrier(s). In other words, the purpose of this book is to describe the following:

- How Eligibility is determined under the Plan;
- When coverage begins under the Plan;
- Certain benefits, such as Life and Accidental Death and Dismemberment (AD&D), and Short Term Disability.
- FCE's administration of COBRA benefits under the Plan
- Your ERISA rights under the Plan

Please note that the Summary Plan Description (SPD) does not fully describe covered expenses, coverage limitations, coverage exclusions, or defined terms pertaining to the medical, dental, disability, or Life/AD&D benefits. Information on medical and dental benefits is located in the Certificate of Insurance (COI) issued by SelectCare. Information on disability and/or Life/AD&D benefits is located in the Certificate of Insurance (COI) issued by Reliance Standard Life Insurance Company (RSL).

You must work an average of 30 hours or more per week to have medical benefits under the Plan. Please refer to the Schedule of Benefits.

The applicable Policy, Summary of Benefits and Coverage (SBC), Minimum Essential Coverage (MEC) described herein and/or Trust Agreement will control if they conflict with the information in this Summary Plan Description. If any provision or part of this Plan conflicts with an applicable state or Federal law or mandate, the Plan will be interpreted, and coverage will be provided as required by the applicable law or mandate.

If you wish to cover eligible dependents under the plan, you must authorize the necessary wage deductions by completing, signing and submitting the required wage deduction form. If you have not already filled out an enrollment form, be sure to complete one and return it to the project manager or send it to the FCE Guam Office. The address information can be found in the Contact Information for Benefit Resources section.

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Employer Profile

Summary Plan Description (SPD) of Benefits

This SPD has been prepared to furnish you with information regarding the benefits to which you and your covered eligible dependents, if applicable, are entitled under the Benefit Plan Program in which you have enrolled. The Employee Retirement Income Security Act of 1974 (ERISA) requires that all participants be furnished a summary description of their Benefit Plan. Following is a general outline of the Plan, which gives you this information, and details of your benefits are covered in the provisions which are in this booklet. It has been our objective to describe the Plan clearly and directly; however, if you have any questions concerning the Plan or the information and provisions of this coverage, please consult the Third-Party Administrator, Claims Division.

Name of Plan	CBRE Government & Defense Services Health & Welfare Plan
Plan Effective Date:	January 1, 2026
Plan Year and Financial Reports:	January 1 to December 31
Medical and Ancillary Benefits Annual Coverage Period:	January 1 to December 31
Plan Status Under The ACA:	Non-Grandfathered
Applicable Law:	ERISA
Plan Number:	502
Participating Employer(s):	CBRE Government & Defense Services
The Employer, Plan Sponsor, and Plan Administrator:	CBRE Government & Defense Services 7710 Rialto Blvd, Ste 200, Austin, TX 78735
Employer Identification Number (EIN):	74-1668145
Third-Party Administrator:	FCE Benefit Administrators, Inc. 1528 S. El Camino Real, Suite 407 San Mateo, CA 94402 1-800-298-7269
Plan Trustee:	Trust Management Services Jennifer Riva 1 South Almaden Boulevard, Suite 750 San Jose, CA 95113
Agent for the Service of Process:	FCE Benefit Administrators, Inc. 1528 S. El Camino Real, Suite 407 San Mateo, CA 94402 1-800-298-7269

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Section I – Benefits and Provisions

Schedule of Benefits

IBEW 1260 GUAM		
CBRE Government & Defense Services Exempt Plan		
Preferred Provider - Employee Health and Welfare Plan - Effective 01/01/2026		
EMPLOYEE PLAN INCLUDES :	Exempt Employee	Exempt Employee Waived Medical
	Employee	Employee
LIFE INSURANCE BENEFITS (RSL)		
Employee Life Insurance Benefits	\$50,000	\$50,000
Employee Accidental Death & Dismemberment	\$50,000	\$50,000
SUPPLEMENTAL VISION CARE (FCE)		
Vision Examination (Once in Every Calendar Year)	\$75	N/A
Frame & Lens Materials (Once in Every Two Calendar Years)	\$150	
DENTAL BENEFITS (SelectCare)		
Calendar Year Maximum for Preventive, Basic, Major	\$2,000	
Calendar Year Deductible for Basic and Major	\$50	
Percent Paid for Preventive Services	100%	N/A
Percent Paid for Basic Services	80%	
Percent Paid for Major Services	50%	
<i>Elective Dependent coverage available</i>		
WEEKLY DISABILITY (Available to Employees Only)		
Paid from 8th Day of Accident or Sickness		
Maximum Weekly Benefit (up to 26 Weeks of Disability)	\$500	\$500
Percent of Base Weekly Earnings	66%	66%
Long-Term Disability (Available to Employees Only; RSL)	Voluntary	
Paid from 91st Day of Accident or Sickness		
Maximum Monthly Benefit	\$6,000	
Percent of Base Monthly Earnings	60%	
PPO Network	SelectCare	
Major Medical Coverage (Vision Benefit Included in Medical)	See attached SelectCare Benefit Summaries	N/A
COVERAGE EFFECTIVE/TERMINATION		
Coverage Effective	First of the Month Following Date of Hire	
Coverage Termination	End of Month of Termination of Employment	
Life insurance coverage is underwritten by Reliance Standard Life Insurance Company (RSL).		
Important: This is a highlight sheet. The actual benefits, terms, and conditions are specified in the policy, schedule of benefits, and evidence of coverage.		
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Full-Time Rate Summary

		Effective: 01/01/2026	
Plan Cost	1 <u><i>BASE PLAN Select Care Major Medical Cost (SC-70)</i></u>	\$524.43	
	<u><i>Plan Cost</i></u> *	Monthly rates	Weekly rates
	Single	\$0.00	\$0.00
	Couple	\$450.11	\$103.87
	Family	\$975.87	\$225.20
Plan Cost	2 <u><i>MID PLAN Select Care Major Medical Cost (SC-80)</i></u>	\$577.99	
	<u><i>Plan Cost</i></u> *	Monthly rates	Weekly rates
	Single	\$53.56	\$12.36
	Couple	\$554.14	\$127.88
	Family	\$1,142.73	\$263.71
Plan Cost	3 <u><i>BUY-UP PLAN Select Care Major Medical Cost (SC-10)</i></u>	\$649.06	
	<u><i>Plan Cost</i></u> *	Monthly rates	Weekly rates
	Single	\$124.63	\$28.76
	Couple	\$690.10	\$159.25
	Family	\$1,364.18	\$314.81
Plan Cost	5 <u><i>At-Will Plan (No Major Medical Coverage)</i></u>	\$38.20	
	<u><i>Plan Cost</i></u>	Monthly rates	Weekly rates
	Single	\$38.20	\$8.82
Plan Cost	6 <u><i>Voluntary Long-Term Disability</i></u>	Per \$100 of Covered Payroll (Monthly)	
	<u><i>Age Group</i></u>	<u>Employee Only</u>	
	18-24	\$0.086	
	25-29	\$0.135	
	30-34	\$0.244	
	35-39	\$0.391	
	40-44	\$0.675	
	45-49	\$0.882	
	50-54	\$1.246	
	55-59	\$1.608	
	60-64	\$1.241	
65-69	\$0.838		
	70+	\$0.609	
* Includes employer subsidy of \$524.43 per month for each tier			
- This is a general summary of your benefits. A more complete description of your benefits and the terms under which they are provided, including limitations and exclusions, are contained in the Summary Plan Description (SPD). If there are any discrepancies between the information contained in this highlights of plan benefits and the provisions of the SPD, the SPD is the controlling authority.			

Eligibility

Who is Eligible

An Exempt Employee as defined by the Plan Sponsor for whom the Plan Sponsor makes the required contributions to the Plan is eligible.

When Eligibility Begins

Eligibility begins on the date the Employer begins making the required contributions on the Employee's behalf.

When Coverage Begins

Coverage begins when the eligible Employee completes the Waiting Period.

Waiting Period

The Waiting Period is the period between the first day of eligibility and the first day of coverage under the Plan.

Initially Hired Employees will be covered for benefits under the plan on January 1, 2026.

Subsequently Eligible Employees will be covered for benefits under the plan on the first of the month following date of hire.

"One month" shall mean a full calendar month regardless of the number of days comprising that month. This means that an employee who begins continuous employment on the first of the month will be covered on the first of the first following month. An employee who begins continuous employment on a date other than the first of the month will be covered on the first of the second following month.

