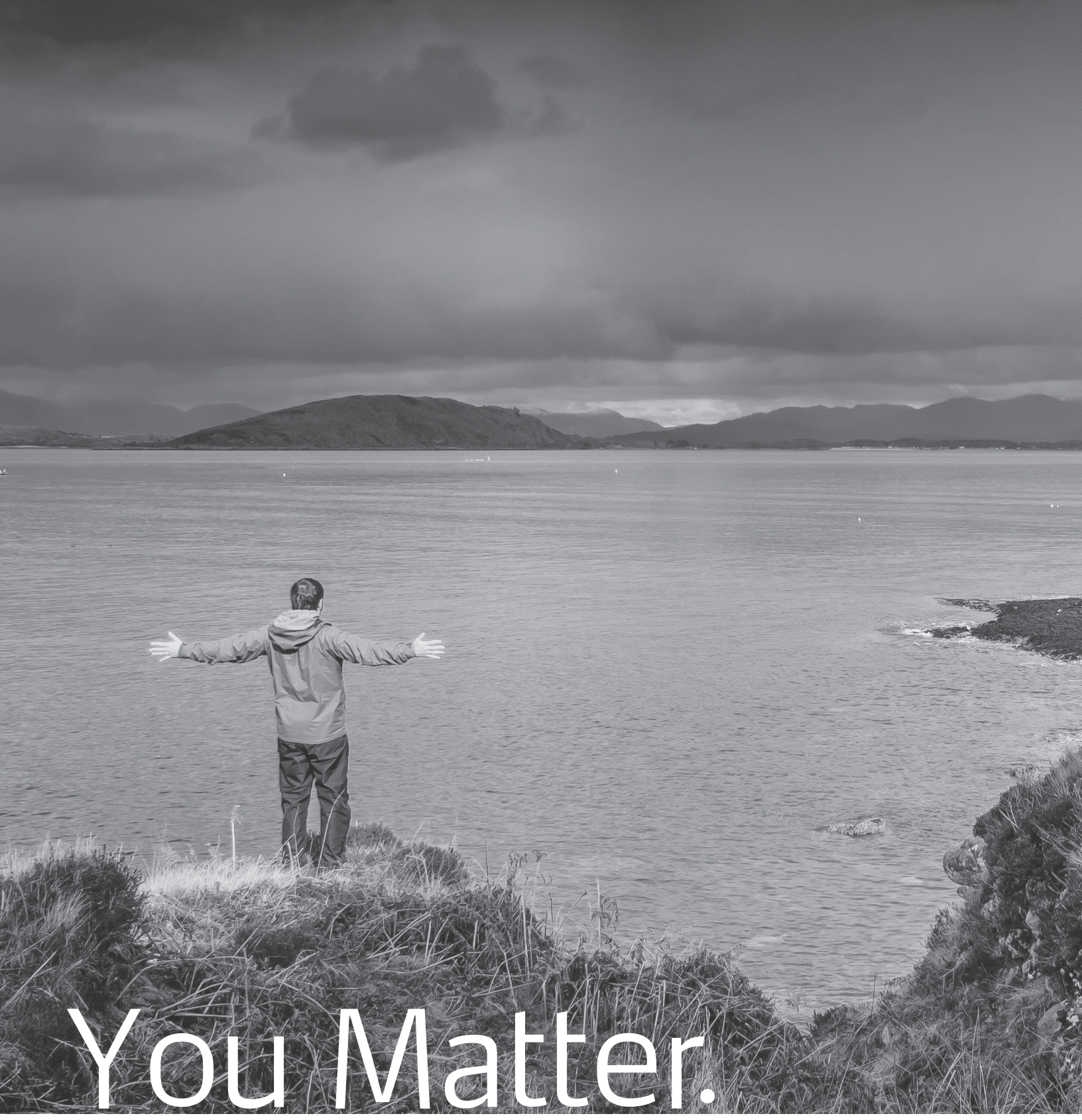


# Securitas Security Services USA, Inc. Health and Welfare Benefit Plan

Summary Plan Description

SECURITAS

Security Officers
July 31, 2017

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# I. INTRODUCTION

Securitas Security Services USA, Inc. sponsors the Securitas Security Services USA, Inc. Health and Welfare Benefit Plan (the "Plan") for the benefit of Employees of Securitas Security Services USA, Inc. and its subsidiaries and affiliates that adopt the Plan (including Paragon Systems, Inc., Securitas Critical Infrastructure Services, Inc., Securitas Electronic Security, Inc., and Pinkerton Consulting and Investigation, Inc.) (the "Company").

The Plan is made up of various benefit programs (each a "Program") offered by the Company, such as medical, dental and vision coverage, life insurance, AD&D insurance, business travel accident insurance, and other benefits. One of the Programs in the Plan is the Securitas Security Services USA, Inc. Flexible Benefits Plan for Security Officers (the "Flex Plan"). This SPD is also the SPD for the Flex Plan.

With respect to certain Programs, such as those related to health care, the Plan is considered a "cafeteria plan" or "§ 125 plan," which means that it offers you the choice of various Programs that you can pay for on a pre-tax basis through salary reduction, as well as the ability to be reimbursed for eligible health care and dependent care expenses. This arrangement helps you because the dollars used to purchase these benefits are not subject to income, Social Security, and Medicare taxes. Certain Programs offered under the Plan, such as life insurance, AD&D, and disability Programs may only be offered on an after-tax basis. Nevertheless, these Programs are offered at group rates and can be very beneficial to you and your family.

This SPD is a summary of the basic features of the Plan as of July 31, 2017. While the SPD provides you with a lot of information regarding the various Programs, it only describes certain portions of the Programs offered through the Plan. Each Program is described in detail in the "Program Documents" for that Program and discusses in further detail whether a particular service or benefit is covered. The Program Documents consist of plan documents, certificates of coverage, administrative services agreement, and the applicable portions of the most recently published SPD for that Program, as supplemented or amended by any subsequent summary of material modifications, annual summary of benefits, or enrollment materials or other materials provided by the Plan to participants for the purpose of informing participants of the most current information regarding the benefits available under a particular Program. The Program Documents are incorporated into the SPD by reference.

In the event of any conflict between the Program Documents and this SPD (and the applicable Supplement to the Plan), the Program Documents will control to the extent that the terms of the Program Documents do not conflict with ERISA (as defined below), the Code (as defined below), or other applicable law. In the event that there is a conflict between the Plan document and this SPD or the Program Documents, the Plan document will control.

You should read this SPD and the Program Documents for each Program in which you participate carefully to determine your rights and responsibilities. The complete terms of the Plan are described in the Plan document, which incorporates the Program Documents. For copies of the Program Documents, please contact the Securitas benefits department at 1-818-705-6800 or benefit.questions@securitasinc.com.

Many important details are included in this SPD. While the SPD provides you with a lot of information with respect to the Programs, you may need additional details. Program Documents are available at any time by contacting the Securitas benefits department at 1-818-705-6800 or

benefit.questions@securitasinc.com. Upon request, the applicable Program Documents will be provided in paper form **free of charge.** This SPD, along with the Program Documents, can help you better understand and use your benefits, replaces previous SPDs, and is intended to comply with U.S. Department of Labor (DOL) requirements.

In addition, the laws relating to employee benefit plans change regularly. Whenever a Plan provision is inconsistent with any change in the law, the Plan and each Program will be administered according to the new law, regardless of the terms of the Plan, this SPD, or the Program Documents for each Program. Whenever significant changes are made to the Plan or a Program, you will be notified through a summary of material modifications. You should keep each summary of material modifications you receive and refer to it any time you refer to this SPD or the Program Documents for any Program.

**This SPD, together with the applicable Program Documents, form the complete summary plan description for each of the Programs subject to ERISA, as required under ERISA.**

## Language Access Services

{Spanish} ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-596-7455 (TTY: 711).

{Chinese} 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-596-7455（TTY: 711）。

{Vietnamese} CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-596-7455 (TTY: 711).

{Korean} 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-596-7455 (TTY: 711)번으로 전화해 주십시오.

{Tagalog} PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-596-7455 (TTY: 711).

{Russian} ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-596-7455 (телетайп: 711).

{Arabic} ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-596-7455 (رقم هاتف الصم والبكم: 711).

{French Creole} ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-596-7455 (TTY: 711).

{Portuguese} ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-596-7455 (TTY: 711).

{French} ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-596-7455 (ATS : 711).

{Polish} UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-596-7455 (TTY: 711).

{Japanese} 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-596-7455（TTY:711）まで、お電話にてご連絡ください。

{Italian} ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-596-7455 (TTY: 711).

{German} ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-596-7455 (TTY: 711).

{Farsi} **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-596-7455 (TTY: 711) تماس بگیرید.

