

**PLAN DOCUMENT**  
**AND**  
**SUMMARY PLAN DESCRIPTION**  
**for the**  
**HORIZON HOUSE, INC.**  
**EMPLOYEE BENEFITS PLAN**  
**(For Full-Time Employees)**

**July 2016**

## INTRODUCTION

**Horizon House, Inc.** ("Plan Sponsor" and "Employer") established the **Horizon House, Inc. Employee Benefits Plan** ("Plan"). The Plan is an "umbrella plan" which includes various health and welfare benefits for employees of Employer.

This document sets forth the terms of the Plan as of **April 1, 2016**. Employer intends that this document serves as the Plan Document and as the Summary Plan Description, along with the documents supplied by the claim administrators, insurers, benefit providers and Employer, for the health and welfare benefits under the Plan.

Many of the benefits under the Plan are provided on a fully-insured basis. Generally, the terms and conditions under which an employee may be eligible to receive these benefits are set forth in the terms of each applicable insurance policy. Because the fully-insured benefits under the Plan are provided solely through insurance companies, Employer is not the insurer of these benefits. The insurance carrier is responsible for determining eligibility for, and the amount of, any benefits that are payable under its respective insurance policy.

Other benefits under the Plan are provided on a self-funded basis. This means that the benefits are paid by Plan Sponsor from its general assets rather than by an insurance company or through a separate trust fund. Employer has selected one or more claim administrators for the self-funded benefits under the Plan. These claim administrators will provide a summary plan description and other information to employees enrolled in the Plan. The claim administrators are not the insurers of the Plan and any and all references in the documents to the claim administrators should be interpreted accordingly.

Finally, Employer provides additional benefits which are not subject to the federal law known as ERISA and are technically not part of the Plan. However, these benefits are referred to in this document for informational purposes.

The specific health and welfare benefits provided under the Plan and any additional benefits provided by Employer are listed in the "EMPLOYEE BENEFIT PLAN" section. This section also indicates whether the health and welfare benefits are self-funded or fully-insured. In addition, the "OTHER BASIC INFORMATION ABOUT THE PLAN" section identifies the claim administrators and insurers for the benefits under the Plan.

The existence of the Plan does not grant you any legal right to continue employment with Employer or affect the right of Employer to discharge you.

If you have any questions about your benefits under the Plan, please contact the Horizon House Benefits Unit.

**HORIZON HOUSE, INC.**

Dated: August 5, 2016

By  \_\_\_\_\_

Its Vice President of Human Resources

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| <b>EMPLOYEE BENEFITS PLAN</b> |
|-------------------------------|

The Plan includes the following benefits:

| <b>HEALTH BENEFITS:</b>      | <b><u>Self-Funded</u></b>           | <b><u>Fully-Insured</u></b>         |
|------------------------------|-------------------------------------|-------------------------------------|
| Medical/Prescription Drug    | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Dental                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Hospital Copay Reimbursement | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |

**WELFARE BENEFITS:**

|                                                                        |                                     |                                     |
|------------------------------------------------------------------------|-------------------------------------|-------------------------------------|
| Basic Group Term Life/Accidental Death and Dismemberment (“AD&D”)      | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Voluntary Group Term Life/Accidental Death and Dismemberment (“AD&D”)  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Long-Term Disability                                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Voluntary Long Term Care                                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Medical Flexible Spending Accounts (under Employer’s Section 125 plan) | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |

**ADDITIONAL BENEFITS:** (These benefits are not subject to ERISA and are technically not part of the Plan but are mentioned in this Plan/SPD for informational purposes.)

|                                                                               |                                     |                                     |
|-------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|
| Dependent Care Flexible Spending Accounts (under Employer’s Section 125 Plan) | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Short-Term Disability                                                         | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Voluntary Whole Life                                                          | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Voluntary Worksite Benefit Plans (Post-tax)                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |

Subsequent references throughout the document to “health benefits,” “welfare benefits” and “additional benefits” mean the benefits described above.

Employees have received or will receive documentation describing each benefit in which they are eligible to participate. This Summary Plan Description is intended to supplement those materials. This document does not replace the provisions of the plan documents, summary plan descriptions, insurance applications, master plans, group insurance contracts and/or other documents for a benefit, including any applicable certificates and/or riders.

The other documentation for a benefit will contain the following information:

- With respect to welfare benefits, the eligibility and participation conditions for any dependent coverage, if applicable.
- A summary of benefits.
- With respect to health benefits:
  - A description of any deductibles, coinsurance or copayment amounts.
  - A description of any limits on benefits.
  - Whether and under what circumstances preventive services are covered.
  - Whether and under what circumstances prescription drugs are covered.
  - Whether and under what circumstances coverage is provided for medical tests, devices and procedures.
  - Provisions governing the use of network providers (if any). If there is a network, the booklet(s) or certificate will contain a general description of the provider network and participants will be entitled to obtain a list of providers in the network.
  - Whether and under what circumstances coverage is provided for any out-of-network services.
  - Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
  - Any conditions or limits applicable to obtaining emergency medical care.
  - Any provisions requiring prior authorization from the health plan as a condition to obtaining a benefit.
- A description of the circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that the employee might otherwise reasonably expect the Plan to provide.

|                                               |
|-----------------------------------------------|
| <b>EMPLOYEE ELIGIBILITY AND PARTICIPATION</b> |
|-----------------------------------------------|

Each full-time employee of Employer who is regularly scheduled to work at least 30 hours per week will become eligible for each benefit under the Plan on the dates specified below.

| <u>Benefit</u>                                                                           | <u>Eligibility Date</u>                                                    |
|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Medical/Prescription Drug Benefit                                                        | 1 <sup>st</sup> day of the month after completing 60 days of employment    |
| Dental Benefit                                                                           | 1 <sup>st</sup> day of the month after completing 60 days of employment    |
| Hospital Copay Reimbursement Benefit                                                     | 1 <sup>st</sup> day of the month after completing 60 days of employment    |
| Basic Group Term Life/AD&D Benefit                                                       | 1 <sup>st</sup> day of the month after completing six months of employment |
| Voluntary Group Term Life/AD&D Benefit                                                   | 1 <sup>st</sup> day of the month after completing 60 days of employment    |
| Long Term Disability Benefit                                                             | 1 <sup>st</sup> day of the month after completing 12 months of employment  |
| Voluntary Long Term Care Benefit                                                         | November 1 after completing 90 days of employment                          |
| Voluntary Whole Life                                                                     | November 1 after completing 90 days of employment                          |
| Flexible Spending Accounts (offered under Employer's Section 125 flexible benefits plan) | April 1 after completing 60 days of employment                             |
| Short-Term Disability                                                                    | 1 <sup>st</sup> day of the month after completing 12 months of employment  |
| Voluntary Worksite Benefit Plans                                                         | 1 <sup>st</sup> day of the month after completing 60 days of employment    |

## **DEPENDENT ELIGIBILITY AND PARTICIPATION**

This section sets forth the rules for a participating employee's spouse or domestic partner, and dependent children, who are eligible for the medical/prescription drug, dental and spousal voluntary life benefits under the Plan.