If you terminate employment or your employer terminates contributions on your behalf, prior to reaching your effective date of coverage, you will not be covered under the plan and your employer paid contributions will not be refunded.

Dependent Eligibility

Dependents who were eligible under the Plan at the time you became eligible, and who were enrolled according to the terms described in the section of this SPD titled "Enrollment," and for whom you have timely made arrangements for payroll deductions, if they are required, will become covered at the same time as your coverage becomes effective. In no event should this occur sooner than the Employee's coverage. In order to ensure your dependent coverage begins at the same time as yours, you must do the following no later than four business days before the last day of your month of hire:

- Elect eligible dependents.
- Authorize payroll deductions.
- Provide any required dependent documentation to FCE.

In order for a Dependent(s) to become eligible under the Plan after you become eligible, the underlying circumstance must satisfy "Qualifying Life Event" status, and timely arrangements for payroll deductions must be made. (Please refer to Qualifying Life Events).

Delay of Effective Coverage

You must satisfy the Waiting Period and your employer must make contributions to the Plan for the Waiting Period (in accordance with your work schedule) in order for your benefit coverage under the Plan to become effective. Should you lose eligibility for any reason during the Waiting Period, your Effective Date will be delayed until you regain eligibility and satisfy the unmet balance of the Waiting Period. In the event you do not regain eligibility within 91 days, a new Waiting Period must be satisfied upon your return.

If you are not actively at work on the day coverage becomes effective, but the Waiting Period and contribution requirement have otherwise been met:

1. Your Effective Date will not be delayed if the reason for your absence is due to health-related factors.
2. Your Effective Date will be delayed until you regain eligibility, if the reason for your absence is due to non-health-related factors. If you do not regain eligibility within 91 days, a new Waiting Period must be satisfied upon your return to eligibility.

Determining Full-Time Employee Status Under ACA

Effective January 1, 2015, an active Employee not eligible for full-time Major Medical coverage for a month under the rules described above shall nonetheless be eligible for full-time Major Medical coverage if the Employee is treated as a full-time employee for that month generally under Treasury Regulation §54.4980H, and specifically under §54.4980H-3(d). For purposes of implementing the provisions of this regulation, the following assumptions apply:

1. Six-month measurement periods shall be applied - these measurement periods will be determined by your employer and communicated to you.
2. Two-month administration periods shall be applied between each measurement and stability period.
3. Six-month stability periods shall be applied - these measurement periods will be determined by your employer and communicated to you.
4. Initial measurement periods for new employees shall begin on the first of the month following, or coincident with, date of hire.
5. Actual hours of service shall be counted without regard to an equivalency rule.

Employees who work an average of 30 or more hours per week of employment during the previous measurement period will receive full-time benefits for the entire six-month stability period.

In the event you become ineligible for full-time Major Medical benefits, you will have the option to “buy back” your Major Medical benefits by electing COBRA continuation coverage at an Affordable rate - meaning you will not be charged more than 9.5% of the individual poverty level in the U.S. An election notice explaining COBRA rights and procedures would arrive in the mail.

In the event your weekly average over the previous Measurement Period falls below 30 hours, you and your covered Dependents, if any, will no longer be eligible for Major Medical benefits. In this case, any premium wage-deducted (or otherwise paid), for Dependent coverage for the month your Major Medical plan eligibility ceases will be refunded to you as a prorated amount (Proration will be based on a 30-day month).

Family and Medical Leave Act

Effective August 5, 1993, the Family and Medical Leave Act of 1993 (FMLA) was enacted to allow eligible Employees the right to take up to 12 weeks of unpaid leave to care for themselves or a relative (or 26 weeks to care for a relative who incurred an Injury or Illness in the line of duty as a member of the U.S. Armed Forces). If you elect to take this leave and later notify the company that you will not be returning, you have the ability to continue your coverage for 18 months from the date benefits are terminated.

Regardless of established leave policies, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his/her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when the coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his/her Dependents when Plan coverage terminated. The level of plan coverage during your disability is based on an average paid hours for the Measurement Period immediately preceding your FMLA leave.

Employees on Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
 - a. The 24-month period beginning on the date on which the person's absence begins;
or
 - b. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
2. A person who elects to continue health plan coverage is not required to pay more than 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If you wish to elect this coverage or obtain more detailed information, contact the Plan Administrator. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Qualified Medical Child Support Order

The Plan recognizes Dependent child coverage as required under a Qualified Medical Child Support Order, a National Medical Support Notice or other appropriate court order, as determined by the Plan Administrator. The Plan also recognizes coverage as required under a Qualified Domestic Relations Order with respect to a former spouse. The Plan has procedures in place to qualify such orders and notices. If you have an order or notice requiring coverage of a child or former spouse under the Plan, you should contact the Plan Administrator immediately to determine whether the order or notice is qualified. You and your beneficiaries may obtain, without charge, a copy of these procedures from the Plan Administrator.

Transferred Employee

If you are covered under another plan sponsored by this Employer and are transferred into the present Plan as a Subsequently Eligible Employee without a lapse in coverage (as defined under HIPAA portability rules), then you are not subject to a waiting period provision upon transfer into the present Plan provided your Employer has made the required contributions on your behalf.

Returning from an Unpaid Leave or Termination

If your Plan coverage ceases due to termination or an unpaid leave of absence:

1. When you return to work and your Employer resumes contributions within 91 days of the termination or the beginning of unpaid leave, you will be eligible for Plan benefits on the first of the month immediately after your return to work.
2. If you return after the 91st day, you are subject to the new employee waiting period.
3. If you are terminated and rehired at the covered site on or before the last day of the month in which you were terminated (the Extended Benefit Period), you will not have a lapse in coverage.
4. If you have coverage under COBRA at the time you return to work, you may avoid a lapse in coverage by continuing COBRA coverage, at your expense, until you become eligible for coverage under the Plan.

Continued Contributions During an Approved Leave of Absence

An Employer may continue to contribute to the Plan on behalf of an Employee who is on an approved medical leave for a period not exceeding three consecutive months. Any part or all of such leave that qualifies under FMLA will be considered FMLA leave only, and this provision shall not apply.

Termination of Coverage

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates

Your eligibility for benefits terminates when your Employer no longer makes contributions on your behalf, which may occur by reason of your termination of employment, unpaid leave of absence or transfer to a class of Employee not covered by the Plan. Your coverage also may terminate if your Employer fails to timely pay the required contributions, and/or if the plan is terminated.

The Extended Benefit Period begins upon the Employee's cessation of eligibility. If an Employee's eligibility ceases the Employee's coverage will end at midnight on the last day of the month in which eligibility ceases. If an Employee becomes covered under another comparable medical plan during the Extended Benefit Period, the Extended Benefit Period shall end upon the effective date of the other coverage. In such a case, it is the Employee's responsibility to notify the Plan of the other coverage.

If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

When Dependent Coverage Terminates

If eligible Dependent contributions are being paid on a pre-tax basis, a covered Dependent for which the Employee has requested termination of benefits, will cease to be covered as of midnight of the date requested (in writing) by the Employee, as long as the reason for such a request qualifies under section 125 of the Internal Revenue Code and/or Plan rules.

If eligible Dependent contributions are being paid on a post-tax basis, a covered Dependent for which the Employee has requested termination of benefits, will cease to be covered as of

midnight of the date requested by the Employee. In this case, the otherwise eligible Dependent may not re-enter the Plan until the next Open Enrollment period.

Otherwise, a Dependent's coverage will cease at midnight on the day on which the Employee's coverage terminates. Any wage deducted contribution made by the Employee in the month of termination will be refunded to the Employee by the Plan.

If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively, the Plan will provide at least 30 days' advance written notice of such action.

Continuation of Coverage After a Loss of Benefits

If an Employee loses eligibility for benefits described in this Summary Plan Description by reason of termination of employment, reduction in hours, or death, such Employee and/or Dependent, at his/her own expense, may elect to continue coverage for such benefits. The length of time such coverage may be continued depends on the reason for loss of eligibility and the physical condition of the Employee.

A detailed description of the rules and procedures governing continuation of coverage is set forth in the section of this SPD titled "Continuation Coverage Rights under COBRA."

Medical and Dental Benefits

In order to ensure smooth and timely access to benefits for you and any eligible Dependents, you will need to fill out and sign an enrollment form and any other form required by the carrier.

These benefits are provided by SelectCare. For a full description of covered expenses, defined terms, limitations and exclusions as they apply to your benefits, please refer to your SelectCare policy.