# II. GLOSSARY

Capitalized terms used in this SPD and not defined in the text have the meanings set forth below:

"***Affordable Care Act***" means the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act.

"***Annual Enrollment Period***" means the enrollment period specified by the Company prior to the first day of a Plan Year during which eligible employees who wish to participate in the Plan for such Plan Year must enroll in accordance with procedures established by the Plan Administrator.

"***CHIP***" means the Children's Health Insurance Program.

"***Claims Administrator***" has the meaning set forth in section VIII of this SPD entitled "CLAIM AND APPEAL PROCEDURES – GENERAL RULES." The Claims Administrators are listed on Appendix B to this SPD.

"***COBRA***" and "***Continuation Coverage***" has the meaning set forth in section VII of this SPD entitled "COBRA CONTINUATION COVERAGE FOR HEALTH CARE BENEFITS."

"***Code***" means the Internal Revenue Code of 1986, as amended, and the rules and regulations thereunder.

***"Company***" has the meaning set forth in the "Introduction" to this SPD.

"***Dependent***" has the meaning set forth in sections IV(F) and V(E) of this SPD entitled "Flexible Spending Accounts – Covered Dependents" and "Eligible Dependents".

"***Domestic Partner***" has the meaning assigned by applicable state law or local law.

"***Employee***" means an individual designated as an employee of the Company in accordance with the Company's (or participating affiliate's) standard employment practices.

"***ERISA***" means the Employee Retirement Income Security Act of 1974, as amended, and the rules and regulations thereunder.

"***External Review***" has the meaning set forth in section IX(K) of this SPD entitled "CLAIMS AND APPEAL PROCEDURES – MEDICAL, DENTAL, AND VISION – External Review"

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

"***Hour of Service***" has the meaning set forth in section (V)(C) of this SPD entitled "Look Back Measurement Period."

"***Plan***" has the meaning set forth in the "Introduction" to this SPD.

"***Plan Year***" means calendar year.

"***Program***" has the meaning set forth in the "Introduction" to this SPD.

"***Qualified Life Event***" has the meaning as set forth in section VI of this SPD entitled "ENROLLMENT AND ELECTION OF BENEFITS – Qualified Life Events."

"***Qualifying Event***" has the meaning set forth in section VII of this SPD entitled "COBRA CONTINUATION COVERAGE FOR HEALTH CARE BENEFITS."

"***Qualifying Individual***" has the meaning set forth in section IV(G) of this SPD entitled "Dependent Care Flexible Spending Account."

"***QMCSO***" means a Qualified Medical Child Support Order.

"***Security Officer***" has the meaning set forth in section V.A of this SPD entitled "Eligibility."

"***SES***" means Securitas Electronic Security, Inc.

"***SPD***" means Summary Plan Description.

"***Spouse***" means the individual to whom you are legally married under federal law.

"***Summary of Benefits and Coverage***" means the document provided that summarize the key features of the plan or coverage.

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

# III. GRANDFATHERED PLAN STATUS

The Plan believes that certain Programs under the Plan are grandfathered health plans within the meaning of the Affordable Care Act. Grandfathered health plans are allowed to preserve certain basic health coverage that was in effect on March 3, 2010, provided the plan complies with disclosure and recordkeeping requirements, and has not made certain plan changes resulting in the loss of grandfathered status. If a Program is a grandfathered health plan, this means that the Program may not include certain consumer protections that are required under the Affordable Care Act. However, grandfathered health plans must still comply with certain other consumer protections under the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Programs under the Plan that are non-grandfathered health plans must comply with all of the applicable provisions under the Affordable Care Act, including, but not limited to, reporting and disclosure obligations, elimination of certain lifetime limits, new requirements for internal claims appeal process and an external review process and provision of certain preventive services. Please see Appendix A for the list of grandfathered and non-grandfathered Programs under the Plan.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Executive Compensation & Benefits Review Committee of Securitas Security Services, USA Inc., at 1-818-706-6800.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or search “grandfathered health plans” at http://www.dol.gov/agencies/ebsa/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

# IV. BENEFITS

## A. Programs Offered

The Plan includes the following Programs:

- Medical
- Dental
- Vision
- Basic and Supplemental Life Insurance
- Basic Accidental Death and Dismemberment Insurance (AD&D)
- Business Travel Accident Insurance
- Employee Assistance Program (EAP)
- Short Term Disability (STD)

- Long Term Disability (LTD)

### B. Employee and Company Contribution

The Company determines how to allocate the costs of each Program. The Company may pay all costs of a Program, require participants to pay all costs of a Program, or share the costs of a Program with participants.

Before you enroll in a Program, you will be provided with information about the cost of each Program. The Company may modify the allocation of costs from time to time and will notify you of any changes. The Employee cost of each Program is paid via payroll deduction, if you are actively employed by the Company. If you are not actively employed, the Plan Administrator will provide you with the procedures for payment of the cost of each Program.

You should consult the Program Documents for each Program and read them together with this SPD.

### C. Pre-Tax Deduction

When you elect to participate in the Medical, Dental, or Vision Program(s), your portion of the premiums is deducted from your paycheck before Federal and State taxes are taken out. This means your actual cost for these benefits is less than if you were paying on an after-tax basis.

### D. After-Tax Deduction

When you elect to participate in the Life, AD&D, STD, or LTD Program(s), your portion of premiums (if any) are deducted from your paycheck after Federal and State taxes are taken. Therefore, when you or your beneficiaries receive benefits under these Programs, those benefits are not taxable.

## V. ELIGIBILITY

### A. Eligible Employees

The Plan is only open to security Employees, referred to in this SPD as Security Officers, of the Company working under a client contract with the Company as established by the standard employment practices of the Company.

If you are an eligible Security Officer, you are eligible to participate in the Plan after a waiting period of 90 calendar days (or the number of days specified in a client contract not to exceed 90 calendar days) of continuous full-time employment (regularly scheduled to work and performs services for thirty (30) or more hours per week). If during the waiting period you experience an unpaid break in service for any reason other than a leave of absence under the FMLA, USERRA, or jury duty, the time during your break in service will not count as service for purposes of satisfying the waiting period requirement. Upon returning to work, your prior service will count toward the waiting period requirement, if the break in service is less than 13 weeks. If the break in service is 13 weeks or longer, your prior service with the Company will not be counted in determining satisfaction of the waiting period requirement.

If you are a Security Officer, as described above, you should consult the Program Documents for each Program to determine if you are eligible for that Program. You may also be eligible to enroll your Dependents (e.g., your Spouse, children or other eligible dependents) in certain Programs, depending upon the terms of each Program. Eligibility requirements for these individuals are described generally below and in the Program Documents for each Program.

You are eligible to participate in the Plan for medical benefits if:

- You are a Full-Time Employee who is a Security Officer, who, based on the position, is reasonably expected to work on average at least 30 Hours of Service per week; you also will be scheduled to work at least 30 Hours of Service per week by the Company. Security Officers who are hired as Full-Time Employees will generally be eligible to enroll in medical benefits.
- You are a Part-Time Employee who is a Security Officer, who is ***not*** reasonably expected to work on average at least 30 hours per week upon hire and you are **scheduled** to work less than 30 Hours of Service per week for the Company, but you have **actually** worked on average at least 30 Hours of Service per week during an Initial Measurement Period ("Initial ACA Eligibility"). You therefore are eligible to enroll for the medical benefits for the associated Initial ACA Eligibility Period.
- You are a Part-Time Employee who is a Security Officer, who is ***not*** reasonably expected to work on average at least 30 hours per week and you are **scheduled** to work less than 30 Hours of Service per week for the Company, but you have **actually** worked on average at least 30 Hours of Service per week during a Standard Measurement Period ("Ongoing ACA Eligibility"). You therefore are eligible to enroll or continue in medical benefits for the associated Ongoing Stability Period.

In some cases, you may be eligible for continued coverage under the Plan for a limited time after certain events occur that cause you to lose your coverage. A description of this limited continuation coverage can be found in section VII of this SPD called "COBRA Continuation Coverage for Health Care Benefits."

## B. Rehire Rules

### "New" Employee Upon Reemployment

You will be considered as a new Security Officer for health benefit plan purposes if you have a period of at least 13 consecutive weeks during which you are not credited with any Hours of Service due to a break in service, such as a termination of employment, an unpaid, unprotected leave of absence, or in a non-benefit eligible employee status immediately before resuming services with the Company. If you are rehired as a new Full-Time Employee (i.e., the Company reasonably expects, upon re-employment, that you will average 30 or more Hours of Service per week) after experiencing a break in service of at least 13 consecutive weeks, you may enroll in benefits that will become effective after the applicable waiting period. If you are rehired as a new Part-Time Employee after experiencing a break in service of at least 13 consecutive weeks, you will be placed into a new Initial Measurement Period.