### **Spouse**

For purposes of eligibility for medical/prescription drug and dental benefits, "spouse" means a person of the same-sex or opposite-sex who is legally married to an employee. The term "spouse" does not include:

- A spouse who is legally separated (e.g., an order of separate maintenance has been entered with the court) or divorced from the employee. Moving out and filing for divorce is not legal separation for this purpose; or
- A spouse who is incarcerated.

### **Domestic Partners**

For purposes of eligibility for medical/prescription drug, dental benefits and Spousal Voluntary Life, a “domestic partner” means a person of the same or opposite sex who resides with the employee, shares a committed relationship with the employee, and who satisfies the additional criteria set forth in the documentation from the insurers for the medical/prescription drug, dental and spousal voluntary life benefits.

### **Dependent Children**

For purposes of eligibility for medical/prescription drug and dental benefits, an eligible dependent child includes the following:

- The employee’s natural child, legally adopted child or child placed with the employee for adoption.
- The employee’s step child.
- The employee’s foster child.

An eligible child may participate in the medical/prescription drug and dental benefits under the Plan until the end of the month during which the child turns age 26.

|                                  |
|----------------------------------|
| <h2><b>ENROLLMENT RULES</b></h2> |
|----------------------------------|

When employees initially become eligible to participate in the Plan, they may make the following benefit elections:

### **Medical/Prescription Drug and Dental Benefits**

Employees may elect to participate in the medical/prescription drug and dental coverage upon initial eligibility by applying for coverage and agreeing to pay the required premium. There are HMO and PPO options available under the medical/prescription drug plan.

### **Flexible Spending Accounts**

Employees may elect to contribute to the medical and/or dependent care flexible spending accounts under Employer’s Section 125 flexible benefits plan upon initial eligibility.

## **Other Voluntary Benefits**

Employees also have the right to elect to purchase certain other voluntary benefits upon initial eligibility such as voluntary group term life/AD&D insurance, voluntary long term care insurance and other voluntary worksite benefit plans.

Employees will be automatically enrolled in certain benefits upon initial eligibility, including long term disability, short-term disability and basic group term life/AD&D coverage. Additionally, employees who elect medical/prescription drug coverage will be automatically enrolled in the hospital copay reimbursement benefit. Once an employee makes his or her elections upon initial enrollment, the elections may not be changed until the first day of the next plan year unless the employee experiences a change in status or other qualifying event (see the summary plan description for Employer's Section 125 flexible benefits plan for details) or a special enrollment rights circumstance occurs as explained below.

## **ANNUAL AND SPECIAL ENROLLMENT PERIODS**

### **Annual Enrollment**

Before the beginning of each plan year, employees will be notified by Employer of the dates for the open enrollment period. During the open enrollment period, employees will have the opportunity to make benefit election changes. Benefit elections will remain in effect until the end of the plan year unless the employee requests an election change due to a change in status or other qualifying event (see the summary plan description for Employer's Section 125 flexible benefits plan for details) or the employee has a special enrollment rights circumstance as explained below.

### **Special Enrollment**

If an individual experiences a loss of coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee and/or a dependent may have special enrollment rights to participate in medical/prescription drug coverage under the group health plan immediately without being required to wait until the next annual open enrollment period.

- A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), or a benefit package option is terminated unless the individual is provided a current right to enroll in alternative health coverage. But a loss of other coverage for this purpose does not include:
  - Nonpayment of required contributions.

- Filing of a fraudulent application or claim.
- Voluntary termination of the other coverage.
- The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption.
- If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual has special enrollment rights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow immediate enrollment if the individual submits a request within 60 days after the loss or gain of eligibility.

## SOURCES OF CONTRIBUTIONS AND COST OF COVERAGE

Employer may contribute to the cost of each benefit. In addition, employees may be required to contribute to the cost of one or more of the benefits, as periodically determined by Employer. Employer will notify employees of the required contribution, if applicable. Benefits are funded in the following manner:

### **Self-Funded**

Benefits may be funded on a self-funded basis. Employer will pay the self-funded benefits from its general assets. Employer may establish a separate bank account for the payment of self-funded benefits. If a separate bank account is established, however, it will be for bookkeeping purposes only.

Participant contributions to the medical flexible spending accounts may be paid on a pre-tax basis under Employer's Section 125 flexible benefits plan. The hospital copay reimbursement benefit and short-term disability benefit are noncontributory (funded solely by Employer).

### **Fully-Insured**

Employer may purchase insurance to provide benefits on a fully-insured basis or, in the case of benefits funded on a self-funded basis, to protect Employer from large individual and aggregate losses. Any required participant contributions, if applicable, may be paid on a pre-tax basis under Employer's Section 125 flexible benefits plan or on a post-tax basis.

If participating employees become entitled to a refund in connection with any fully-insured benefit under the Plan (for example, due to a medical loss ratio rebate), the refund

will be used for the exclusive benefit of participants within three months after Employer receives the refund.

## **TERMINATION OF COVERAGE**

To remain eligible for benefits under the Plan, an employee must be actively working the required number of hours on a regular basis. (See the “EMPLOYEE ELIGIBILITY AND PARTICIPATION” section.) However, all benefits under the Plan can be continued if the employee goes on a family or medical leave, as defined by the Family and Medical Leave Act of 1993 (“FMLA”). (See the “Family and Medical Leave Act” subsection.)

Further, if you go on a non-FMLA Employer-approved leave of absence, certain benefits under the Plan may be continued on a case-by-case basis. You should consult your Employee Handbook or contact the Horizon House Benefits Unit for more information.

Except as otherwise described above, the basic group term life/AD&D, voluntary group term life/AD&D, long-term disability, short-term disability, voluntary long term care, medical and dependent care flexible spending accounts and voluntary worksite benefit plan benefits of an employee who quits, is terminated, or otherwise leaves active full-time regular employment, and the coverage of the employee’s eligible dependents who participate in the Plan terminates on the day the employee’s active regular employment ends (or the day the employee ceases to be actively working the required number of hours to remain eligible, as applicable). However, the medical/prescription drug, dental and hospital copay reimbursement benefits terminate on the last day of the month in which the employee quits, is terminated, or otherwise leaves active full-time regular employment.