You must work an average of 30 hours or more per week to have medical benefits under the Plan. Please refer to the Schedule of Benefits.

Waiver of Medical Benefits

If you have other current, active, comparable, employer-sponsored group medical coverage, you may elect to waive the medical benefits under the present Plan. For the purpose of waiving medical coverage under the present Plan, “another employer-sponsored group medical plan” shall mean currently active medical benefits to which you are entitled because:

- You are a Dependent on your spouse’s employer-sponsored group plan; or
- You are covered under a retiree plan through a previous employer; or
- You are covered under another plan through another current employer; or
- You are covered under Tricare.

Medicare and an entitlement to Veterans Administration (VA) Services do not qualify as “another employer-sponsored group medical plan” for the purpose of waiving medical coverage under the present Plan. Federal regulations intend for Medicare beneficiaries to enroll in employer-sponsored medical coverage when offered.

If you elect to so waive, you must complete, sign and submit a Waiver of Medical Benefits form. Also, you must provide evidence of your other coverage. “Evidence” in this context means a photocopy of both sides of the ID card issued to you as a participant in the other plan. Failure to provide evidence to FCE within your enrollment period will nullify this election to waive and will result in your automatic enrollment in the medical benefits under the present Plan.

You may only waive medical coverage as a new hire or during an Open Enrollment Period.

If you waive medical benefits under the Plan, your waiver will not affect the Plan’s responsibility to provide you with certain core benefits under the Plan. Accordingly, participation in the Plan is mandatory for all Employees, regardless of other coverage, insofar as the following benefits are concerned:

- Life Insurance / Accidental Death & Dismemberment Benefits
- Short Term Disability
- Employee Assistance Program (EAP)
- Voluntary Long-Term Disability

Your election to waive medical coverage under the Plan will result in an allocation of Plan assets to fund another benefit for you in lieu of the Plan’s medical coverage. These funds will not be released for this purpose until FCE has received a completed and signed Waiver of Medical Benefits and has validated the evidence submitted in support of your waiver election.

Having waived medical benefits under the Plan, you may not become covered under the Plan’s medical benefits prior to the next Open Enrollment Period unless you lose your other employer-sponsored group medical coverage and provide evidence to that effect. If you lose your other coverage, you are entitled to Special Enrollment, as described in the “Enrollment” section of this SPD. If you do not exercise your Special Enrollment rights, then a “break” in coverage will begin on the date following your last day of other coverage.

Life Insurance Benefit

The life insurance benefit is a fully insured benefit. Please refer to the carrier certificate for more information regarding benefit details.

In order to ensure smooth and timely access to benefits you may have to fill out and sign an enrollment form and any other form required by the carrier.

The benefit is administered by a carrier. For a full description of covered expenses, defined terms, limitations, and exclusions as they apply to this benefit, please refer to the carrier certificate. Any differences or conflict between the statements in this booklet and the terms and definitions of the certificate will be resolved in favor of the certificate.

Accidental Death & Dismemberment Benefit

The accidental death & dismemberment benefit is a fully insured benefit. Please refer to the carrier certificate for more information regarding benefit details.

In order to ensure smooth and timely access to benefits you may have to fill out and sign an enrollment form and any other form required by the carrier.

The benefit is administered by a carrier. For a full description of covered expenses, defined terms, limitations, and exclusions as they apply to this benefit, please refer to the carrier certificate. Any differences or conflict between the statements in this booklet and the terms and definitions of the certificate will be resolved in favor of the certificate.

Supplemental Vision Benefits

Coverage is provided for you or your eligible Dependent for an eye examination, the purchase of vision frames and the purchase of one style of vision lenses (single vision or bifocal or contacts). The maximum amount paid for each vision benefit is listed on the Schedule of Benefits.

Your Vision Benefits cover charges made for the following:

1. One Optical examination by an optometrist or ophthalmologist per person per Calendar Year.
2. One set of Frames per person every two Calendar Years.
3. Not more than two Lenses per person every two Calendar Years.
4. One lens type per person (e.g., single vision, Lenticular lenses, bifocal lenses, trifocal lenses, progressive multifocal lenses, contact lenses, disposable contact lenses); every two Calendar Years.

This Plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, this Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the additional costs for the options, unless the extra is defined as a Plan Benefit.

Restriction on Payment of Vision Benefits

In addition to the exclusions and limitations listed in the section of this SPD titled "General Limitations and Exclusions", no benefits are payable for:

1. Procedures or supplies furnished on account of visual defect, which arises out of or in the course of your or your Dependent's job.
2. Any medical or surgical treatment of the eye.
3. Safety lenses or goggles.
4. Orthoptics, vision training or aniseikonia, and any associated supplemental testing.
5. Optional cosmetic processes.
6. Anti-reflective coating.
7. Color coating.
8. Cosmetic lenses.
9. Scratch resistant coating.
10. Mirror coating.
11. Laminated lenses.
12. Tinted lenses.
13. Oversize lenses.
14. Polycarbonate lenses.
15. Photochromic lenses.
16. UV (ultraviolet) protected lenses.
17. Certain limitations on low vision care.

Additional Exclusions and Limitations

There is no benefit under this Plan for professional services or materials connected with:

- Two pairs of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances.
- Services/materials not indicated as covered Plan Benefits.

Note:

A Calendar Year means January 1st through December 31st.

Two Calendar Years mean January 1st through December 31st of the following year.

Example of How the Vision Lens Limitation Works

Consider a covered Employee who purchases frames under the Plan in 2026. Regardless of what day this purchase occurs, this Employee will not become eligible to purchase additional frames of any style under the Plan until January 1, 2028. In this example, the balance of 2026 (whatever period of time that may be) and the whole of 2027 must elapse before the limitation of "Two Calendar Years" is satisfied.

Voluntary Long-Term Disability

Please refer to the carrier certificate for more information regarding benefit details.

In order to ensure smooth and timely access to benefits you may have to fill out and sign an enrollment form and any other form required by the carrier.

The benefit is administered by a carrier. For a full description of covered expenses, defined terms, limitations, and exclusions as they apply to this benefit, please refer to the carrier certificate. Any differences or conflict between the statements in this booklet and the terms and definitions of the certificate will be resolved in favor of the certificate.

Short-Term Disability

Maximum Weekly Benefit

Maximum 66% of Weekly Base Wage (up to 26 weeks).

Please refer to the Schedule of Benefits for the maximum weekly benefit amount.

Paid from the 8th day of accident or 8th day of accident or sickness.

This benefit is provided to the Employee only. No family members are eligible for this benefit.

The Plan pays you a monetary benefit while you are sick or injured and prevented from working provided, that the Illness or Injury preventing you from working occurred on or after the Effective Date of Coverage under the Plan, and that you are under the care of a legally qualified Physician and your Illness or Injury results from a non-job related accident, Illness or disease for which benefits are not payable under any workmen's compensation law. In order to receive this monetary benefit, the claim form must be completed and filed with the claims office within 90 days of the elimination period. This benefit is provided to the Employee only. No family members are eligible for this benefit. This benefit is exclusively a monetary benefit and provides no other benefits during an allowable and covered absence from work.

Maximum Amount of the Benefit

The maximum amount of this monetary benefit is stated in the Schedule of Benefits and is based in part on your coverage classification. In addition, the benefit amount may also be expressed as a percent of base weekly wage, not to exceed the maximum amount. Please be advised that this monetary benefit is subject to required Federal withholding taxes. Prior to paying out a valid claim, FCE will reduce the claim amount by the required withholding taxes.

Elimination Period

The appropriate elimination period that must be satisfied before this monetary benefit begins to be paid is set forth in the Schedule of Benefits. This benefit is not payable from the first day of an eligible Illness or Injury unless it is so stated in the elimination period.

Maximum Number of Weeks

Your weekly accident and Illness benefit has a maximum of 26 weeks per unrelated disability. The 26 week period starts on the date the disability first becomes payable. The Plan will not cover more than the specified number of weeks for any separate period of a related disability, regardless of the inception date.

Must I Be Confined to Home?

It is not necessary to be confined to your home to collect benefits, but you must be under the care of a legally qualified Physician during the period of your covered absence from work and you must not be actively at employed.

Enrollment

Although FCE can issue ID cards and will process most health and welfare claims for you solely on the basis of payroll information received from your company, the properly completed enrollment form is the only source we have that informs us about your eligible Dependents and your chosen beneficiary for the death benefit. Therefore, you must fill out the enrollment form, identifying your eligible Dependents where indicated, and submit the completed, signed form to FCE through your Employer.