### Continuing Employee Upon Reemployment

If the period of your break in service is less than 13 consecutive weeks during which you are not credited with any Hours of Service, upon your return to the Company, you will be considered a

continuing Employee. If you were enrolled in the group health plan prior to your absence, your benefits will be effective on your return to work date. The period of your break in service will be counted as zero (0) Hours of Service in the ongoing Standard Measurement Period you were in prior to your absence, for purposes of determining your eligibility for benefits in the next associated Stability Period.

If you are rehired, you must meet the eligibility requirements of the Plan and each Program to re-enroll. If your rehire date is within thirty (30) days following the date of your termination, your elections in effect on the date of your termination will be reinstated. If your rehire date is more than thirty (30) days after the date of your termination of employment, you may reinstate the elections in effect on your date of termination or make new elections within 30 days.

## C. Look Back Measurement Period (Medical Benefits Only)

Through the eligibility terms described in this SPD for medical benefits, the Company applies the look-back measurement method as defined under, and according to the requirements of, Code section 4980H to all of its Employees to determine eligibility to enroll in the medical plan. To the extent the eligibility terms described in this SPD do not comply with the minimum requirements of Code section 4980H and its regulations, the eligibility terms will be modified as necessary to comply with those requirements.

The Company will perform periodic look back calculations of actual hours worked to ensure compliance with the employer mandate of the Affordable Care Act. This calculation will only affect eligibility for medical benefits and is done to determine if an Employee worked 30 or more hours per week on average during the look-back period to be eligible for health benefits.

After you have been employed with the Company for an entire Standard Measurement Period, your eligibility for the medical plan for each subsequent Stability Period will be conditioned on your remaining employed with the Company on average at least 30 Hours of Service per week during each Standard Measurement Period associated with a subsequent Stability Period or you continuing to be **scheduled** to work at least 30 Hours of Service per week for the Company.

- **Part-Time** means that you are not reasonably expected by the Company to work an average of 30 Hours of Service per week over a 12-month period and therefore are not expected to be a Full-Time Employee as of your date of hire. As a result, your Hours of Service must be measured during an Initial Measurement Period and subsequent Standard Measurement Periods to determine whether or not you are eligible to enroll in medical benefits for an associated Stability Period.
- **Hour of Service** means each hour for which you are paid, or are entitled to be paid, by the Company for the performance of duties for the Company; and each hour for which you are paid, or you are entitled to be paid, by the Company for a period of time during which you perform no duties for the Company due to, for example, approved vacation or holiday time or other approved paid leaves of absence.
- **Initial Measurement Period** means the 11-month period beginning from the date of hire as a Part-Time Employee to test for an average of 30 Hours of Service per week or more. Therefore, the Part-Time Employee must have 1,430 Hours of Service or more during the Initial Measurement Period.
- **Initial ACA Eligibility** means you are a Part-Time Employee who is not regularly **scheduled** to work an average of 30 Hours of Service per week or more but you **actually**

worked on average at least 30 Hours of Service per week during your Initial Measurement Period and therefore are eligible to enroll in the medical plan for medical benefits for the following Initial Stability Period.

- **Initial Stability Period** means the 12-month period beginning no later than the first day of the second month beginning after the end of the Initial Measurement Period. If you gained Initial ACA Eligibility, you may enroll in the medical plan for this 12-month period. An Employee's eligibility for health benefits is generally locked in for the full stability period, regardless of the Employee's actual worked hours during the stability period (provided that the Employee continues to be employed during the stability period). If you did not gain Initial ACA Eligibility, you are not eligible for medical benefits during the Initial Stability Period.
- **Standard Measurement Period** means the 12-month period beginning October 15 of a calendar year and ending October 14 of the next calendar year – for example, October 15, 2017 to October 14, 2018. An ongoing Employee must have 1,560 Hours of Service or more during a Standard Measurement Period.
- **Ongoing ACA Eligibility** means you are a Part-Time or per diem Employee not ***scheduled*** to work an average of 30 Hours of Service per week or more but you **actually** worked on average at least 30 Hours of Service per week during a Standard Measurement Period and therefore are eligible to enroll in the medical plan for medical benefits for the following Ongoing Stability Period.

  **Ongoing Stability Period** means the plan year (January 1 to December 31), that begins after the end of the Standard Measurement Period. An Employee's eligibility for health benefits is generally locked in for the full stability period, regardless of the Employee's actual worked hours during the stability period (provided that the Employee continues to be employed during the stability period). .

## D. Employees Not Eligible

You are not eligible to participate in the Plan if you are not a Security Officer. Further, an Employee or other individual who works for the Company on a Part-Time basis (regularly scheduled to work less than 30 Hours of Service per week and does not actually work 30 Hours of Service per week, as explained above) or who provides services to the Company as a: temporary employee, leased employee, casual employee, volunteer, agent, intern, co-op, independent contractor, or sub-contractor is not eligible to participate in the Plan. Lastly, you are not eligible to participate in the Plan if you are a non-resident alien or if you are covered by a collective bargaining agreement.

## E. Eligible Dependents

A number of the Programs offered under this Plan permit participants to enroll their Dependents. Generally, you should consult the Program Documents for each Program to determine which of your Dependents may be eligible. However, see below for an explanation of the Dependent requirements for certain Programs.

Anyone who is eligible as a Security Officer will not be considered a Dependent, and no one may be considered a Dependent of more than one Employee of the Company.

You may be required to provide applicable legal documentation and submit certain forms to

verify eligibility prior to a Dependent being enrolled or at any time as governed by the Plan.

Dependents eligible for coverage under the Plan:

- Your Spouse, which may include your Domestic Partner. Please refer to section V(I) of this SPD entitled “Domestic Partners” for additional information on the Plan’s eligibility requirements for Domestic Partner benefits;
- Your children and your Spouse’s children who are under age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support;
- Your legally adopted children or children placed in your home for adoption;
- Children for whom you are appointed as legal guardian and who are chiefly dependent on you for support and maintenance;
- Children for whom the plan is required to provide coverage under a QMCSO; and
- Your permanently and totally disabled adult child as defined below.
- To determine your eligible Dependents, “children” include natural children, adopted children or children placed with you in anticipation of adoption (the child must be available for adoption and the legal process to adopt must have been started). If you are the legal guardian of a child or children, these children may be enrolled as covered Dependents.
- If your Domestic Partner is eligible to participate in the Plan, the children of your Domestic Partner who are under the age of 26 are also eligible to participate. Please refer to section V(I) of this SPD entitled “Domestic Partners” for additional information on the Plan’s eligibility requirements.
- Note that New York State law, for certain fully insured programs, allows for extension of medical benefits coverage up to age 29 if certain eligibility criteria are met. Please see the applicable Program Document for more information.

**Permanently and Totally Disabled**

For purposes of the definition of Dependent, your child will be considered permanently and totally disabled if he or she is incapable of self-sustaining employment by reason of mental or physical handicap, provided he or she became disabled prior to his or her 26th birthday and was covered under the Company’s medical plan on his or her 26th birthday. Proof of the child’s condition and dependence may be required for initial and continued enrollment. For health coverage where government sponsored medical assistance programs exist, the disabled Dependent must enroll in the government plan and this Plan will be secondary to the extent permitted by law.

## F. Dependents Not Eligible

The individuals not eligible for benefits under the Plan include:

- A person living outside the United States;
- A parent;

- A sibling;
- An ex-Spouse, if you are already covering a current Spouse;
- A Domestic Partner, unless your state or jurisdiction mandates domestic partner coverage;
- Nonresident aliens.

## G. When Coverage Ends

The typical reasons why your coverage might end are your termination of employment from the Company and its affiliates and subsidiaries, a reduction in hours below the eligibility threshold, change to another location or job position, failure to pay premiums, and violation of Plan rules (e.g., enrolling individuals as your Dependents who do not qualify).

In addition, the Company reserves the right to modify, amend or terminate the Plan and any Program, in which case your current coverage could change or end.

## H. Prohibition on Rescission

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

## I. Domestic Partners

**No Domestic Partner benefits are provided unless required by state law for a particular Program**.

If your state or jurisdiction mandates Domestic Partner coverage for certain insured Programs, references in this SPD to “Spouse” or “child(ren)” or “Dependents” with respect to such Programs may include Domestic Partners or their children for certain purposes and only to the extent required by law. For purposes of the Plan, a participant may not have a Spouse as a Domestic Partner. If state law requires coverage for your Domestic Partner, note that your Domestic Partner will only qualify as a Dependent for federal tax purposes if:

- You provide more than half of your Domestic Partner's support for the year;
- Your Domestic Partner earns less than the IRS exemption amount;
- Your Domestic Partner is a member of your household; and
- Neither you nor your Domestic Partner are legally married to another person nor have a domestic partnership with another person.