Benefits under the Plan will also terminate on:

- The date an individual ceases to be eligible for coverage.
- The first day any required participant contributions are not timely paid.
- The effective date of the individual’s voluntary withdrawal from the Plan due to a change in status or during an open enrollment period.
- The date the Plan is discontinued as a whole or a particular benefit is discontinued.
- The date on which the participant’s coverage is terminated for cause by the plan administrator. (Termination for cause means the participant is found to have misrepresented information in the application for participation or on a claim for benefits.)

In certain circumstances after coverage ends as described above, the employee and/or his or her eligible dependents may be eligible for COBRA continuation coverage and/or a conversion policy, as explained in the following sections.

## **CONTINUATION OF HEALTH COVERAGE UNDER COBRA AND USERRA**

The federal law known as COBRA allows eligible individuals to temporarily extend health coverage under the Plan in certain circumstances where health coverage would otherwise end. The federal law known as USERRA gives employees who cease to be eligible for health coverage due to service in the U.S. military additional rights regarding continuation of health coverage. This section provides information regarding extensions of coverage under these laws.

### **COBRA Continuation Coverage**

COBRA continuation coverage allows the employee and/or his or her dependents (including a child for whom the employee is required to provide health insurance coverage pursuant to a QMCSO) an opportunity to temporarily extend health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end. The employee may also have continuation coverage rights with respect to his or her medical flexible spending account under Employer's Section 125 flexible benefits plan. (See the summary plan description of that plan for details.)

The plan administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator. The employee and spouse (if any) will be informed if a COBRA administrator is appointed and which responsibilities the COBRA administrator has assumed, including whether notices required to be provided to the plan administrator should be sent to the COBRA administrator.

### **Eligibility**

The employee and/or his or her dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to or adopted by or placed for adoption with the employee during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a qualified beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if Employer pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum continuation period are described in the following chart:

| <u>Qualifying Event</u>                                              | <u>Qualified Beneficiary</u>        | <u>Continuation Period (Months)</u> |
|----------------------------------------------------------------------|-------------------------------------|-------------------------------------|
| Reduced hours <sup>1</sup> or termination of employment <sup>2</sup> | Employee and Dependents             | 18                                  |
| Employee's death                                                     | Dependents                          | 36                                  |
| Employee's entitlement to Medicare                                   | Dependents not entitled to Medicare | 36                                  |
| Dependent child becomes ineligible for coverage                      | Ineligible Dependent                | 36                                  |
| Employee's divorce/legal separation <sup>3</sup>                     | Dependents                          | 36                                  |

### **Extension of Continuation Coverage**

If the employee and/or his or her dependents become entitled to continuation coverage as a result of the employee's termination of employment or reduction in hours, the 18-month continuation period may be extended for the employee and/or his or her dependents in the three circumstances described below ("extension events").

#### **Second Qualifying Event**

If a second qualifying event that is a divorce, legal separation, the employee's death, or a dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or 29 months, if there is a disability extension), the employee's dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of the employee's termination of employment or reduction in hours. ***Notice of this second qualifying event must be provided to the plan administrator within 60 days of the date of the second qualifying event.***

#### **Employee's Entitlement to Medicare**

If the employee becomes entitled to Medicare benefits during the initial 18-month period, his or her dependents may be eligible to elect

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<sup>1</sup> A reduction in hours due to a family or medical leave, as defined by the FMLA, will not cause an employee's participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if the employee does not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

<sup>2</sup> Continuation coverage is not available if employment is terminated for gross misconduct.

<sup>3</sup> Elimination of the employee's spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example), is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the date of the divorce or legal separation.

continuation coverage for a period of 36 months, if, ignoring the original qualifying event, the employee's entitlement to Medicare would have been a qualifying event under the Plan. The 36-month continuation period begins on the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the date on which the employee became entitled to Medicare.***

A special rule applies if the employee became entitled to Medicare before his or her termination of employment or reduction in hours. In that situation, the maximum continuation period for the employee's dependents may be extended, and may end on the later of: 36 months after the date of the employee's Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the employee's termination of employment or reduction in hours.***

### **Social Security Disability Determination**

If it is determined that the employee or one of his or her dependents is entitled to Social Security disability benefits either before the employee's termination of employment or reduction in hours or within 60 days after the employee's termination of employment or reduction in hours, the disabled individual and the qualified beneficiaries who are his or her family members will be entitled to an additional 11 months of continuation coverage (29 months total). ***Notice of the Social Security disability determination must be provided to the plan administrator within 60 days of the date of the disability determination (or within 60 days of the employee's termination of employment or reduction in hours, if later) and before the end of the 18-month continuation period.***

If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary ***must notify the plan administrator of that determination within 30 days of the date of the final determination.*** In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

### **Plan Administrator's Notice Obligations**

The plan administrator will provide the employee and his or her spouse (if any) with certain information regarding their rights under COBRA in the following situations:

### **Notice of Eligibility to Elect COBRA**

The plan administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event.

However, a special rule applies where the qualified beneficiary is required to provide the plan administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the plan administrator will notify the qualified beneficiary of his or her eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was timely submitted in accordance with the requirements described in the "Notice Procedures" subsection.

### **Notice of Unavailability of Continuation Coverage**

The plan administrator will provide a notice of the unavailability of continuation coverage in the following situations:

- Where the plan administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event that is a divorce, legal separation or a dependent child's loss of eligibility for health coverage under the Plan.
- Where the plan administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

The determination that continuation coverage or an extension of continuation coverage is not available could be made because the plan administrator determines that no qualifying event or extension event occurred, or because the notice of the qualifying event or extension event was defective. A notice will be defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the "Notice Procedures" subsection.

The plan administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the plan administrator receives the notice of the potential qualifying event or extension event, or if later, the deadline for submission of additional information requested by the plan administrator to supplement a defective notice. The notice of the unavailability of continuation coverage will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

## **Qualified Beneficiary's Notice Obligations**

In some situations, the employee and/or his or her dependents have the obligation to provide notice of a qualifying event or extension event to the plan administrator in order to trigger eligibility for continuation coverage or an extension of continuation coverage. The employee and/or his or her dependents have this obligation in the following situations:

### **Notice of Certain Initial Qualifying Events**

The employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependents must inform the plan administrator of a qualifying event that is a divorce or legal separation, or of a child losing dependent status under the Plan within 60 days after the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

### **Notice of an Extension Event**

In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, the employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependent must notify the plan administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

***These notices must be provided in accordance with the requirements of the "Notice Procedures" subsection.*** If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

### **Notice Procedures**

This subsection describes the procedures a qualified beneficiary must follow to notify the plan administrator of qualifying events and extension events.