Enrollment forms are available from your Employer.

Enrolling Dependents

While eligible Dependents of a covered Employee will technically be covered under this Plan on the later of the date of the Employee's eligibility or the date of the Dependent's eligibility, FCE's ability to describe benefits, authorize treatment and pay claims is contingent upon the receipt of a signed, updated enrollment form from the Employee containing complete information requested about the eligible Dependents.

Treatment will not be authorized, and claims will not be paid for otherwise eligible Dependent who have not been included in or added to a signed enrollment form. Failure to add an otherwise eligible Dependent within 30 days after the Employee first performs service on a covered contract or within 30 days after a life status change (as defined in the Internal Revenue Code) for an otherwise eligible treatment will cause that claim to be denied and returned to the Provider as the Employee's responsibility.

During Open Enrollment, you will be asked for the documentation necessary for the Plan to verify your dependents' eligibility (e.g., birth certificate, marriage certificate, etc.). If you do not provide the requested documentation by the effective date of Dependent coverage, your unverified Dependent(s) will not be covered. If you are enrolling on-line, simply follow the electronic prompts concerning Dependent verification. If you are enrolling through a paper process, please refer to the Dependent-verification instructions in your enrollment kit.

Enrollment Requirements for Newborn Children

A newborn child of a covered Employee is automatically enrolled in this Plan for 30 days. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for the cost.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollment.

General Considerations Concerning the Enrollment Form

1. All enrollment forms should be signed and returned.
2. If a contribution is made for the Employee, but no enrollment form is received, FCE will:
 - a. Verify benefits subject to eligibility.
 - b. Pay all allowable employee claims.
 - c. "Pend" dependent claims until the completed, signed enrollment form is received.
3. If a completed enrollment form includes an eligible Dependent or spouse with a different last name, a birth certificate listing the parents' names must be submitted with the dependent claim and a marriage certificate needs to be submitted with the spouse's claim.
4. Guardianship information will not be verified until a Claim is submitted.
5. If an unsigned enrollment form is received, it will be returned. If other information is required as well, all information will be requested at the same time as the signature.

Qualifying Life Events

If you have elected to have your premiums deducted pre-tax, mid-year election changes are regulated by federal law. The Internal Revenue Service (IRS) Code Section 125 contains provisions defining "qualifying events" which allow mid-year changes to your medical, dental, vision, life, health and/or dependent care flexible spending account plan elections within **30 days** of the life event date.

Common Mid-Year Qualifying Life Events

The following list represents examples of common IRS mid-year qualifying events:

- Change in legal marital status, domestic partnership or civil union status.
- Change in the number of eligible Dependents of the Employee or Dependents of the domestic partner or civil union partner.
- Gain Dependent—birth, adoption, placement for adoption, etc.
- Loss of Dependent—dies or reaches age 26 unless disabled as defined under the eligibility section.
- Change in Employee's, spouse's, domestic partner's, civil union partner's or dependent's employment status (commencement or termination of employment, strike or lock-out, unpaid leave, etc.)
- Gain / lose entitlement to Medicare or Medicaid (60 days)
- A change in residence of the Employee, spouse, domestic partner, civil union partner or eligible Dependent, which affects eligibility for coverage.
- Judgment, decree, or Qualified Medical Child Support order for health coverage of an eligible child.
- Significant change in health coverage of an eligible child.
- Significant change in coverage or cost of Dependent's plan.

The type of IRS approved qualifying event determines the changes that are permissible. For example, marriage of the Employee would permit a change from Employee only coverage to Employee + 1 coverage as well as the option to change medical plan elections, e.g., Green Plan to POS Plan.

Official Documentation

Before entering a change into Employee Self-Service: it is necessary to provide documentation within 30 days of the effective date to substantiate the qualifying event and to establish the eligibility for, and the effective date of the requested change.

Required documentation due within **30 days** of the effective date include:

- Legal documents for adoption, divorce, marriage, civil union partner, etc.
- Affidavit of Common Law Marriage
- Affidavit of Domestic Partnership
 - A joint financial document must accompany a marriage certificate or affidavits.
- Letter on company letterhead which include:
 - Defined qualifying event type and effective date of coverage.
 - Name of individual(s) affected by a status change.
 - Name(s) of individuals who had been covered under another plan.
 - Medical, dental and/or vision coverage effective date or termination date (or other benefits as applicable).

Open Enrollment

Once in every Calendar Year, during the annual Open Enrollment Period, Employees and their eligible Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective on the anniversary of the Plan.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

Timely or Late Enrollment

1. **Timely Enrollment** – The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

In the circumstance where two married Employees are enrolled in the Plan and the Employee who holds the coverage for the dependent children discontinues that coverage, the other covered Employee can maintain the Dependent coverage without any waiting period, provided that the coverage has remained consistent.

2. **Late Enrollment** – An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. If the Plan contains a Waiting Period, then a Late Enrollee will be subject to the Waiting Period, which will begin on the Open Enrollment Effective Date.

Special Enrollment Rights

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, legal guardianship, a foster child being placed with the Employee, adoption or placement for adoption there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

Special Enrollment Periods

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

1. Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:
 - a. The Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - c. The coverage of the Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

- d. The Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
2. For purposes of these rules, a loss of eligibility occurs if one of the following occurs:
 - a. The Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time Employees).
 - b. The Dependent has a loss of eligibility as a result of Legal Separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - c. The Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
 - d. The Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

3. Dependent beneficiaries. If:
 - a. The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
 - b. A person becomes a Dependent of the Employee through marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, legal guardianship, a foster child being placed with the Employee, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- i) In the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received.
 - ii) In the case of a Dependent's birth, as of the date of birth; or
 - iii) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
 - iv) In the case of a legal guardianship, on the date on which such child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as Legal Guardian for the child; or
 - v) In the case of a foster child being placed with the Employee, on the date on which such child is placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.
4. Medicaid and State Child Health Insurance Programs. An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if:
- a. The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
 - b. The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

Claims

Medical and Dental Claims

Please refer to your carriers Certificate of Insurance for a complete description of your plan's claims procedures.

CLAIM PROCEDURES FOR CLAIMS FILED WITH RELIANCE STANDARD LIFE INSURANCE COMPANY

Claims for Benefits

Claims may be submitted by mailing the completed form along with any requested information to Reliance Standard Life Insurance Company. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections. Claim forms are available from your benefits representative or may be requested by contacting Reliance Standard Life Insurance Company.

Timing of Notification of Benefit Determination

Life and AD&D Benefit Claims

If a non-disability claim is wholly or partially denied, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after RSL's receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined 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 that the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Manner and Content of Notification of Benefit Determination

Life and AD&D Benefit Claims

A Claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific plan/policy 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; and

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974 as amended (ERISA) (where applicable), following an Adverse Benefit Determination on review.

Appeals of Adverse Benefit Determinations

Appeals of Adverse Benefit Determinations may be in accordance with the following procedures to Reliance Standard Life Insurance Company. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

Life and AD&D Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed.
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal.
3. Claimants 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.
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal.
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Timing and Notification of Benefit Determination Review

Life and AD&D Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined 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 shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Manner and Content of Notification of Benefit Determination Review

Life and AD&D Benefit Claims

A claimant shall be provided with written notification of the benefit determination on review. In the case of an Adverse Benefit Determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific plan/policy 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 information relevant to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Third-Party Recovery Provision

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a Third-Party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, Third-Party assets, Third-Party insurance, and/or guarantor(s) of a Third-Party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and Third-Party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or Third-Party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a Third-Party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
 - a. Crime victim restitution funds
 - b. Civil restitution funds
 - c. No-fault restitution funds such as vaccine injury compensation funds
 - d. Any medical, applicable disability or other benefit payments
 - e. School insurance coverage

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is

fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness, injury, or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any Third-Party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable Third-Party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a Third-Party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
 - a. Crime victim restitution funds
 - b. Civil restitution funds

- c. No-fault restitution funds such as vaccine injury compensation funds
- d. Any medical, applicable disability or other benefit payments
- e. School insurance coverage

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a Third-Party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any Third-Party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Certain Plan Participant Rights under ERISA

As a Plan Participant in this FCE Administered Health and Welfare Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or Dependents may have to pay for such coverage.
- Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or Dependent has Creditable Coverage from another plan. The Employee or Dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage, but only for Plan Years that begin before January 1, 2014.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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 a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

Continuation Coverage Rights Under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under The Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

Information on the Plan Administrator can be found in the Contact Information for Benefit Resources section.