The payroll contributions for your Domestic Partner’s coverage and for his or her eligible Dependent children’s coverage are deducted from your pay on an after-tax basis. Additionally, you must pay taxes on the value of the Company-paid portion of their coverage. The value of the Company-paid portion of such coverage will be added to your income on your pay stubs and

W-2, and is subject to ordinary Federal, state, local, FICA and other applicable payroll taxes.

For additional information on Continuation Coverage, please refer to section VII of this SPD entitled “COBRA Continuation Coverage for Health Care Benefits.”

# VI. ENROLLMENT AND ELECTION OF BENEFITS

## A. How to Enroll

When you are first hired by the Company, you will receive an enrollment package for the various Programs in which you may be eligible to enroll upon your satisfaction of any waiting period requirements applicable to new or rehired Employees. In addition, the Company holds an Annual Enrollment Period, at which time you may enroll in one or more Programs, drop coverage, or change your previous enrollment elections. You must complete your enrollment within the timeframes required under each Program in order to be enrolled. Your enrollment deadline is the last day of the Annual Enrollment Period for each Program. Once you are enrolled in a Program (or if you fail to enroll in a Program) you will remain enrolled in that Program and cannot make any changes until the next Annual Enrollment Period, unless you have a special enrollment event or Qualified Life Event, which are explained later in this Section of the SPD. If you don’t make an election during an Annual Enrollment Period, your previous elections will remain the same.

## B. HIPAA Special Enrollment Events

If you or your eligible Dependent declined medical, dental, or vision coverage because you had other coverage, then you may enroll in that Program if:

- the other coverage is terminated because of a loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in hours);
- the other coverage is COBRA continuation coverage and that coverage expires; or
- the employer contribution to the other plan is terminated.

You must notify your local Human Resources representative within 30 days following the occurrence of the event or you will not be permitted to enroll until the next Annual Enrollment Period.

If you have a new child by birth, adoption, placement for adoption, or marriage, you may enroll that child in the Program for medical, dental, and vision coverage in which you are eligible. If you are not already enrolled, you may enroll in order to enroll the child (and your Spouse may enroll if you are married). Alternatively, you may elect to enroll without enrolling your new child, or, if you have a Spouse, you and your Spouse may enroll without enrolling the child. However, you may not enroll any other children you already had who were not enrolled. You must notify your local Human Resources representative and request enrollment within 30 days of the occurrence of the birth, adoption, placement for adoption, or marriage. Otherwise you will not be permitted to enroll until the next Annual Enrollment Period.

The Plan must allow a HIPAA special enrollment for Employees and Dependents who are eligible, but not enrolled, if they lose Medicaid or a state Children's Health Insurance Program (CHIP) coverage because they are no longer eligible, or if they become eligible for assistance under Medicaid or CHIP. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan.

CHIP is a law that allows states to help pay premiums for employer-provided group health coverage for eligible children and families. If you are eligible for the Plan, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a state that participates in the program, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW (1-877-543-7669)** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

To see if your state has a premium assistance program or for more information on special enrollment rights, you can contact:

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

Please contact your local Human Resources representative to request a special enrollment or to obtain more information.

## C. Making Changes to Your Coverage During the Year

Normally, your elections under the Plan cannot be changed during the plan year except during the Annual Enrollment Period. However, Federal law permits you to make new elections if certain circumstances change. The changes described in this section apply to the medical Program, the dental Program, and the vision Program. If you have a Qualified Life Event as described below and would like to change your elections, you must notify your local Human Resources representative within 30 days following the event, or 60 days following certain events as described under the HIPAA Special Enrollment Events section above.

## D. Qualified Life Events

The following is a list of events (in addition to the HIPAA Special Enrollment events above) that may allow you to make a change to your elections outside of the Annual Enrollment Period (subject to the consistency requirements, as described below).

- Any event that changes your legal marital status, including marriage, divorce, death of a Spouse or eligible Domestic Partner, legal separation, and annulment;

- Any event that changes your number of eligible Dependents including birth, death, legal guardianship, and placement for adoption;

- Any event that changes your or your eligible Dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:

    - Beginning or ending employment;
    - A strike or lockout;
    - Starting or returning from an unpaid leave of absence;
    - Changing from part-time to full-time employment or vice versa; and
    - A change in work location that affects your eligibility under the Plan

- Any event that causes your Dependents to become eligible or ineligible for coverage because of age or similar circumstances;

- A change in the place of residence for you or your eligible Dependents if the change results in your or your eligible Dependents living outside your medical or dental plan's network service area; and

- You or your Dependent child becomes eligible for a state plan under CHIPRA, or qualifies for the CHIP premium subsidy program

## E. Consistency Requirements for Changes in Status

Except for election changes due to HIPAA Special Enrollment, changes made to your coverage due to the qualified life events described above must be made "on account of and corresponding with" the event. To satisfy the "consistency rule," both the event and the corresponding change in coverage must meet all the following requirements:

- Effect on eligibility: The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependents who may benefit from coverage under the Plan.

- Corresponding election change: The election change must correspond with the event. For example, if your dependent loses eligibility for coverage under the terms of the health plan, you may cancel health coverage only for that dependent. You may not cancel coverage for yourself or other covered dependents.

## F. Other Events

The following is a list of other events that may allow you to make a change to your elections outside of the Annual Enrollment Period:

- Cost changes: If the cost to participants of medical, dental, or vision coverage increases or decreases significantly during the year, the Plan Administrator may announce that affected participants can make corresponding election changes. If this occurs, you will be notified with the details of the permitted changes. In addition, the Plan Administrator may increase or decrease Salary Reduction Contributions of all participants if the cost to participants increases or decreases during the year. Salary Reduction Contributions are contributions from your salary to purchase benefits under the Plan.

- Coverage changes: Certain changes to your medical, dental, or vision coverage can result in permitted election changes as described below:

    - Significant Reduction without Loss of Coverage: If medical, dental, or vision coverage is significantly reduced during the year, but the reduction does not result in a "loss of coverage" (see next bullet), you may revoke your elections that pertain to that coverage, including Salary Reduction Contributions, and elect to receive, on a prospective basis, another benefit that provides similar coverage and is available under the Plan or Program.

    - Significant Reduction with Loss of Coverage: If medical, dental, or vision coverage is significantly reduced during the year and the reduction results in a "loss of coverage" as described below, you may revoke your election pertaining to that coverage, including elections of Salary Reduction Contributions, and elect to receive, on a prospective basis, another benefit that provides similar coverage and is available under the Plan or Program. If no similar coverage is available under the Plan, you may elect to drop coverage. A "loss of coverage" means a complete loss of medical, dental, or vision coverage under the Program. However, the Plan Administrator may, in its discretion, determine that the following events constitute a loss of coverage: (a) a substantial decrease in the medical care providers available under the Program; (b) a reduction in benefits for a specific type of treatment that you or your Dependent is currently receiving; (c) a reduction in benefits for a specific medical condition for which you or your Dependent is currently receiving treatment; or (d) any other similar fundamental loss of coverage.

    - Addition or Improvement of Programs: If a new Program is added under the Plan, or an existing Program is significantly improved, and you are eligible for that Program, you may change or revoke your benefit elections and make a corresponding change in the amount of your Salary Reduction Contributions to add coverage under the new or improved Program.

    - Change in Coverage Under Another Employer Plan: If your coverage (or your Dependent's coverage) changes under another employer plan, you may change or revoke your benefit elections under this Plan and make a corresponding change in the amount of your Salary Reduction Contributions, but only if: (a) the other employer plan permits participants to make an election change pursuant to Code Section 125 and applicable Treasury regulations; or (b) the other employer plan has a benefit period that differs from the Plan Year under this Plan (which is the calendar year).

    - Loss of Other Group Health Coverage. If you or your Dependent loses coverage under any group health plan sponsored by a governmental or educational institution, including a state children's health insurance program, a medical care program of an Indian tribal government, a state health benefits risk pool or a foreign government health plan, then you may change or revoke your benefit elections and make a corresponding change in the amount of your Salary Reduction Contributions to add coverage for yourself and/or your eligible Dependent.

    - Judgments, Decrees or Orders**:** You may change or revoke your medical, dental, or vision elections and make a corresponding change in the amount of your Salary

Reduction Contributions for the remainder of the year if the change or revocation is on account of a judgment, decree or order (including, but not limited to, a qualified medical child support order) resulting from a divorce, legal separation, annulment or change in legal custody of a Dependent that requires accident or health coverage for a Dependent child. In these cases, you may change your elections to: (i) add coverage for a Dependent child if the judgment, decree, or order requires you to provide coverage for the Dependent (and you may add coverage for yourself if not enrolled and if required by the Program as a condition of enrolling a Dependent); or (ii) drop coverage for a Dependent child if the judgment, decree, or order requires your current or former Spouse (or other individual) to provide coverage for the Dependent and that coverage is, in fact, provided.