***The plan administrator has a form which may be used to provide the required notice.*** The form may be obtained by contacting the plan administrator at the address or telephone number listed at the end of this Summary Plan Description. While use of the notice form will help ensure that the qualified beneficiary provides all of the required information, use of the notice form is not required.

Written notification that contains all of the following information will also be accepted:

- The name of the employee or former employee.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).
- The current address of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the qualifying event or extension event.
- The nature of the qualifying event or extension event (for example, a divorce).
- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the judgment of separate maintenance or other relevant court documents establishing the legal separation.
- If the notice relates to the employee's entitlement to Medicare, a copy of the document(s) establishing the entitlement.
- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.
- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline, is not made in writing and/or does not contain all of the required information is deemed to be defective and may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

If the plan administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the plan administrator will request the missing information. If the defective notice was provided by the representative of a qualified beneficiary or a potential qualified beneficiary, the plan administrator will send the request to the representative and each individual who is a qualified beneficiary or a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the plan administrator requests the additional

information, the notice may be rejected. If the notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The plan administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the plan administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

### **Qualified Beneficiary's Election of Continuation Coverage**

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the plan administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or
- The date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage.

***Notification is made by timely returning the election form to the plan administrator at the address specified in the election notice.*** If the qualified beneficiary does not choose continuation coverage during the 60-day period, his or her participation in the Plan will end as provided in the "Termination" subsection.

### **Coverage**

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the qualified beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage. Alternatively, the qualified beneficiary may initially elect to purchase one or more of the medical/prescription drug and dental coverages which are provided by Employer pursuant to any separate group health plans and/or which may be separately elected pursuant to Employer's Section 125 plan, if applicable. However, each coverage is initially available only if the qualified beneficiary was receiving coverage immediately before the qualifying event.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to the qualified beneficiary and his or her dependents. Qualified beneficiaries who purchase

continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

### **Cost of Continuation Coverage**

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

### **Termination**

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

#### **Coverage Terminated**

Employer no longer offers a group health plan to any of its employees.

#### **Unpaid Premium**

The premium for continuation coverage is not timely paid, to the extent payment is required.

#### **Other Coverage**

A qualified beneficiary becomes covered under another group health plan. Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan.

#### **Medicare**

A qualified beneficiary becomes entitled to Medicare (Part A or Part B). Continuation coverage will end as of the date on which the qualified

beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B).

### **Cause**

A qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits). Continuation coverage will end as of the date on which the qualified beneficiary's coverage is terminated for cause.

The plan administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the qualified beneficiary has elected continuation coverage. The notification will be provided as soon as practicable following the plan administrator's determination that continuation coverage will terminate.

### **Other Coverage Options**

There may be other coverage options for you and your family. Now that key parts of Health Care Reform have taken effect, you have the opportunity to buy coverage through the Health Insurance Marketplace (also known as the exchange). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov). Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

### **Questions**

Employees and/or their dependents should contact the plan administrator at the address or telephone number listed at the end of this Summary Plan Description if they have questions regarding COBRA that are not answered in this Summary Plan Description. They may also visit the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call their toll-free number at 1-866-444-3272.

### **Keep Plan Administrator Informed of Address Changes**

To protect their rights under COBRA, it is important that the employee and the employee's dependents keep the plan administrator informed of any changes in

address. They should also keep a copy, for their records, of any notices that are sent to the plan administrator.

### **Continuation of Health Coverage Upon Military Leave**

If an employee ceases to be eligible for health coverage under the Plan due to service in the U.S. military, the employee and his or her eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (“USERRA”). The employee and his or her dependents may also be entitled to elect to continue health coverage under COBRA if the employee ceases to be eligible for health coverage due to his or her military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

### **Length of USERRA Continuation Coverage**

An employee may elect to continue health coverage under the Plan for himself or herself and his or her eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day the employee is absent from work to perform military service; or
- The period beginning on the first day the employee is absent from work to perform military service and ending with the date the employee fails to return to employment or apply for reemployment as provided under USERRA.

### **Electing USERRA Continuation Coverage**

If an employee gives Employer advance notice of a period of military service that will be 30 days or less, the plan administrator will treat the employee’s notice as an election to continue health coverage during his or her military service unless the employee specifically informs Employer, in writing, that he or she wants to cancel health coverage during his or her military leave. The employee will have to pay the required premiums for his or her health coverage, but the employee will not have to complete any additional forms or paperwork to continue health coverage during his or her military service.

If an employee gives Employer advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide the employee with a notice of his or her right to elect to continue health coverage pursuant to USERRA and a form for the employee to elect USERRA continuation coverage for himself or herself and his or her eligible dependents. Unlike COBRA, the employee’s dependents do not have a separate right to elect USERRA coverage. If the employee wants USERRA continuation coverage for any member of his or her family, the employee must elect it for himself or herself and all eligible dependents who are covered under the Plan when the employee’s military service begins.

If an employee chooses USERRA continuation coverage, he or she must return the USERRA election form to the plan administrator within 60 days of the date it was provided to the employee. If the employee does not timely return the election form, USERRA continuation coverage will not be available to the employee and his or her eligible dependents.

A special rule applies if the employee does not give Employer advance notice of his or her military service. In that case, the employee and his or her eligible dependents will not be provided with USERRA continuation coverage during any portion of the employee's military service, but the employee can elect to reinstate health coverage (and the coverage of his or her eligible dependents) retroactive to the first day the employee was absent from work for military service under the following circumstances:

- The employee is excused from providing advance notice of his or her military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for the employee to provide advance notice or the advance notice was precluded by military necessity);
- The employee affirmatively elects to reinstate the coverage; and
- The employee pays all unpaid premiums for the retroactive coverage.

### **Paying for USERRA Continuation Coverage**

For the first 30 days of military service, the employee's required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If the employee's period of military service is more than 30 days, beginning on the 31<sup>st</sup> day of his or her military service the employee's required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if the employee does not timely pay any required premiums for health coverage. If the employee's USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated.

The initial premium must be paid within 45 days after the date the employee elects USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the employee initially elects USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30

days late will result in automatic termination of the employee's USERRA continuation coverage.

If the employee complies with USERRA upon returning to active employment after military service, the employee may re-enroll himself or herself and his or her eligible dependents in health coverage immediately upon returning to active employment, even if the employee and his or her eligible dependents did not elect USERRA continuation coverage during the employee's military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

## **CONVERSION PRIVILEGES**

When the employee or one of his or her dependents is no longer eligible under the Plan (either as an active participant, the eligible dependent of an active participant or as a qualified beneficiary receiving continuation coverage), the employee and/or his or her dependents may be eligible to obtain an individual conversion policy for one or more fully-insured benefits. The availability of this conversion and the rules concerning eligibility are set forth in the policy with each insurance carrier. See Employer for details.