COBRA continuation coverage for the Plan is administered by FCE Benefit Administrators, Inc.

Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants 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 Plan coverage that the 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).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

1. 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 Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. 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 Plan 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 (e.g., common-law Employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan 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. A domestic partner and his or her children are treated as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. This gives the domestic partner and children the contractual rights outlined in this Section but does not extend statutory provisions to the domestic partner or child.

Federal law does not recognize a Domestic Partner or his or her children as Qualified Beneficiaries. However, the Plan will treat a Domestic Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them.

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.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant 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:

1. The death of a covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
3. 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.

4. A covered Employee's enrollment in any part of the Medicare program.
5. 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 the Family and Medical Leave Act of 1993, as amended ("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. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day the leave begins.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (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. You may want to check to see if your 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

can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor to discuss options. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

- **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 participants 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.

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, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options online at the Healthcare.Gov website. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

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 no 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, 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 and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 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 the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Recent changes in the law increased this

assistance temporarily to 80%, and temporarily extended the period of COBRA continuation coverage for eligible individuals. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

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 of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. The end of employment or reduction of hours of employment,
2. Death of the Employee,
3. Commencement of a proceeding in bankruptcy with respect to the employer, or
4. Enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or Legal Separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your 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. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be *in writing*. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

**FCE Benefit Administrators
4615 Walzem Road, Suite 300
San Antonio, Texas 78218**

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

- The **name of the plan or plans** under which you lost or are losing coverage,
- The **name and address of the 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**, your notice must include **a copy of the divorce decree or the Legal Separation agreement**.

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 you or your Spouse or 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 can 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 (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

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:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - a. 29 months after the date of the Qualifying Event, or
 - (ii) 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
- b. The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can 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:

1. 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.
2. In the case of a covered Employee's enrollment in the Medicare program 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:
 - a. 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or
 - b. 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.
3. 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.
4. 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 can 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-month 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 can 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 COBRA Administrator 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 should be sent to the COBRA Administrator 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 must pay for COBRA continuation coverage. Qualified beneficiaries will 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. "Applicable premium" refers to the actual premium cost of fully insured COBRA-eligible benefits provided through a policy of insurance. "Applicable premium" also refers to the actuarially determined equivalent premium cost of self-funded COBRA-eligible benefits. 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 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.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

Keep Your 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. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

Responsibilities for Plan Administration

Plan Administrator

The Plan is the benefit plan of the Employer, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by the Employer as Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, the Employer shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

The Plan has designated a Privacy Officer responsible for implementation of policies and procedures regarding the Privacy Rules and for handling complaints. The contact person for receiving complaints and providing additional information regarding the Plan's privacy procedures is The Plan Administrator. Contact information can be found in the Contact Information for Benefit Resources and Employer Profile sections.

Duties Of the Plan Administrator

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation.
2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and,
3. in accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator Is Not a Fiduciary

A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Compliance With HIPAA Privacy Standards

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employees are permitted to have such access subject to the following:

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

2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employer.
 - a. **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
 - b. **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
 - c. **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
 - i. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
 - ii. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment.
 - iii. Mitigating any harm caused by the breach, to the extent practicable; and
 - iv. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
4. **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
 - a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law.

- b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information.
- c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer.
- d. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law.
- e. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards.
- f. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards.
- g. Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards.
- h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards.
- i. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- j. Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of the Plan Sponsors' workforce are designated as authorized to receive Protected Health Information from The Plan in order to perform their duties with respect to the Plan: **HR Manager**.

Compliance With HIPAA Electronic Security Standards

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

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

2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

Funding The Plan and Payment of Benefits

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived solely from the funds of the Employer.

For Dependent Coverage: Funding is derived from the contributions (payroll deductions) made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

Plan Is Not an Employment Contract

The Plan is not to be construed as a contract for or of employment.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

Miscellaneous Plan Provisions

Funding

Participation in the Plan is mandatory for those Employees who meet the eligibility requirements and for whom the Employer pays contributions to the Plan. The Plan Sponsor pays the entire cost of Employee coverage under this plan. Coverage for eligible Dependents is paid by Employee through payroll deductions on a pre-tax basis under IRS tax code §125. Benefits are paid from the trust that has been established to receive contributions from the Plan Sponsor and to pay benefits due under the Plan. The Plan's Health & Welfare Trust Agreement is the funding medium used for accumulation of assets and disbursement of benefits.

Participation Rules

The contribution rate structure/benefit design for Plan Participants has been actuarially determined based on the assumption that all employees within a specified group will participate in the Plan. If all employees within a specified group do not participate in the Plan, the Employer must inform FCE in writing, timely, and the contribution rate structure/benefit design for the group may be revised to minimize any potential negative effect on the Plan as a result of adverse selection. FCE reserves the right to request proof of participation by all employees within the specified group.

Plan Cost Reserve

Because Employee's hours can vary, the initial hourly assumption at the beginning of every coverage year that sets the anticipated costs of the benefit program may from time to time be less than or greater than the Employer's contributions for a given period. At the beginning of every coverage year, the anticipated plan costs for the year are based upon:

1. The Contract's hourly Health and Welfare obligation.
2. The pattern of Employee's hours for the previous coverage period; and
3. Whether the Plan costs for the just ended coverage year were greater than or less than the Health and Welfare obligation for the previous year.

In the event that the Plan costs are less than the contributions, the Plan will record a Plan Cost Reserve. These reserves will be reviewed every year and benefits adjusted accordingly so that over a number of years the Reserve will approach \$0.00. However, at termination of employment, if a particular employee's cost of benefits has not reconciled to the Employer's contributions for that Employee, where the costs have been greater than obligated contributions, the Employee is under no obligation to reimburse the Plan. Likewise, where the costs have been less than the obligated contributions, the Plan is under no obligation to provide the Employee with additional benefits and/or a refund.

Assignment of Benefits

As a convenience to participants of the FCE administered Plan, Assignment of Benefits to providers of services is required. Benefits provided for a specific service shall be paid to the Provider of that specific service except when the claim is accompanied by a paid receipt.

It is the responsibility of the participant to give proper notice of other coverage when filing a claim with FCE.

Fully Insured Carrier Provisions

In the event that a provision, rule or definition stipulated in this Summary Plan Description disagrees with a provision, rule or definition stipulated by a carrier fully insuring benefits under this Plan, then the carrier's provision, rule or definition will prevail.

Administration of the Plan

The Employer has retained the services of FCE Benefit Administrators, Inc., a Third-Party Claims Administrator, to handle the day-to-day operations of the Plan. Under the terms of the agreement between FCE Benefit Administrators, Inc. and the Employer, FCE Benefit Administrators, Inc. will collect, record all employer and employee contributions, maintain employee statistics and eligibility.

Type of Plan

This Plan is an Employee Welfare Benefit Plan. For the list of benefits, please see the Schedule of Benefits.

Funding Medium

The Plan's Health & Welfare Trust is the funding medium used for accumulation of assets and disbursement of benefits.

Pension Benefit Guaranty Corporation

The benefits provided under the Plan are not insured by the Pension Benefit Guaranty Corporation, since the Corporation does not insure health and welfare benefits.

Amendment of the Plan

Employer shall have the right to modify or amend the Plan from time to time, in whole or in part, provided that no amendment shall be made which shall divert Trust Funds to purposes other than for the exclusive benefit of participants and their beneficiaries. Third-Party Administrator, upon direction from the Trustee and/or the Employer, shall have the right to modify or amend the Plan from time to time if necessary to conform to the requirements of ERISA, SCA or other applicable law or to insure Plan viability. Plan Amendments shall be distributed to participants within a reasonable period of time of enactment.

Termination of the Plan

The Plan shall remain in existence from year to year unless one party gives notice of termination to the other parties at least 60 days but not more than 90 days prior to the anniversary date of effective coverage under this Plan. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Extended Benefit Period shall not be observed upon termination of the Plan unless the Plan Administrator, at its sole discretion, provides otherwise.

Section II – Appendix

Definitions

Any differences or conflict between the definitions set forth below and those set forth in the applicable Policy, Summary of Benefits and Coverage (SBC), Minimum Essential Coverage (MEC) and/or Trust Agreement shall be resolved in favor of the applicable Policy, Summary of Benefits and Coverage (SBC), Minimum Essential Coverage (MEC) and/or Trust Agreement.