- Entitlement to Medicare or Medicaid: If you or your Dependent becomes entitled to Medicare (Part A or B) or Medicaid, you may make an election to drop or reduce medical coverage and make a corresponding change in the amount of your Salary Reduction Contributions for the remainder of the Plan Year for the individual who became entitled to Medicare. In addition, if you or your Dependent loses entitlement to Medicare, you may make a corresponding election change to add or increase medical coverage for the individual who lost entitlement to Medicare or Medicaid.

- FMLA leave: If you take leave under FMLA, you may revoke your existing medical, dental, and vision election and make another election for the remainder of the Plan Year to the extent required under FMLA.

## G. Effective Date of Elections

Elections made during the Annual Enrollment Period become effective January 1 of the following year.

For new Employees, coverage generally begins after a waiting period of 90 calendar days (or the number of days specified in a client contract not to exceed 90 calendar days) of continuous full-time employment (regularly scheduled to work and performs services for thirty (30) or more hours per week), as long as you meet the applicable eligibility requirements and enroll before the deadline.

Election changes made in accordance with the rules described above become effective retroactive to the Qualified Life Event date and you must provide proof consistent with the event.

A summary of the Plan's enrollment deadlines for each Program, which are explained further in this SPD, are summarized below:

- You (or your eligible Dependents) must enroll in the Plan within 30 days after first becoming eligible to participate in the Plan following your date of hire or meeting the eligibility requirements under the Plan. If you (or your eligible Dependent) experience a Qualified Life Event, you must enroll in the Plan within 30 days following the event.

- If you (or your eligible Dependent) experience a HIPAA Special Enrollment event, you must enroll in the Plan within 30 days (or 60 days for certain events as described under the HIPAA Special Enrollments section above) following the event.

- The last day of the Annual Enrollment Period for coverage beginning as of the first of the day of the next Plan Year.

Failure to meet the enrollment deadlines above will result in your inability to enroll in the Plan until the following Annual Enrollment Period.

## H. Coverage During Leave of Absence

### Military Service

If you will be absent due to "uniformed service," as that term is defined by USERRA, you should contact your local Human Resources representative to discuss how this will impact your benefits under each Program. If you qualify, you may elect to continue participation in the Plan up to twenty-four (24) months (or until you fail to apply for reinstatement or return to employment with the Company within the required timeframes). Any period of unpaid leave of absence subject to USERRA will be excluded from the applicable Measurement Period. This ensures that any period of unpaid leave you take under USERRA does not count against you in determining whether or not you are eligible for health benefits. You are responsible for making the required employee contributions during the period in which you are in "uniformed service." Your local Human Resources representative can explain how to make contributions while you are away.

### Contributions During FMLA Leave

If you take an unpaid leave of absence under the FMLA, this period of absence will be excluded from the applicable Measurement Period for group health coverage. This ensures that any period of unpaid leave you take under FMLA does not count against you in determining whether or not you are eligible for group health coverage. Please note that once FMLA is exhausted, if you continue on a leave of absence, the period of leave after the FMLA will be included in determining your average Hours of Service. If you elect to continue participation under the Plan, you are responsible for making your required contributions toward the cost of any Programs in which you participate. Contact your local Human Resources representative for information on how to make these payments.

### Employee Responsibility for Premium Contributions

If you temporarily cease to make timely payments for your contributions under a Program, either through direct payment or payroll deductions, that coverage is subject to cancellation of coverage and loss of benefits. Employees on approved leaves of absence must make arrangements to pay premium contributions directly to the Western Operations center (WOC) Benefits Department, 4330 Park Terrace Drive, Westlake Village, CA 91361. As of the 91st day of any leave your benefits will be cancelled (unless extended by regulations due to specific circumstances) and, if applicable, you will be offered COBRA. Once you return to active duty your benefits can be reinstated although specific plans and premiums may differ depending upon assignment. Please contact your local HR representative for more information.

# VII. COBRA CONTINUATION COVERAGE FOR HEALTH CARE BENEFITS

A federal law, called the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires that group health plans provide the right to continue coverage for a limited time after the occurrence of certain events that cause a loss of coverage. This continued coverage under COBRA is referred to as "Continuation Coverage" in this SPD.

The Program Documents for each Program may include specific Continuation Coverage provisions applicable to that Program. You should consult the Program Documents for specific information related to that Program's Continuation Coverage provisions. This section describes the Continuation Coverage requirements as they apply generally to the Programs offered under this Plan.

COBRA applies to the medical, dental, and vision coverage.

## A. Qualifying Events

If you, your Spouse, or your Dependent children are enrolled in a Program that provides medical, dental, and/or vision coverage and you experience a "Qualifying Event" (defined below) that will cause a loss of coverage, then you, your Spouse and Dependent children are considered Qualified Beneficiaries entitled to elect Continuation Coverage. Note that Qualified Beneficiaries who elect Continuation Coverage must pay for it on an after-tax basis. A loss of coverage means that you have ceased to be eligible to participate in a Program under the same terms and conditions as in effect immediately before the Qualifying Event.

Qualifying Events under COBRA:

- For an Employee:
  - reduction in work hours to less than 30 hours weekly; or
  - termination of employment (except for gross misconduct).
- For a Spouse:
  - death of the Employee;
  - reduction in the Employee's work hours;
  - termination of the Employee's employment from the Company and its affiliates and subsidiaries (except for gross misconduct);
  - divorce or legal separation from the Employee (the filing of a petition for a divorce or legal separation is not sufficient; there must be a final court order);
  - the Employee's becoming entitled to Medicare; or
  - commencement of a Federal bankruptcy proceeding by or against the Company after the Employee's retirement.
- For a Dependent child:
  - his or her ceasing to qualify as a Dependent under the Plan;
  - death of the Employee;

- reduction in the Employee's work hours;
- termination of the Employee's employment from the Company and its affiliates and subsidiaries (except for gross misconduct);
- the Spouse's divorce or legal separation from the Employee (the filing of a petition for a divorce or legal separation is not sufficient; there must be a final court order);
- the Employee's becoming entitled to Medicare; or
- commencement of a federal bankruptcy proceeding by or against the Company after the Employee's retirement.

If a Qualifying Event is a participant's death, termination of employment (for reasons other than gross misconduct), reduction in hours of employment, entitlement to Medicare, or the bankruptcy of the Company, the Company will notify the Plan Administrator of that Qualifying Event within 30 days after the date of the Qualifying Event.

If the Qualifying Event is your divorce or legal separation or a Dependent child ceasing to be an eligible Dependent, you (or the affected Qualified Beneficiary) must notify the Plan Administrator of that Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date coverage under the Program would be lost.

Within 14 days after the Plan Administrator receives notification of a Qualifying Event, the Plan Administrator will notify each Qualified Beneficiary of the individual's right to elect Continuation Coverage.

## B. Electing COBRA Continuation Coverage

You, your Spouse and your Dependent children could become Qualified Beneficiaries if you are covered under the Plan on the day before the Qualifying Event and that coverage is lost because of the Qualifying Event. Qualified Beneficiaries also include any Children born to you or placed for adoption with you during the Continuation Coverage period.

Qualified Beneficiaries must make their elections no later than 60 days following the later of the date coverage ends or the date that they are sent the notice of right to elect Continuation Coverage. The elections must be submitted on an election form provided by the Plan Administrator, which will include the address where the form must be submitted.

Unless the election specifies otherwise, a participant's election of Continuation Coverage is deemed to include an election of Continuation Coverage on behalf of that participant's Qualified Beneficiaries who would lose coverage under the Plan because of the Qualifying Event. In addition, unless the election specifies otherwise, an election of Continuation Coverage by a Qualified Beneficiary who is a participant's Spouse is deemed to include an election of Continuation Coverage on behalf of the Spouse and the participant's other Qualified Beneficiaries who would lose coverage under the Plan because of the Qualifying Event. If a choice among types of coverage under the Plan is available, each Qualified Beneficiary is entitled to make a separate selection among the types of coverage.

An individual's election of Continuation Coverage is deemed to be made on the date the individual's election is sent to the address listed on the election form. If a participant or other Qualified Beneficiary waives Continuation Coverage during the election period, that waiver may be revoked at any time before the end of the election period. If any waiver is revoked before the end of the election period, however, Continuation Coverage under the Plan is effective

prospectively only, from the date the waiver is revoked.

If you get married during the Continuation Coverage period or acquire a child (whether through birth, adoption or otherwise) during the Continuation Coverage period, your Spouse or child is eligible to be enrolled as a Dependent. The standard enrollment requirements of the Plan apply to enrollees during the Continuation Coverage period.

A Domestic Partner does not have independent election rights under the rules for Continuation Coverage. But, if you have a Domestic Partner who is covered under the Plan and you both lose coverage due to your termination of employment or reduction in hours, you may elect to continue the coverage in effect for you and your Domestic Partner before the termination or reduction.