## **SPECIAL RULES REGARDING THE HEALTH BENEFITS**

There are several special rules which apply to the health benefits under the Plan but do not apply to the welfare benefits (such as group term life/AD&D and long term disability). This section summarizes these special rules.

### **Qualified Medical Child Support Orders ("QMCSO")**

Despite any contrary provision in any group health benefit under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a QMCSO. Participants can obtain, without charge, a copy of the Plan's QMCSO procedures from the plan administrator.

### **Health Care Reform**

The medical/prescription drug benefits under the Plan have been amended and will continue to be amended to comply with the insurance market reforms of the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act ("HCERA"). Collectively, the PPACA and the HCERA are known as Health Care Reform. The required changes include the following:

- Dependent children must be eligible to participate in the medical/prescription drug benefits under the Plan until at least the child's 26<sup>th</sup> birthday. However, Employer has extended coverage until the end of the month in which the child turns age 26.

**NOTE:** The dental benefit provided under the Plan is an “excepted benefit” which is not subject to Health Care Reform. However, Employer amended the definition of dependent child for dental benefit purposes to include older children until the end of the month in which the child turns age 26.

- Any lifetime limits on the dollar value of essential health benefits under the Plan no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan were eligible to enroll in the Plan.
- Any annual limits on the dollar value of essential health benefits under the Plan no longer apply.
- Coverage may not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation or failure to timely pay required premiums for coverage. Thirty days advance notice is required before coverage may be retroactively terminated.
- Any pre-existing condition limitations or exclusions no longer apply.
- The Plan is not a grandfathered plan under Health Care Reform and as a result, the following additional insurance market reforms apply:
  - The Plan must provide certain preventive care items and services without required participant cost-sharing.
  - The Plan must provide certain patient protections such as:
    - Where a participant is required to have a primary care physician (PCP), the participant may designate any participating PCP, including a pediatrician, as the PCP.
    - The Plan may not require preauthorization or referral when a participant seeks coverage for obstetric or gynecological care from a participating OB-GYN.
    - The Plan may not require preauthorization for emergency services.
    - The Plan may not impose a copayment amount or coinsurance rate for emergency services in an out-of-network emergency department of a Hospital that exceeds the requirements for in-network emergency services.
    - Maximum out-of-pocket limits are restricted.
    - Certain routine patient costs associated with clinical trials are covered.

- Participants must be afforded additional rights with respect to internal appeals under the Plan and must be provided with the opportunity to undergo a new external review procedure.

For more information concerning Health Care Reform or any of these required changes, please contact the plan administrator.

### **Newborns' and Mothers' Health Protection Act**

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the 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 may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### **Women's Health and Cancer Rights Act**

The Women's Health and Cancer Rights Act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

### **Health Insurance Portability and Accountability Act**

Under the Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, certain privacy and security rules apply to the Plan. Specifically, group health plans and health insurance issuers must make sure that medical information identifying a participant is kept private, must maintain and follow privacy policies and procedures and must notify participants of the privacy policies and procedures. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form. Further, group health plans and health insurance issuers must comply with the changes made to the HIPAA privacy and security rules under the federal law known as HITECH, including, but not limited to, the new breach notification requirements. (See the "HIPAA PRIVACY AND SECURITY RULES" section for further details.)

## **Family and Medical Leave Act**

The Family and Medical Leave Act of 1993 (“FMLA”) applies to the Plan during any calendar year when Employer employs 50 or more employees (including part-time employees) each working day during 20 or more calendar weeks in the current or preceding calendar year. Further, the FMLA provisions apply only to eligible employees (i.e., participating employees who have been employed by Employer for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave).

A participant on an FMLA leave may continue health coverage, and all other coverages under the Plan as permitted by Employer, during the leave on the same basis and at the same participant contribution rate as if the employee had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by Employer). However, if the employee takes a leave under the FMLA to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA is 26 weeks per 12-month period. If health coverage ends at the end of an FMLA leave, COBRA continuation coverage is available.

## **CLAIMS AND APPEAL PROCEDURES**

Each insurance carrier is responsible for prescribing the claims procedures to be followed with regard to the benefits provided pursuant to that carrier’s policy. The insurance certificate(s) or booklet(s) from the insurer(s) contain a summary of the claims procedures for the fully-insured benefits. The claims procedures for the medical flexible spending accounts are set forth in the summary plan description for Employer’s Section 125 flexible benefits plan. However, the claims procedures for any benefit under the Plan must provide each claimant with claims and appeal rights that are at least as favorable as the following:

### **Initial Decision**

A claimant will be notified of a benefit determination as follows:

#### **Urgent Care Health Claims**

An urgent care health claim is a pre-service claim for medical care or treatment to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A claimant will be notified of a benefit determination regarding an urgent care health claim as soon as possible, consistent with the medical exigencies involved, but no later than 72 hours after the Plan’s receipt of the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or

payable under the Plan. In the case of such a failure, the claimant will be notified within 24 hours after the Plan's receipt of the claim of the information necessary to complete the claim. The claimant will be granted 48 hours to provide the information. The claimant will then be notified of the benefit determination within 48 hours after the earlier of the Plan's receipt of the information or the end of the period granted the claimant to provide the information.

### **Pre-Service Health Claims**

A pre-service health claim is a claim for a benefit which is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. A claimant will be notified of a benefit determination regarding a pre-service health claim within 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be granted 45 days from receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

### **Post-Service Health Claims**

A post-service health claim is a claim for a health benefit which is not a pre-service claim or an urgent care claim. If a post-service health claim is denied, in whole or in part, the claimant will be notified of the adverse determination within 30 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will be granted 45 days from the receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

### **Concurrent Care Health Claims**

If the Plan has approved an ongoing course of health treatment to be provided over a period of time or over a number of treatments, any reduction or termination by the Plan of that course of treatment (other than by Plan amendment or termination), will constitute an adverse benefit determination. Notice will be provided in accordance with the “Benefit Determination Notice” subsection below and will be given at least 30 days before the course of treatment is reduced or terminated in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. Any request to extend a course of treatment for urgent care will be decided as soon as possible and the claimant will be notified of the determination within 24 hours, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed course of treatment for urgent care.

### **Disability Claims**

If a disability claim is denied, in whole or in part, the claimant will be notified of the adverse benefit determination within 45 days after receipt of the claim. This period may be extended for up to 30 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be made. If, prior to the end of the first 30-day extension period, the Plan determines that, due to matters beyond the control of the Plan, a decision cannot be made within the first 30-day extension period, the time for making the determination may be extended for up to an additional 30 days provided the Plan notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which a decision is expected to be made. Any extension notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. The claimant will be granted 45 days within which to provide the required information. The Plan’s period for making the benefit determination will be the 30-day period beginning on the date the claimant responds to the request for additional information. If the claimant does not provide the additional information within 45 days from the date of the receipt of the extension notice, the Plan may issue a denial of the claim within 30 days after the end of the 45-day period.