Administrative Period: The 2-month period between the Measurement Period and the Stability Period during which an Employee's eligibility is calculated based on the just ending Measurement Period. *Please also refer to the definitions for Measurement Period and the Stability Period in this section.*

Adverse Benefit Determination: Adverse Benefit Determination shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Allowable Charge: For in-network services, the billed charge less the contractually agreed-upon PPO discount.

In the event that you use an Out-of-Network Provider, your benefits will be reduced as indicated on the Schedule of Benefits.

Please note: For out of network or non-network charges, the Maximum Allowable Charge will be determined by the Plan to be the customary reimbursement rate for like services in the region but not to exceed 150% of the Medicare reimbursement rate. To reference the out-of-pocket costs in advance by selecting the Medicare-based button on the results page of the FH Medical Cost Lookup. <https://www.fairhealthconsumer.org/estimate-costs/step-2>

Assignment of Benefits: An arrangement whereby the Covered Person assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Covered Person and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Benefit Plan Year: Calendar year.

Birthing Center: Means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre or post-delivery confinement.

Calendar Year: January 1st through December 31st of the same year.

Certified IDR Entity: Certified IDR Entity shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Clean Claim: A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a Third-Party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Medical Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Medical Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

COBRA: Consolidated Omnibus Reconciliation Act of 1985, as amended

Contribution: The Benefit Amounts, which Employer is required to pay for its Employees' benefits by the Contracting Agency, as amended from time to time. Contribution shall also mean the Benefit Amounts, which Employer is required to pay for its Employees' benefits by virtue of any Federal, State, municipal or other Ordinance or Statute, as amended from time to time. Contribution shall also mean amounts, which Employer is required to pay for its Employees'

benefits, which are agreed upon between the Employer/Sponsor, Trustee and TPA for the Employees who are not governed or regulated by a Contracting Agency.

Coronary Care Unit (CCU): An in-hospital specialized facility or emergency mobile unit equipped with monitoring devices, staffed with trained personnel, and designed to treat coronary patients.

Covered Medical Expense(s): The eligible and Medically Necessary services or supplies covered under this Plan that do not exceed the Maximum Allowable Charge. The Plan has the discretionary authority to decide if an expense exceeds the Maximum Allowable charge for a Medically Necessary and reasonable service.

In the event that you use an **Out-of-Network** Provider, your benefits will be reduced as indicated on the Schedule of Benefits.

Please note: For out of network or non-network charges, the Maximum Allowable Charge will be determined by the Plan to be the customary reimbursement rate for like services in the region but not to exceed 150% of the Medicare reimbursement rate. To reference the out-of-pocket costs in advance by selecting the Medicare-based button on the results page of the FH Medical Cost Lookup. <https://www.fairhealthconsumer.org/estimate-costs/step-2>

All services and supplies are subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in the document.

Covered Person: An Employee or Dependent who is covered under this Plan.

Custodial Care: Care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist: A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent: A Dependent is any one of the following persons:

1. A covered Employee's Spouse or Domestic Partner (subject to state approval)

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married and shall include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

Employee and Spouse shall not have been engaged in a trial separation for more than 12 consecutive months upon the date a Clean Claim for Covered Expense(s) provided to spouse are received by the Plan.

Employee and Spouse shall have been cohabitating at the same residence for the majority of the applicable Plan Year. When an Employee or Spouse is traveling or residing elsewhere as part of their profession, to care for a family member (due, for instance, to Illness or Injury), and/or is residing elsewhere due to their own Illness or Injury, for more

than half of the applicable Plan Year (and thus residing with each other for less than the majority of the applicable Plan Year), but the primary residence of the Employee is also the Spouse's primary residence for all legal, regulatory, and statutory purposes, this constitutes cohabitation as required by this provision.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

The term "Domestic Partner" shall mean an Employee's opposite-sex and/or same-sex Domestic Partner as defined by the law of the state in which they reside. If there is no state definition, the domestic partner is not eligible for coverage under the Plan.

Common Law Spousal Eligibility

Common law spouses are not recognized as eligible under the Plan unless both of the following conditions are met:

- a. The Employee must prove the existence of a common law marriage by providing documentation to the Plan from the state in which the common law marriage agreement was initiated; and
 - b. The Employee must provide documentation to the Plan satisfying at least four of the following requirements (i through viii):
 - i. Proof of shared residence for a minimum of three years. Three of the following must be presented to be considered proof of residence:
 1. Driver's license.
 2. Residential utility bills.
 3. Voter registration cards.
 4. Lease containing both signatures.
 5. Mortgage listing both as mortgagees.
 - ii. Birth certificates listing both the Employee and common law spouse as parents of any minor children.
 - iii. Federal income tax return filed jointly.
 - iv. Proof of a shared surname.
 - v. Life insurance policies listing one common law spouse as a beneficiary of the other.
 - vi. Policy from another insurance plan listing the one common law spouse as a covered Dependent of the other.
 - vii. Proof of joint ownership of property (e.g., vehicle, house, etc.).
 - viii. Proof of joint checking and/or savings accounts.
2. A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, foster child, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the month of the child's birthday.

However, for Plan Years beginning before January 1, 2014, an Employee's Child is not an eligible Child if the Child is eligible to enroll in an employer-sponsored health plan other than the group health plan of a parent of the Child.

The phrase "placed for adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 26 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

This definition of Dependent Child applies to medical benefits and, as such, complies with the Patient Protection and Affordable Care Act (PPACA). Carriers providing non-medical benefits under the Plan do not necessarily observe this definition and may, therefore, impose requirements concerning residency, financial dependency, student status, employment status, and the Employee's insurable interest in the Dependent Child. Moreover, such carriers providing non-medical benefits may impose a limiting age less than 26. In order to determine the applicable definition of Dependent Child for a non-medical benefit under the Plan, please refer to the carrier's policy.

3. A covered Employee's Qualified Dependents

The term "children" shall include natural or adopted children, children for who the Employee is a Legal Guardian who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years. When a Qualified Dependent reaches the applicable limiting age, coverage will end on the last day of the month of the Qualified Dependent's birthday.

If a covered Employee or Spouse is the Legal Guardian of a child or children, under the limiting age of 26 and primarily dependent upon the Employee for support and maintenance, these children may be enrolled in this Plan as Qualified Dependents.

Any Child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

4. A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.
5. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any Spouse who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not both.

Durable Medical Equipment: Equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Effective Date: The date on which a participant's coverage for benefits under this Plan starts.

Emergency Services: A medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee: A person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. For the purposes of the Plan, a retiree or his surviving spouse of at least 10 years is an Employee were provided by employment contract and approved by the Plan Sponsors' Board of Directors.

Employer: The Plan Sponsor and any successor or assign thereof, and any other company which is related or affiliated or engaged in a joint venture therewith.

Enrollment Date: The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA: The Employee Retirement Income Security Act of 1974, as amended. A federal law that exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination and other state reforms.

Essential Health Benefits: Include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational: means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis: or
4. if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

Extended Benefit Period: The period of continued coverage under the Plan after a participant loses his/her eligibility for coverage.

Extended Care Facility: An Extended Care Facility is an institution providing organized facilities for medical treatment including the dispensing and administration of medication, has available the services of a Physician on a regularly established basis, provides 24-hour nursing service under the full-time supervision of a Physician or an R.N. and has transfer arrangements with one or more Hospitals. The Facility must be approved by Medicare and licensed as being operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Illness or Injury or for individuals who are terminally ill. An Extended Care Facility does not include any institution, which is primarily: (1) a clinic; (2) a rest home; (3) a home for the aged; (4) a place for alcoholics or drug addicts; or (5) a place for custodial care.

Family and Medical Leave Act (FMLA): passed into law on February 5, 1993, is a United States Federal Law requiring covered employers to provide employees job-protected and unpaid leave for qualified medical and family reasons. Qualified medical and family reasons include personal or family illness, military service, family military leave, pregnancy, adoption, or the foster care placement of a child. The FMLA is administered by the Wage and Hour Division of the United States Department of Labor.

FCE: FCE Benefit Administrators, Inc.

Genetic Information: Information about the genetic tests of an individual or his or her family members, and information about the manifestations of disease or disorder in family members of the individual. A “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): enacted by the United States Congress on August 21, 1996, protects health insurance coverage for workers and their families when they change or lose their job. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.

The Administrative Simplification provision also addresses the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation’s health care system by encouraging the widespread use of electronic data interchange in the U.S. healthcare system.