If the children of your Domestic Partner are covered under the Plan, then these children will be Qualified Beneficiaries in connection with the typical Qualifying Events that would cause them to lose coverage under the plan (e.g., your termination or death).

**Maximum COBRA Continuation Coverage Period**

| *Qualifying Event* | *Maximum Continuation Coverage Period – Medical, Dental and Vision* |
|---|---|
| • Employee's termination or reduction in hours to less than 30 hours weekly | • Employee – up to 18 months<br>• Spouse/Dependent Child – up to 18 months (may be extended to 29 months if disabled – see page 15) |
| • Divorce or Legal Separation<br>• Death of Employee<br>• Employee entitled to Medicare | • Spouse/Dependent Child – up to 36 months |
| • Loss of Dependent Child Status | • Dependent Child – up to 36 months |

The periods described above commence on the first day of the month following the Qualifying Event.

The extension to 29 months described in the chart is available if a Qualified Beneficiary is determined within the first 60 days of Continuation Coverage to be eligible for Social Security disability benefits under Title II or XVI of the Social Security Act. You must provide written notice to the Plan Administrator of the disability determination during the initial 18-month period as noted below. To be eligible for this 11-month extension:

- Your Qualifying Event must have been a termination of employment or reduction in hours.
- The disability must have started at some time before the 60th day of Continuation Coverage and last at least until the end of the 18-month period of Continuation

Coverage.

- A copy of the Notice of Award from the Social Security Administration is provided to the Claims Administrator within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA coverage.
- An increased premium of up to 150% of the monthly cost of coverage is paid, beginning with the 19th month of coverage.

If a Qualified Beneficiary is entitled to and elects Continuation Coverage that has a maximum period of 18 months or 29 months, and during that period experiences one or more Qualifying Events (not including the bankruptcy of the Company) which would entitle him or her to a maximum period of Continuation Coverage of 36 months, then the Continuation Coverage period is extended to 36 months from the date coverage was lost.

## C. Events That End Continuation Coverage

Certain events may cause the period of Continuation Coverage to terminate earlier than the end of the applicable 18-month, 29-month or 36-month period. Except as otherwise specified, a Qualified Beneficiary's Continuation Coverage will terminate immediately upon the occurrence of any of the following events:

- The individual becomes covered under any other group health plan (as an Employee or otherwise), provided that the other plan does not contain any exclusion or limitation with respect to any preexisting condition of such individual.
- The individual becomes entitled to Medicare under Title XVIII of the Social Security Act.
- The Company terminates the Plan.
- The individual fails to pay the required premium in a timely manner. If the premium payment is the first payment and if the election of Continuation Coverage occurs after the Qualifying Event, the premium payment may be made within 45 days after the election. A payment of any premium, other than the first premium, is considered to be timely if made within 30 days after the premium due date specified by the Plan Administrator, provided that coverage for the month may be terminated subject to reinstatement once the timely payment is received.
- The Company no longer sponsors or maintains any group health plan (including successor plans) for any of its Employees.
- A final determination is made that the individual is no longer entitled to Social Security disability benefits), in the case of an individual who is receiving extended Continuation Coverage under the 11-moth disability extension. Continuation Coverage for all Qualified Beneficiaries who are receiving coverage under the 11-month extension will end as of the later of first day of the month that begins more than 30 days after the date the final determination by the Social Security Administration and the end of the Continuation Coverage period that applies without regard to the disability extension. The individual must notify the Plan Administrator within 30 days following the determination that he or she is no longer disabled.

## D. Cost of Coverage

The monthly premium for Continuation Coverage can be no more than the full cost of your coverage plus a 2% administrative fee. However, if you are disabled (see above) and have extended the Continuation Coverage period beyond the initial 18-months based on disability, the monthly premium for Continuation Coverage can be no more than the full cost of your Coverage plus a 50% administrative fee. The election form will indicate the amount you are required to pay.

Initial payment is due within 45 days from the date that the enrollment form is mailed. The initial payment includes coverage for the current month plus any previous month(s). Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example the June payment is due June 1 but will be accepted if postmarked by June 30).

## E. Other Coverage Options Besides COBRA

Instead of enrolling in Continuation Coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than Continuation Coverage. You should compare your other coverage options with Continuation Coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it's important that you choose carefully between Continuation Coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

## F. Trade Adjustment Assistance

If you become eligible for trade adjustment assistance ("TAA") under the Trade Adjustment Assistance Reform Act of 2002, as reinstated and modified under the Trade Adjustment Assistance Reauthorization Act of 2015, because of your termination of employment or reduction in hours which resulted in your loss of coverage under the Plan, and you did not elect COBRA coverage during your initial COBRA election period, you may have a second 60-day COBRA election period to elect COBRA coverage for yourself and other Qualified Beneficiaries in your family. This second COBRA election period begins on the first day of the month in which you are determined to be eligible for TAA. However, your COBRA election must be made not later than 6 months after the date you lost coverage under the Plan. If you elect COBRA during the second election period, your COBRA coverage will begin on the first day of the second election period. If you elect COBRA Continuation Coverage during a special second COBRA election period, the maximum duration of your COBRA coverage will still be measured from the date you originally lost coverage. You must notify your local Human Resources representative if you become eligible for a special second COBRA election period.

## G. Cal-COBRA

Certain Programs may be subject to Cal-COBRA with respect to California Employees. For certain fully insured Programs in California, the Plan must offer any Qualified Beneficiary who is entitled to less than 36 months of Continuation Coverage under COBRA and has exhausted such coverage, the opportunity to extend coverage under Cal-COBRA to a total of 36 months from the date Qualified Beneficiary's Continuation Coverage began. Please refer to the Program

Documents for information regarding your rights and responsibilities under Cal-COBRA.

### H. New York State Continuation of Coverage

Certain Programs may be subject to New York State continuation of coverage with respect to New York Employees. For certain fully insured Programs in New York, if an individual has exhausted federal COBRA coverage under the Plan, he or she may receive an additional 18 months of continuation coverage under New York State law, up to a total of 36 months from the date federal COBRA continuation coverage began. Please refer to the Program Documents for information regarding your rights and responsibilities under New York State continuation of coverage.

## VIII. CLAIMS AND APPEAL PROCEDURES – GENERAL RULES

Each of the Programs under this Plan has different procedures for submission and review of claims. You should consult the Program Documents for each Program for details.

If you or your authorized representative file a claim under the Plan and your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the minimum requirements for a full and fair review under applicable federal regulations. The term “Claims Administrator” generally refers to any third party company that the Plan Administrator appoints to administer a Program and may be different for each Program. In certain cases the Plan Administrator may act as Claims Administrator for purposes of claims or appeals. Consult the Program Documents for each Program to determine who the Claims Administrator is for that Program.

## IX. CLAIMS AND APPEAL PROCEDURES – MEDICAL, DENTAL, AND VISION

Each of the Programs under this Plan has different procedures for submission and review of claims. You should consult the Program Documents for each Program for details. This section describes the minimum requirements for claims as required by Department of Labor Regulations Section 2560.503-1 for medical, dental, and vision claims. All grandfathered and non-grandfathered health plans follow the claims and appeal procedures below.

For the purposes of these claims and appeal provisions, “claim for benefits” means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.
- If the Plan has approved an ongoing course of treatment to be provided over a period of

time or for a specified number of treatments, this is known as a **concurrent care** decision.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the minimum requirements for a full and fair review under applicable federal regulations. The term “Claims Administrator” generally refers to any third party company that the Plan Administrator appoints to administer a Program and may be different for each Program. In certain cases the Plan Administrator may act as Claims Administrator for purposes of claims or appeals. Consult the Program Documents for each Program to determine who the Claims Administrator is for that Program.

## A. Pre-Service and Urgent Care Claims

If you file a pre-service claim and that claim is denied, the Claims Administrator will provide you with notice of the denial within a reasonable period appropriate to the medical circumstances, but no later than 15 days after its receipt of the claim. If special circumstances require a 15-day extension of time to review your claim, the Claims Administrator will notify you of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 15-day period. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required, you will be given at least 45 days to provide the information. The deadline for making a decision on your claim will then be extended for 45 days or, if shorter, for the length of time it takes you to provide the additional information.

If you file an urgent care claim, the Claims Administrator will notify you of any determination on the claim (whether favorable or unfavorable) as soon as possible, but no later than 72 hours after receipt of your claim. If you do not provide sufficient information to determine whether benefits are payable, the Claims Administrator will notify you as soon as possible, but no later than 24 hours after receipt of your claim. You will be given at least 48 hours to provide the necessary information. The Claims Administrator will notify you of its determination (whether favorable or unfavorable) as soon as possible, but no later than 48 hours after receipt of the additional information required (or, if earlier, the date by which the additional information was required to be submitted). If the Claims Administrator denies your claim, it may provide you notice orally, provided that it provides you written notification within 3 days after the oral notification.