### **Other Welfare Claims**

If a claim for another welfare benefit (such as group term life/AD&D insurance) is denied, in whole or in part, the Plan must notify the claimant of the adverse benefit determination within 90 days after receipt of the claim, unless the Plan determines that special circumstances require an extension of the time for processing the claim. If the Plan determines that an extension of time for processing the claim is required, written notice of the extension will be furnished

to the claimant before the end of the initial 90-day period. In no event will the extension exceed a period of 90 days from the end of the initial period. The extension will indicate the circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

### **Benefit Determination Notice**

The claimant will be provided with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, refer to the Plan provisions on which the determination is based, and describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The notice will also describe the Plan's review procedures and related time limits and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA (a federal law) following an adverse benefit determination on review.

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a statement will be included that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will contain a statement that such an explanation will be provided free of charge to the claimant upon request.

### **Appeal of Denial**

The claimant may request a review of an adverse benefit determination regarding a health or disability claim by submitting a written application to the Plan within 180 days following the denial of the claim. However, in the case of an adverse benefit determination regarding a welfare benefit claim such as group term life/AD&D insurance, the time deadline is 60 days rather than 180 days. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In addition, with respect to a non-grandfathered health plan subject to Health Care Reform, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under a non-grandfathered health plan subject to Health Care Reform. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination.

In filing the appeal, the claimant will 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. For this purpose, a document, record or other information will be considered relevant if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit. In connection with the appeal of an adverse benefit determination under a non-grandfathered health plan subject to Health

Care Reform, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale for the adverse benefit determination. Further, with respect to an appeal of an adverse benefit determination under a non-grandfathered health plan subject to Health Care Reform, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

The appeal procedure will provide for a review that does not rely on the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor is a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involving the judgment. The health care professional engaged for purposes of reviewing the appeal will be an individual who is neither an individual who is consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual. The Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination without regard to whether the advice was relied upon. With respect to a claim under a non-grandfathered health plan subject to Health Care Reform, the Plan shall not base decisions regarding the hiring, compensation, termination or promotion of a claims adjudicator, medical expert or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

In an appeal of an adverse benefit determination regarding an urgent care health claim, a request for an expedited appeal may be made orally or in writing. All necessary information, including the Plan's determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or any other available, similarly expeditious method.

### **Final Decision**

The Plan will make a decision regarding a request for review as follows:

#### **Urgent Care Health Claims**

The claimant will be notified of the Plan's determination on review regarding an urgent care health claim within 72 hours after the Plan's receipt of the claimant's request for a review of an adverse benefit determination.

#### **Pre-Service Health Claims**

There will be one or two levels of appeal for pre-service health claims. In either case, the appeal process must be completed within 30 days and notification must be provided to the claimant.

### **Post-Service Health Claims**

There will be one or two levels of appeal for post-service health claims. In either case, the appeal process must be completed within 60 days and notification must be provided to the claimant.

### **Disability Claims**

The claimant will be notified of the Plan's determination on review regarding a disability claim within 45 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination unless the Plan determines that special circumstances require an extension of time for processing the appeal. If the Plan determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 45-day period. In no event will such an extension exceed a period of 45 days from the end of the initial period. The notice will indicate the special circumstance requiring an extension and the date by which a decision is expected to be made.

### **Other Welfare Claims**

The claimant will be notified of the Plan's determination on review regarding a welfare benefit claim such as group term life insurance within 60 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination unless the Plan determines its special circumstances require an extension of time for processing the appeal. If the Plan determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 60-day period. In no event will an extension exceed a period of 60 days from the end of the initial period. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected to be made.

### **External Review**

If the claimant has exhausted the internal appeal procedure with regard to the non-grandfathered health benefits that are subject to Health Care Reform, the claimant may submit a request for an external review with respect to a denied claim. The external review procedure must comply with the requirements of Health Care Reform. If the non-grandfathered health benefits are fully-insured, the requisite external review procedure will be prescribed by applicable state insurance law (if the state insurance law procedure complies with the external review procedure requirements of Health Care Reform). Otherwise, the procedure described in the balance of this section will apply. The primary type of external review is a standard external review. A claimant must file a request for a standard external review within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination.

Within five business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether:

- The claimant had coverage under the Plan at the time the service or supply was provided;
- Whether the claimant has exhausted the Plan's internal appeal process unless not required to do so as described above; and
- Whether the claimant has provided all information and forms necessary to process the external review.

Within one business day after completing the preliminary review, the Plan will issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In such case, the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If the Plan determines that an adverse benefit determination or final internal adverse benefit determination is eligible for external review, the Plan shall assign the external review to an independent review organization ("IRO") that is accredited by URAC or by a similar nationally recognized accrediting organization. The Plan shall take action against bias and to ensure independence. Contracts shall be in place with at least three IROs. External reviews shall be rotated among the IROs. In addition, an IRO shall not be eligible for any financial incentive based on the likelihood that the IRO will support the denial of benefits.

- The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. In order to be eligible for external review, the adverse benefit determination or final internal adverse benefit determination must involve a medical judgment or rescission of coverage. The IRO shall make this determination when considering the request's eligibility for external review. If accepted, the notice will include a statement that the claimant may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information for the IRO to consider when conducting the external review.
- Within five business days after the date of the assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

- Upon any receipt of any information submitted by the claimant, the IRO must, within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination. The external review may be terminated as a result of the reconsideration only if the Plan reverses its adverse benefit determination or final internal adverse benefit determination and provides coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO shall terminate the external review upon receipt of the notice from the Plan.
- The IRO will review all the information and documents timely received. In reaching a decision the assigned IRO will review the claim “de novo” (i.e., anew) and will not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. The IRO may also consider additional documents and information in conducting the external review including the claimant’s medical records, the attending health care professional’s recommendation, reports from appropriate health care professionals and other documents submitted by the Plan, claimant or claimant’s treating provider, the terms of the Plan, appropriate practice guidelines (including applicable evidence-based standards), any applicable clinical review criteria developed and used by the Plan, unless inconsistent with the terms of the Plan or applicable law, and the opinion of the IROs clinical reviewer(s).
- The IRO must provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of its final external review decision to the claimant and the Plan.
- The IRO’s decision notice will contain a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date(s) of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial), the date the IRO received the assignment to conduct the external review and date of the IRO decision, references to the evidence or documentation considered in reaching its decision, a discussion of the principal reason(s) for its decision, a statement that the determination is binding except to the extent that other remedies may be available under state or federal law, a statement that judicial review may be available, and current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.