Hospice Agency: An organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospital: An institution which is engaged primarily in providing inpatient diagnostic and therapeutic services at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission, the American Osteopathic Association, or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises which are provided by or under the supervision of a staff of Physicians; and it continuously provides on the premises 24 hour a day nursing services by or under the supervision of registered nurses (R.N.s). The Plan Administrator may accept accreditation of a Hospital by an organization other than those specifically listed, provided that the designation of an alternative accreditation body is consistently applied across institutions.

The definition of "Hospital" shall be expanded to include the following:

A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full time facilities for bed care and full time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24 hour a day nursing service by a registered nurse (R.N.); has a full time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness: A bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Incurred: A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Medical Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Medical Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department: Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

Initially Covered Group: Those Employees already covered under the Plan on the Effective Date of Benefits under This Summary Plan Description (as shown on the cover of this booklet).

Initially Eligible Group: Those Employees who were covered for benefits under this Plan on the earliest Effective Date of this Plan.

Injury: An accidental physical Injury to the body caused by unexpected external means.

In-Network: A Provider on the roster of the SelectCare Network, or services rendered by such a Provider.

Intensive Care Unit (ICU): A separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee: A Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Leave of Absence: Leave of Absence shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

Legal Separation and/or Legally Separated: Legal Separation and/or Legally Separated shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Legal Guardian: A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Maximum Allowable Charge: The "Maximum Allowable Charge" shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be the provider's contracted, In-Network rate.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the section "Major Medical Benefits,") the Maximum Allowable Charge will be the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined by the Plan to be the customary reimbursement rate for like services in the region but not to exceed 150% of the Medicare reimbursement rate.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on one of the following:

- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS.
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained Providers of care; or
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained Providers of care in traditional settings.

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, amounts actually collected by Providers in the region for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Measurement Period: The "look-back" measurement period during which an Employee's class assignment is measured for the ensuing Stability Period. Those employees who average at least 30 hours per week are considered eligible for Class IV benefits for the entire following Stability Period. *Please also refer to the definitions for Administrative Period and the Stability Period in this section.*

Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care: Care which can safely and adequately be provided other than in a Hospital.

Medical Record Review: Medical Record Review is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medically Necessary: Care and treatment that is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare: The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder: Any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Collectively, the Mental Health Parity Provisions in Part 7 of ERISA:

The Mental Health Parity Provisions shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

Morbid Obesity: A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Open Enrollment Period: The annual period wherein Employees may make or change benefit elections without qualifying under the Special Enrollment rules of the Plan, or the Change of Status rules of the IRS code.

Out-of-Network: A Provider who is not on the roster of the SelectCare Network, or services rendered by such a Provider.

Outpatient Care and/or Services: Treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Participating Health Care Facility: Participating Health Care Facility shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Period of Confinement: Successive periods of hospital confinement or disability shall be considered one period of confinement or disability except for the following circumstances:

1. The subsequent confinement or disability begins after complete recovery from a sickness or illness: a temporary, transient condition of unwellness.
2. The subsequent confinement is due to causes entirely unrelated to the cause of the previous confinement and occurs after resumption of normal duties on a full-time active basis.
3. In the case of an Employee, in addition to satisfying #1 or #2 above, the subsequent illness or accident must also be preceded by a return to full-time active work for at least two weeks.
4. In the case of an eligible Dependent, in addition to satisfying #1 or #2 above, the subsequent illness or accident must also be preceded by a period of three months following the most recent discharge from a hospital for that illness or accident.

Pharmacy: A licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician: A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.) Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan: The Plan, which is a benefits plan for certain Employees of the Plan Sponsor and is described in this document.

Plan Participant: Any Employee or Dependent covered under this Plan.

Plan Sponsor/Plan Administrator: See the Employer Profile page.

Plan Year: The 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

PPACA: The Patient Protection and Affordable Care Act.

Pregnancy: Childbirth and conditions associated with Pregnancy, including complications.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting

with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prescription Drug: Any of the following: A Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventive Care: means certain Preventive Care services.

To comply with the Affordable Care Act (ACA), and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Prosthetic: Referring to prosthesis, an artificial substitute or replacement of a part of the body such as a tooth, eye or facial bone, the palate, a hip, a knee or another joint, the leg, an arm, etc. A prosthesis is designed for functional or cosmetic reasons or both.

A prosthesis may be removable as in the case of most prosthetic legs or a prosthetic breast form used after a mastectomy. A person who uses a removable prosthesis – for example, an artificial hand – may want to have more than one available for different types of tasks. Other types of prosthetic devices are permanently implanted, like an artificial hip, or tooth.

Provider: A Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

Qualified Medical Child Support Order or QMCSO: Qualified Medical Child Support Order or QMCSO shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

Qualifying Payment Amount: Qualifying Payment Amount means the median of the contracted rates recognized by the Plan or recognized by all plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a

Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Recognized Amount: Recognized Amount shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

Special Enrollment: An enrollment period, other than the Open Enrollment Period, wherein Employees or Dependents may enroll because of a loss of other coverage (as described in this SPD) or new eligibility.

Spinal Manipulation/Chiropractic Care: Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Stability Period: The period during which an Employee receives benefits in accordance with their eligibility status determined during the just prior Measurement Period. Please also refer to the definitions for Administrative Period and Measurement Period in this section.

Subsequently Eligible Employees: Those Employees hired after the Effective Date of Benefits under this Summary Plan Description (as shown on the cover of this booklet).

Substance Abuse and/or Substance Use Disorder: means any illness, injury, disease or condition that is related to or resulting from substance use or abuse, including but not limited to those classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

Temporomandibular Joint (TMJ) syndrome: The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Urgent Care Services: Care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Waiting Period: If indicated on the Schedule of Benefits on page 1, the period prior to the Effective Date.

You: The Employee. (Note: This defined term is not capitalized.)

Contact Information for Benefit Resources

Contact Name	Contact Information	Website
FCE Benefit Administrators, Inc. Guam Office	1-671-687-1957 CBRESupport@fcebenefts.com P.O. Box 2677 Hagatna, Guam 96932	www.fcebenefts.com
FCE Benefit Administrators, Inc. Operations Center	1-800-298-7269 CBRESupport@fcebenefts.com 4615 Walzem Road, Suite 300 San Antonio, TX 78218-1610	
Department of Labor and Employee Benefits Security Administration (EBSA)	1-866-4-USA-DOL 1-866-487-2365 200 Constitution Ave NW, Washington, DC.	www.dol.gov www.dol.gov/ebsa/
Health Coverage Tax Credit Consumer Contact Center	1-866-628-4282 TTD/TTY callers may call toll-free at 1-866-626-4282	More information about the Trade Act is also available at www.doleta.gov/tradeact .
Reliance Standard Life Insurance Company	1-800- 351-7500 P.O. Box 8330 Philadelphia, PA 19101-8330	www.reliancestandard.com

Legal Notices & Other Rights under the Law

Newborns And Mothers Health Protection Act

Group health plans and health insurers 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 the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under federal law, require that a Provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Rights of States with Respect to Medicaid

Payments for benefits with respect to a participant under the Plan is to be made in accordance with any assignment of rights made by or on behalf of such participant or a beneficiary of the participant as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912 (a) (1) (A) of such an Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993). In enrolling an individual as a participant or beneficiary or in determining or making any payments for benefits of an individual as a participant or beneficiary, the fact that an individual is eligible for or is provided medical assistance under the State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a participant to such payment for each items or services.

Special Enrollment Rights Under SCHIP

If an Employee has declined enrollment in the Plan for his or her Dependents (including a spouse) because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if an Employee has declined enrollment in the Plan for his or her Dependents (including a spouse), and later becomes eligible for state assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

If you have any questions regarding the application of this provision to you, contact the Plan Administrator.

Mental Health Parity

The treatment or diagnosis of mental health conditions are covered services under the Plan and subject to The Mental Health Parity Act (MHPA), signed into law on September 26, 1996, which requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan.

Moreover, under the Mental Health Parity and Addiction Equity Act of 2008, regardless of any limitations on benefits for Mental Disorders/Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders/Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Genetic Information Nondiscrimination Act (“GINA”)

“GINA” prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about any of the following:

1. Such individual’s genetic tests.
2. The genetic tests of family members of such individual.
3. The manifestation of a disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums, or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

Women’s Health and Cancer Rights Act of 1998

The Plan covers medical and surgical benefits for mastectomies. This coverage includes:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, or
- Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.
- The covered person who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient.