If you attempt to file an urgent care or pre-service claim, but you do not properly follow the Plan’s procedures, you will be notified of the failure and of the proper procedures for filing a pre-service claim. This notification will be given, orally or in writing, no later than 5 days after your initial attempt to file a claim (or 24 hours in the case of an urgent care claim). You will be considered to have attempted to file an urgent care or pre-service claim if you have communicated with the Claims Administrator and you have named a specific medical condition, symptom, treatment, service, or product for which you are seeking approval.

## B. Concurrent Care Claims

Concurrent care decisions are subject to special rules. First, any "reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments" is treated as an adverse benefit determination subject to appeal. In addition, a request to extend the period or number of treatments is treated as a claim**.**

If you file a concurrent claim for benefits that is denied, the Claims Administrator will send a notice of denial to you as soon as possible, but in no more than 24 hours following receipt of your claim it is for an urgent extension of concurrent care and the request is made within 24 hours of the end of the period or the number of treatments. Otherwise, the concurrent care claim is treated as an urgent care or pre-service claim, whichever is applicable.

## C. Post-Service Claims

If you file a post-service claim and that claim is denied, the Claims Administrator will notify you of the denial no later than 30 days after its receipt of your claim. If special circumstances require a 15-day extension of time to review the claim, the Claims Administrator will notify you of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 30-day period. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required, you will be given at least 45 days to provide the information. The deadline for making a decision on your claim will then be extended for 45 days or, if shorter, for the length of time it takes you to provide the additional information.

## D. Notice of Adverse Benefit Determination

If your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the claims administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on

medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and

- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and

- the Claims Administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

## E. Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

## F. Mandatory First Level Appeal

The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;

- the date (s) of the medical service;

- the specific medical condition or symptom;

- the provider's name;

- the service or supply for which approval of benefits was sought; and

- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing, except where the acceptance of

oral appeals is otherwise required by the nature of the appeal (e.g. urgent care).

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. “Relevant” means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or concur
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan’s policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

## G. How Your Appeal Will Be Decided

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

## H. Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

## I. Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the claims administrator will include all of the information set forth in the above subsection entitled “Notice of Adverse Benefit Determination.”

## J. Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

## K. External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to the Claims Administrator within four (4) months following the notice of your final internal adverse determination.

You may not request an External Review of a decision that you are ineligible for coverage under the terms of the Plan.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator’s internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator’s decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider’s name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement.

If your request is complete and eligible, the Plan will assign an accredited independent review organization ("***IRO***") to conduct the external appeal. Within five business days after the ***IRO*** is assigned to your external appeal, the Plan must provide the ***IRO*** with the documents and any information considered in making the decision you are appealing. If the Plan fails to timely provide the documents and information, the ***IRO*** may terminate its review and reverse the decision you are appealing. The ***IRO*** will notify you and the Plan of this decision within one business day after making the decision.

If the Plan does timely provide the documents and information, you may submit additional information in writing to the ***IRO*** that the ***IRO*** must consider when conducting the external appeal. You must submit any additional information within 10 business days after you are notified that your request for an external appeal is complete and eligible. The ***IRO*** will forward any additional information you submit to the Plan within one business day of its receipt. Upon receipt of any such information, the Plan may reconsider your claim. The Plan's reconsideration will not delay the ***IRO's*** review. The Plan may terminate the ***IRO's*** review if it decides to reverse the decision you are appealing and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to you and the ***IRO***. Upon receipt of such notice, the ***IRO*** will end its review.

The ***IRO*** will review your claim without giving any effect or regard to the previous decisions. In addition to the documents and information provided, the ***IRO*** may consider the following in reaching a decision:

- your medical records;
- your attending healthcare professional's recommendation;
- reports from appropriate healthcare professionals and other documents submitted by the Plan, you, or your treating provider;
- the terms of the Plan;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- any applicable clinical review criteria developed and used by the Plan; and
- the opinion of the ***IRO's*** clinical reviewer or reviewers.
- You will receive notice of the ***IRO's*** decision within 45 days after the ***IRO*** receives your request for an external appeal. The ***IRO*** must deliver the notice of its decision to you and the Plan. The ***IRO's*** decision notice will contain:
- A general description of the reason for your request for an external appeal, including information sufficient to identify your claim (including the date or dates of service, the healthcare provider, the claim amount (if applicable), and the reason for the previous denial);
- The date the ***IRO*** was assigned to conduct the external appeal and the date of the ***IRO's*** decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

The diagnosis and treatment codes and their corresponding meanings are available upon request.

If the ***IRO*** reverses the decision you are appealing, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits).

After the ***IRO's*** decision, the ***IRO*** will maintain records of all claims and notices associated with your external appeal for six years.

Your decision to seek External Review will not affect your rights to any other benefits under the Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or Section 502(a) of ERISA.

# X. CLAIMS AND APPEAL PROCEDURES – DISABILITY BENEFITS

This section describes the minimum requirements for claims as required by Department of Labor Regulations for claims in which eligibility for a benefit is conditioned upon a finding of disability by the Claims Administrator (e.g., STD Program).

## A. Disability Claims

If the Claims Administrator denies your claim, in whole or in part, the Claims Administrator will notify you of the denial within 45 days after the Claims Administrator's receipt of your claim. If special circumstances require an extension of time, the Claims Administrator will notify you prior to the termination of the initial 45-day period which explains the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to decide your claim. The notice will also explain the standards on which entitlement to a Benefit is based, any unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. There may be up to two extensions of 30 days each, for a maximum of 105 days. In the case of a second 30-day extension, you will receive notice of the second extension (as described above) prior to the end of the first 30-day extension. In the case where you are required to provide additional information, you will be provided at least 45 days within which to provide the additional information.

Any adverse benefit determination will be in writing and include:

- specific reasons for the decision;
- specific references to the Policy provisions on which the decision is based;

- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

- a description of the review procedures and time limits applicable to such procedures;

- a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal; and

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request; or

- if denial is based on medical judgment, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

## B. Appeals

You may request review of a denied claim for disability benefits at any time within 180 days following the date you received written notice of the denial. If you do not file a request for review within 180 days, you waive your right to request a review of the denial of the claim for disability benefits. You must request review in writing to the Claims Administrator and must state your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, the reason(s) for disputing the denial, and any other information as the Claims Administrator may reasonably require in order to make a determination upon review of the claim.

During the appeal process, you have the right to request reasonable access to and copies of all documents, records and other information relevant to your claim (free of charge), including the identity of those medical experts whose advice was obtained in connection with your claim. You also have the right to submit written comments, documents, records and other information relating to your claim.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Claims Administrator will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Claims Administrator grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

The Claims Administrator will notify you of its decision on appeal within 45 days following receipt of the request for review. The period for decision may be extended to a date not later than 90 days after the Claims Administrator's receipt if the Claims Administrator determines that special circumstances require extension. If special circumstances require an extension of time, the Claims Administrator will notify you in writing prior to the termination of the initial 45-day period.

The notice will explain the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to decide your appeal.

### C. Disability Determinations Under Non-STD/LTD Programs

In the case of any Program other than a STD or LTD Program, if the Program provides that eligibility for a benefit is conditioned upon a finding under the Company's long-term disability plan or by the Social Security Administration that the claimant is "disabled," the claim will be governed by the general claims procedures described in the next section instead of the disability claims procedures.

## XI. CLAIMS AND APPEAL PROCEDURES – NON-HEALTH/NON-DISABILITY BENEFITS

This section describes the minimum requirements for claims as required by Department of Labor Regulations Section for claims that are not governed by the health and disability procedures described in the previous two sections. These Programs include the Life, AD&D, Business Travel Accident Insurance and the Employee Assistance Programs.

### A. General Claims Process

If the Claims Administrator denies your claim, in whole or in part, the Claims Administrator will notify you of the denial within 90 days after the Claims Administrator's receipt of the claim, or within 180 days after the Claims Administrator's receipt if special circumstances require an extension of time. If special circumstances require an extension of time, the Claims Administrator will notify you of the extension prior to the end of the initial 90-day period. The notice of extension will explain the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to decide your claim.

### B. Appeal

You may request review of a denied claim at any time within 60 days following the date you received written notice of the denial. If you do not file a request for review within 60 days, you waive your right to request a review of the denial of the claim. You must request review in writing to the Claims Administrator and must state your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, the reason(s) for disputing the denial, and any other information as the Claims Administrator may reasonably require in order to make a determination upon review of your claim.

During the appeal process, you have the right to request reasonable access to and copies of all documents, records and other information relevant to your claim (free of charge). You also have the right to submit written comments, documents, records and other information relating to your claim.