- After a final external review, the IRO must maintain records of all claims and notices associated with the external review for six years. The IRO must make such records available for examination by the claimant, Plan or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of final external review reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment in connection with the claim.

The second type of external review is an expedited external review. The Plan must allow a claimant to make a request for an expedited external review in two situations. First, an expedited external review is available where the claimant has received an adverse benefit determination and it involves a medical condition of the claimant for which the time frame for completing an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited external appeal. Second, an expedited external review is available where the claimant has received a final internal adverse benefit determination and the claimant has a medical condition where the time frame for completing a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged for a facility.

- Immediately upon the receipt of a request for an expedited external review, the Plan must determine whether the request meets the review ability requirements set forth above for a standard external review. The Plan must immediately send a written notice that meet the requirements set forth above for a standard external review to the claimant regarding its eligibility determination.
- Upon a determination that the request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for a standard external review. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the same procedures for a standard external review. In reaching a decision, the IRO must review the claim "de novo" (i.e., anew) and is not bound by any decisions or conclusions reached during the Plan's internal claim and appeals process.
- The IRO shall provide notice of its decision in the same manner as a standard external review and shall do so as expeditiously as the claimant's

medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

### **Legal Actions**

No legal action may be brought to recover benefits under the Plan until the participant has exhausted the claim review procedure. Further, with respect to the self-funded benefits under the Plan, no legal action may be brought after the expiration of one year after the participant has been provided with a written notice denying the final level of Plan appeal concerning a claim.

If the Plan fails to strictly adhere to the internal claims and appeal procedures described in this section with respect to a claim under a non-grandfathered health plan subject to Health Care Reform, the claimant will be deemed to have exhausted the internal claims and appeal procedures and as a result, may immediately initiate an external review and/or file a legal proceeding. However, this rule shall not apply to minor, de minimis violations.

## **ADMINISTRATION**

Plan Sponsor is the plan administrator. The plan administrator is the designated named fiduciary and is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan.

With respect to the self-funded benefits, Plan Sponsor, as the plan administrator, has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the Plan. However, the plan administrator may delegate claims administration for some or all of the self-funded benefits to a third party administrator. Such a third party administrator may be a named fiduciary for benefit appeals pursuant to the applicable benefit.

The fully-insured benefits are provided pursuant to an insurance policy and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy. The insurers are the exclusive source of payment for the fully-insured benefits.

## **AMENDMENT OR TERMINATION**

Although Plan Sponsor intends to maintain the Plan indefinitely, Plan Sponsor has the authority to amend or terminate the Plan or any benefit at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits. Participants

will be informed of any material amendment affecting their coverages or changing the operation of the Plan.

## **HIPAA PRIVACY AND SECURITY RULES**

This section applies to the health benefits under the Plan and is required by the privacy and security rules of HIPAA.

### **Permitted and Required Uses and Disclosure of Protected Health Information (“PHI”)**

Subject to obtaining written certification (see below), the Plan may disclose PHI to Plan Sponsor, provided Plan Sponsor does not use or disclose such PHI except for the following purposes:

- Performing Plan Administrative Functions which Plan Sponsor performs for the Plan.
- Obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan; or
- Modifying, amending or terminating the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event will Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

### **Conditions of Disclosure**

Plan Sponsor agrees that with respect to any PHI, it will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Plan Sponsor with respect to PHI.
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor.
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.

- Make available to a participant who requests access, the participant's PHI in accordance with 45 CFR §164.524.
- Make available to a participant the right to request an amendment to the participant's PHI and incorporate any amendments to the participant's PHI in accordance with 45 CFR §164.526.
- Make available to a participant who requests an accounting of disclosures of the participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
- Make its internal practices, books, and records, relating to the use and disclosures of PHI received from the Plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy rules.
- If feasible, return or destroy all PHI received from the Plan that Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure that the adequate separation between Plan and Plan Sponsor, required in 45 CFR §164.504(f)(2)(iii), is satisfied and that terms set forth below are followed.
- Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and Plan Sponsor will ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware.

### **Certification of Plan Sponsor**

The Plan will disclose PHI to Plan Sponsor only upon the receipt of a certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Plan Sponsor agrees to the conditions of disclosure set forth above.

### **Permitted Uses and Disclosure of Summary Health Information**

The Plan may disclose Summary Health Information to Plan Sponsor, provided such Summary Health Information is only used by Plan Sponsor for the purpose of:

- Obtaining premium bids from health plan providers for providing health coverage under the Plan; or
- Modifying, amending or terminating the Plan.

### **Adequate Separation between Plan and Plan Sponsor**

- The employees, or classes of employees, listed in Plan Sponsor's HIPAA privacy policies and procedures will be given access to PHI.
- The access to and use of PHI by the individuals described above will be restricted to the Plan Administrative Functions that Plan Sponsor performs for the Plan.
- In the event any of the individuals described above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the plan administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.
- To comply with the HIPAA security rules, Plan Sponsor will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

### **Disclosure of Certain Enrollment Information to Plan Sponsor**

Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any health insurance issuer or health maintenance organization offered by the Plan.

### **Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage**

Plan Sponsor authorizes and directs the Plan, through the plan administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the HIPAA privacy rules.

## Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the HIPAA privacy rules.

## Definitions

For purposes of this section, the following terms have the following meanings:

- **“Business Associate”** means a person or entity who:
  - Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.); or
  - Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.
- **“Plan Administrative Functions”** mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administrative functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-plans—such as dental. PHI for these purposes may not be used by or between the Plan or business associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan administrative functions specifically do not include any employment-related functions.
- **“Protected Health Information” or “PHI”** means information that is created or received by the Plan, or a business associate of the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant (whether living or deceased). The following components of a participant’s information are considered to enable identification:
  - Names;
  - Street address, city, county, precinct, zip code;
  - Dates directly related to a participant’s receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death;

- Telephone numbers, fax numbers and electronic mail addresses;
  - Social Security numbers;
  - Medical record numbers;
  - Health plan beneficiary numbers;
  - Account numbers;
  - Certificate/license numbers;
  - Vehicle identifiers and serial numbers, including license plate numbers;
  - Device identifiers and serial numbers;
  - Web Universal Resource Locators (URLs);
  - Biometric identifiers, including finger and voice prints;
  - Full face photographic images and any comparable images; and
  - Any other unique identifying number, characteristic or code.
- **“Summary Health Information”** means information that may be individually identifiable health information:
    - That summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Employer has provided health benefits under a health plan; and
    - From which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

### **Fully-Insured Health Plans Administered Under “Hands Off” Approach**

Pursuant to HIPAA, if a group health plan is fully-insured and only enrollment/disenrollment information and Summary Health Information rather than Protected Health Information is disclosed to Plan Sponsor and Plan Sponsor only uses the Summary Health Information to obtain premium bids and/or to amend/terminate the Plan, then the responsibility to comply with the HIPAA privacy rules generally shifts from the Plan to the insurer. This is known as the “hands off” approach to administration. Any fully-insured health benefits under the Plan which are administered under the hands off approach shall not otherwise be subject to the HIPAA privacy and security rules set forth

in this Article (i.e., simply because they are included in the Plan for Form 5500 filing purposes).