This coverage is subject to the Plan’s annual deductibles and coinsurance provision and benefit limits.

Please refer to your ID card for our toll-free telephone number that you can call for more information.

For Illinois Residents

This reminder is for individuals who have insurance coverage through Your Employer’s Health & Welfare Plan (the “Plan”).

Illinois Consumer Coverage Disclosure Act

FCE Benefit Administrators, Inc. is the Third-Party Administrator for the Plan. You will find the Illinois Disclosure on the member portal or, you may call us, and we will send you a copy in the mail.

Please refer to your ID card for our toll-free telephone number that you can call to request a copy to be sent to you, or go to our website at www.fcebenefits.com and login into the portal at <https://fcebenefits.com/Login>.

HIPAA Notice of Privacy

This reminder is for individuals who have insurance coverage through Your Employer’s Health & Welfare Plan (the “Plan”).

HIPAA Notice of Privacy

FCE Benefit Administrators, Inc. is the Third-Party Administrator for the Plan. You will find our Notice of Privacy Practices on our website or, you may call us, and we will send you a copy in the mail.

Please refer to your ID card for our toll-free telephone number that you can call to request a copy to be sent to you or go to our website at www.fcebenefits.com.

Michelle's Law Enrollment Notice

Michelle's Law requires a group health plan to continue coverage of a dependent child due to a medically necessary leave of absence that causes the child to lose their student status before the date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence started; or
- the date on which such coverage would otherwise terminate under the terms of The Plan.

Medically necessary leave of absence means any change in enrollment status in a postsecondary educational institution that starts while the dependent child is suffering from a serious illness or injury; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of The Plan.

A dependent child is a beneficiary who is a dependent child under the terms of The Plan, of a participant or beneficiary under The Plan and who was enrolled in The Plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence involved.

You may be required to provide written certification by a treating physician of the dependent child which states that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.



Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing

involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Please refer to the websites on the last page for more specific information pertaining to your rights under Federal State Law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. Please refer to the webpages on the last page for more specific information pertaining to your rights under Federal and State Law.

When balance billing isn't allowed, you also have the following protections:

- **You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).**
- **Your health plan generally must:**
 - **Cover emergency services without requiring you to get approval for services in advance (prior authorization).**
 - **Cover emergency services by out-of-network providers.**
 - **Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.**
 - **Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.**
 - **If you believe you've been wrongly billed, you may contact the appropriate Federal or State agency to file a complaint. Please refer to the websites on the last page for more specific information pertaining to your rights under Federal and State Law.**

Websites with Additional Information¹

¹ We do not guarantee the accuracy, applicability, or availability of the information on any of these sites.

1. <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>
2. US-<https://www.cms.gov/nosurprises/consumers>
3. AZ-<https://difi.az.gov/soonbdr>
4. CA-
<https://dmhc.ca.gov/portals/0/healthcareincalifornia/factsheets/fsab72.pdf>
5. CO-<https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/out-of-network-health-care>
6. CT-<https://www.cga.ct.gov/2020/rpt/pdf/2020-R-0204.pdf>
7. DE-<https://legis.delaware.gov/SessionLaws/Chapter?id=19067>
8. FL-<https://www.flhealthcomplaint.gov/>
9. GA-
[https://www.gha.org/Portals/0/Documents/Health%20Care%20Finance/Surprise%20Billing/GHA%20Surprise%20Billing%20FAQs%20\(02-03-2021\).pdf?ver=6OsY-plc8I7LbTVeloihGQ%3D%3D](https://www.gha.org/Portals/0/Documents/Health%20Care%20Finance/Surprise%20Billing/GHA%20Surprise%20Billing%20FAQs%20(02-03-2021).pdf?ver=6OsY-plc8I7LbTVeloihGQ%3D%3D)
10. IL-<https://www.team-iha.org/files/non-gated/finance/iha-summary-no-surprises-implementing-regulations.aspx?ext=.pdf>
11. IN-
<https://content.govdelivery.com/accounts/INDOI/bulletins/29ac870>
12. IA-<https://www.legis.iowa.gov/docs/publications/BF/1069201.pdf>
13. ME-<https://legislature.maine.gov/statutes/22/title22sec1718-D-1.html>
14. MA-<https://www.mass.gov/doc/out-of-network-billing-in-massachusetts-chartpack/download>
15. MD-
<https://insurance.maryland.gov/Consumer/Documents/publications/AssignmentofBenefitsFAQ.pdf>
16. MI-<https://www.michigan.gov/difs/0,5269,7-303--560598--,00.html>
17. MN-https://www.mnmed.org/MMA/media/Hidden-Documents/FAQ_SurpriseBilling_Final.pdf
18. MS-
<https://www.mid.ms.gov/healthcare/questionsanswers/TopicTwo.pdf>
19. MO-<https://www.muhealth.org/your-visit/billing-insurance-financial-assistance/balance-billing-protection>

20. NE- <https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/ConsumerFactSheetBalanceBillingandOutOfNetworkProviders.pdf>
21. NV- https://doi.nv.gov/Consumers/Health_and_Accident_Insurance/Balance_Billing_FAQs/
22. NH- <https://www.nh.gov/insurance/media/bulletins/2019/documents/ins-19-015-ab-hb-1809-nh-balance-billing-and-network-adequacy-laws.pdf>
23. NJ- https://www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html
24. NM- <https://www.osi.state.nm.us/wp-content/uploads/2019/06/Press-Release-Surprise-Medical-Billing-Proposed-Legislation-2.1.19.pdf>
25. NY- https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills
26. NC- <https://www.ncleg.gov/Search/BillText/0/0/2021/?sSearchText=surprise%20billing&sSortBy=0>
27. OH- <https://insurance.ohio.gov/consumers/health/surprise-billing>
28. OR- <https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=64697>
29. PA- <https://www.insurance.pa.gov/Coverage/health-insurance/no-surprises-act/Pages/default.aspx>
30. RI- <https://www.nhpri.org/wp-content/uploads/2021/12/NHP-Surprise-Billing-Flyer-V2-1.pdf>
31. TX- <https://www.tdi.texas.gov/tips/texas-protects-consumers-from-surprise-medical-bills.html>
32. VA- <https://scc.virginia.gov/pages/Balance-Billing-Protection>
33. VT- <https://legislature.vermont.gov/statutes/fullchapter/33/065>
34. WA- https://www.insurance.wa.gov/sites/default/files/documents/final-consumer-notice-of-surprise-billing-rights_0.pdf
35. WV- https://www.wvinsurance.gov/no_surprises_act

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofa/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Plan Administrator's office at FCE Benefit Administrators, Inc.. 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. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or hand-deliver your notice to the person, department or firm listed below, at the following address:

**FCE Benefit Administrators
4615 Walzem Road, Suite 300
San Antonio, Texas 78218**

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

- **The name of the plan or plans under which you lost or are losing coverage,**
- **The name and address of the 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, your notice must include a copy of the divorce decree or the legal separation agreement.

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

How is COBRA continuation coverage provided?

Once the Plan Administrator receives 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 on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. 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 should be sent to the COBRA Administrator in accordance with the procedures above.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.

Plan contact information

If you have any questions regarding this notification of your COBRA rights, please feel free to contact the Plan Administrator's office at:

FCE Benefit Administrators, Inc.
4615 Walzem Road, Suite 300
San Antonio, Texas 78218
(800) 298-7269

Important Notice from FCE Benefit Administrators, Inc. on behalf of CBRE Government & Defense Services About Your Prescription Drug Coverage and Medicare

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

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

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. CBRE Government & Defense Services Health & Welfare Plan has determined that the prescription drug coverage offered by CALVO Selectcare Inc. is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current **CBRE Government & Defense Services Health & Welfare Plan** coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current **CBRE Government & Defense Services Health & Welfare Plan** coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with **CBRE Government & Defense Services Health & Welfare Plan** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information or call FCE Benefit Administrators at (800) 298-7269. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **CBRE Government & Defense Services Health & Welfare Plan** changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

- Call your State Health Insurance Assistance Program (see the inside back cover of the “Medicare & You” handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE** (633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	10/15/2025
Name of Entity/Sender:	FCE Benefit Administrators, Inc.
Contact--Position/Office:	4615 Walzem Road, Suite 300
Address:	San Antonio, TX 78218-1610
Phone Number	1-800-298-7269