### **Hybrid Entity**

To the extent the Plan provides any non-health benefits such as (but not limited to), disability benefits or group term life insurance benefits, those benefits shall be considered “non-covered functions.” The Plan is a separate legal entity whose business activities include the functions covered by the HIPAA privacy and security rules and non-covered functions. As a result, the Plan is a hybrid entity, as that term is defined in HIPAA. The Plan’s covered functions are its health benefits (“health care component”). All other benefits are non-covered functions. Therefore, the Plan hereby designates that it shall only be a covered entity under the HIPAA privacy and security rules with respect to the health care component (the health benefits) of the Plan.

## **GOVERNING LAW**

The Plan is subject to the Employee Retirement Income Security Act of 1974 (“ERISA”), as well as other various federal laws, including, but not limited to, the Newborns’ and Mothers’ Health Protection Act, the Women’s Health and Cancer Rights Act, HIPAA, FMLA, COBRA, USERRA and Health Care Reform, as well as certain state insurance laws. However, this document refers to certain benefits (such as the voluntary worksite benefit plans, short-term disability benefit, and the dependent care flexible spending accounts) that are not subject to ERISA.

To the extent not preempted by the federal law known as ERISA, the Plan will be construed in accordance with the laws of the state of Pennsylvania. Further, state laws apply to the Plan’s fully-insured health benefits. For example, some states mandate that certain benefits be provided under a group health insurance policy or may impose dependent eligibility requirements which are broader than federal law. Further, some states maintain laws which are similar to federal laws like COBRA and the HIPAA privacy rules but which require additional protections for participants.

## **FORM 5500**

The health and welfare benefits described in this Plan (except for the non-ERISA benefits) shall be considered a single plan for purposes of satisfying any obligation to file an annual Form 5500.

## **PLAN PARTICIPANTS’ RIGHTS**

Notwithstanding anything to the contrary in a booklet or certificate, participants in the Plan are entitled to certain rights and protections under ERISA with respect to the benefits under the Plan that are subject to ERISA.

## **Information About the Plan and its Benefits**

ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the plan administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, any updated Summary Plan Description and, if 100 or more participants, a copy of the latest annual report (Form 5500 Series). The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report if there are 100 or more participants in the Plan and the Plan is not funded solely through Employer's general assets. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for themselves, spouses or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Participants or their dependents may have to pay for such coverage. Participants should review the rules governing COBRA continuation coverage rights described elsewhere in this Summary Plan Description.

## **Plan Fiduciaries**

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

## **Enforcement of Rights**

If a participant's claim for a welfare 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 limits.

Under ERISA, there are steps participants can take to enforce the above rights. For instance, if a participant requests materials from the plan administrator and does not receive them within 30 days, the participant may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay the participant up to \$110 a day until the participant receives the materials, unless the

materials were not sent because of reasons beyond the control of the plan administrator. If the participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in a state or federal court. In addition, if the participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the participant may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the participant is discriminated against for asserting his or her rights, the participant may seek assistance from the U.S. Department of Labor, or the participant may file suit in federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person the participant sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees, for example, if it finds the participant's claim is frivolous.

### **Assistance With Questions**

If the participant has any questions about the Plan, he or she should contact the plan administrator. If the participant has any questions about this statement ("PLAN PARTICIPANTS' RIGHTS") or about his or her rights under ERISA, or needs assistance in obtaining documents from the plan administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. The participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or viewing its website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

|                                               |
|-----------------------------------------------|
| <b>OTHER BASIC INFORMATION ABOUT THE PLAN</b> |
|-----------------------------------------------|

Name of Plan: Horizon House, Inc. Employee Benefits Plan

Name, Address, Telephone Number  
and Taxpayer Identification Number  
of Plan Sponsor: Horizon House, Inc.  
3275 Stokley Street  
Philadelphia, PA 19129-1128  
(215) 386-3838

23-1413304

Plan Number: 503

Type of Plan: Group Health and Welfare Benefits Plan providing medical/prescription drug, dental, hospital copay reimbursement, basic group term life/AD&D, voluntary group term life/AD&D, long term disability, voluntary long term care benefits and medical flexible spending accounts. In addition, Employer provides dependent care flexible spending accounts, self-funded short-term disability, voluntary whole life and voluntary worksite benefits which are not subject to ERISA and technically are not part of this Plan.

Type of Administration: The Plan is administered by the plan administrator. With respect to each self-funded benefit, the plan administrator may retain the services of a third party administrator to provide administrative services. With respect to each fully-insured benefit, the insurer provides administrative services.

Plan Administrator: Plan Sponsor

Agent for Service of Legal Process: Vice President of Finance  
Horizon House, Inc.  
3275 Stokley Street  
Philadelphia, PA 19129-1128

Service of legal process may also be made on the plan administrator.

Claim Administrators/Insurers:

**For Fully-Insured Medical/Prescription Drug Benefits:**

Keystone Health Plan East (HMO)  
AmeriHealth HMO of PA, Inc. (HMO)  
Independence Blue Cross (PPO)

**For Self-Funded Hospital Copay Reimbursement Benefits:**

Horizon House, Inc.

**For Fully-Insured Dental Benefits:**

The Guardian Life Insurance Company of America

**For Fully-Insured Basic and Voluntary Group Term Life/AD&D, Long-Term Disability, Voluntary Worksite Benefit Plans and for the Self-Funded Short-Term Disability Benefits:**

The Guardian Life Insurance Company of America

**For Fully-Insured Voluntary Long Term Care and Whole Life Benefits:**

UNUM

**For Medical (and Dependent Care) Flexible Spending Account Claims under the Section 125 flexible benefits plan:**

Discovery Benefits

See booklets for addresses and telephone numbers of claim administrators and insurers.

Plan Year for Fiscal Record  
Purposes:

April 1 through March 31

However, the Plan may maintain a different 12-month period for other purposes. For example, insurance policies may renew based on a different 12-month cycle, participants may make annual benefit elections on a different 12-month cycle and the period of coverage for deductibles, annual out-of-pocket limits and other annual benefit provisions may operate on a different 12-month period.