Unless special circumstances require an extension of time for processing, the Claims Administrator will notify you of its decision on review within 60 days after receipt of the written request for review. If an extension is necessary due to special circumstances, the Claims Administrator will notify you of the required extension prior to the expiration of the initial 60-day period. The notice will indicate the circumstances requiring the extension and the date by which the Claims Administrator expects to decide your appeal. The extension may be for up to 60

additional days.

# XII. CLAIMS – ADDITIONAL RULES

## A. General Rules

The following general rules apply to all claims:

- All claims for benefits under any Program are subject to any review procedures established for the Program by the Plan Administrator or applicable Claims Administrator.

- Unless claims are submitted by the provider, you must submit written proof of your claim to the Claims Administrator for that Program within 12 months following the end of the Plan Year during which the expense is incurred (unless it is not reasonably possible to do so and you furnish proof as soon as reasonably possible).

- A claimant is entitled to designate in writing an authorized representative to act on his or her behalf in pursuing a claim under the Plan. The Plan Administrator or Claims Administrator may require that the designation be made on a specific form.

- Before approving any claim under the Plan, the Plan Administrator or the Claims Administrator may request, and shall be entitled to receive (to the extent lawful) from any health care providers, such information and records relating to attendance to, examination of, or treatment provided to a claimant as may be required in the administration of such claims. The Plan Administrator or the Claims Administrator may also require that a claimant be examined by a dentist or physician or other appropriate provider or consultant retained by the Plan Administrator or the Claims Administrator in or near the claimant's community of residence. This may be done as often as the Plan Administrator or Claims Administrator may reasonably require. Payment of benefits is conditioned upon the Plan Administrator's right to require the examination of any participant or Dependent whose loss is the basis for a claim and to perform an autopsy where not forbidden by law.

- You may not file suit under ERISA against the Plan with respect to any benefit claim until you have exhausted all administrative procedures outlined above and those established under any Program in accordance with the procedures and timeframes set forth above and in the applicable Program. In addition, you may not file suit at all after one year has passed from the time your final appeal is denied. If you do file a claim under ERISA, the evidence presented will be limited to the evidence timely presented to the Claims Administrator.

- If the Plan fails to follow the internal claims and appeals process, you may request a written explanation of the violation from the Plan. The Plan will provide the explanation within 10 days of your request, including a specific description of the Plan's basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

- For violations of the internal and external appeals process, other than *de minimus* violations, you may skip the internal review process and proceed with an external appeal, if your claim is eligible for external appeal, or you may take legal action. If the external reviewer or court rejects your request for immediate review on the basis that the Plan has followed the appeals process or on the basis that the violations were *de minimums*, you may pursue an internal appeal of your claim. The Plan will notify you of your opportunity to

resubmit and pursue the internal appeal of your claim within 10 days of the external reviewer or court's decision.

- The Plan Administrator and Claims Administrator may act through one or more delegates.

## B. Deadline for Legal Action

If your claim for benefits under the Plan is denied and you file and appeal (as described in the sections above on Claims and Appeals) and you wish to seek a judicial review of any adverse benefit determination, you must file a civil action under Section 502(a) of ERISA no later than the earlier of:

- one year after the date the final decision on the adverse benefit determination on review is issued or should have been issued in accordance with the terms of the Plan; and

- the last day on which the claimant could commence a legal action under the applicable statute of limitations under ERISA (including any applicable state statute of limitations that applies under ERISA).

In reviewing a claim, the Plan Administrator or other person authorized to review the claim is permitted to deny the claim if it is time-barred pursuant to the filing deadlines described in this section on Deadlines for Legal Action.

## C. Claim Overpayments

The Plan Administrator has the power and authority to collect from you (or any other claimant or service provider, including any Claims Administrator) the amount of any overpayment relating to a claim for benefits made under this Plan. An overpayment may be collected regardless of whether the overpayment results from a mistake on the part of a claimant, an administrative error made by a service provider, or from a fraudulent act on the part of a claimant or service provider.

The Plan Administrator may take any of the following steps (without limitation) in response to a verified overpayment of any claim for benefits under this Plan:

- Request repayment from you (or your Dependent if applicable), or from the service provider or other payee;

- Offset the amount of the overpayment against further approved claims to you and your enrolled Dependents (or to your service provider or other payee);

- Pursue collection of the overpayment through legal procedures.

If you or your Dependent fails to respond or comply with a request from the Plan Administrator for repayment, the Plan Administrator may, in its sole discretion, and upon proper notification and in compliance with applicable law, terminate your eligibility to participate in the Plan.

## D. Subrogation and Reimbursement

If you or your Dependent suffer an illness or injury for which you obtain health care or other goods or services covered by the Plan and that illness or injury occurred through the negligence or willful act or omission of another person, benefits provided under this Plan with respect to that

illness or injury will be considered advancements to the extent of any amounts paid to, or for the benefit of, you or your Dependent as a result of any settlement or judgment you or your Dependent receive from that other person.

The Plan Administrator in its discretion may deny payment of benefits otherwise provided under this Plan with respect to that illness or injury, unless you or your Dependent signs a repayment agreement confirming the right of the Plan to receive repayment in full for any such benefit payments. If you or your Dependent acquires any rights of recovery against another for negligence or a willful act or an omission resulting in an illness or injury for which benefits are provided under this Plan, the Plan will be subrogated to those rights, and will be entitled to reimbursement for payments under the Plan to the extent of any settlement or judgment. This also applies to payments received by the parents or legal guardians in the event the Dependent is a minor or the heirs, administrators, or executors of the estate, when applicable. This right includes, but is not limited to, the covered person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage or other insurance, as well as your rights under the Plan to bring an action to clarify your rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

By accepting benefits (either directly or indirectly) under this Plan, you and your Dependents are considered to have assigned any rights of recovery to the Plan Administrator and to have agreed to do whatever is necessary to secure recovery, including to:

- Cooperate fully with the Plan Administrator in obtaining information about the loss and its cause;
- Notify the Plan Administrator of any claim for damages made, or lawsuit filed, on behalf of the Participant or Dependent in connection with the loss;
- Include the amount of benefits paid by the Plan on behalf of you or your Dependent in claims for damages against other parties;
- Provide the Plan Administrator with a lien to the extent of the cash value of the services and supplies provided (which such lien may be filed with the person whose act caused the Injuries, such person's agent, or a court having jurisdiction in the matter);
- Reimburse the Plan Administrator for any damages collected to the extent of the cash value of the services and supplies immediately upon collection of damages, whether by settlement, judgment, or otherwise (whereby the Plan Administrator shall be reimbursed first from any settlement or judgment, and if any balance then remains, it shall be given to you or your Dependent, as applicable);
- Pay to the Plan Administrator all costs and expenses, including attorney's fees, which shall be incurred or expended by the Plan Administrator in obtaining, or attempting to obtain, payment from you or your Dependent if you or your Dependent fails or refuses to reimburse the Plan Administrator as required under the Plan;
- Permit the Plan Administrator to file a lawsuit in the name of you or your Dependent against the person whose act caused the illness or injury;
- Notify the Plan Administrator of a proposal settlement at least thirty (30) days before any

claim or lawsuit is settled in regard to the loss;

- Sign any documents necessary to accomplish the purposes described above; and
- Cooperate with the Plan Administrator to accomplish purposes described above.

## XIII. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A QMCSO is an order from a court or state agency (including a National Medical Support Notice) that creates or recognizes the existence of an alternate recipient's right, or assigns to an alternate recipient the right, to receive benefits for which a participant or Dependent is eligible under this Plan. For example, if you and your Spouse divorce, you could be ordered by a court to provide health coverage for your child, even though he or she is in your Spouse's custody.

The QMCSO must:

- clearly specify the name and the last known mailing address (if any) of the participant (you) and the name and mailing address of each child covered by the order;
- provide a reasonable description of the type of coverage to be provided by the applicable Program to each child, or the manner in which the type of coverage is to be determined;
- clearly specify the period during which coverage is to be provided;
- state each Program to which the order applies; and
- not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, (except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act).

The order must be submitted to the Benefits department.

You will be notified, along with each alternate recipient (and his or her custodial parent or guardian) of the receipt of the order and the Plan's procedures for determining whether medical child support orders are QMCSOs.

## XIV. HEALTH PRIVACY

A federal law called the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the regulations promulgated thereunder at 45 C.F.R. Parts 160 and Part 164, Subparts A, C, D and E, requires that we give you notices about certain very important provisions in the Plan. These notices follow.

- The first notice describes how medical information about you may be used and disclosed, and how you can get access to this information. This notice is referred to as the "Notice of Privacy Practices" or the Plan's "Privacy Notice".
- The second notice explains your right to enroll in the Plan under its "special enrollment provision" if you acquire a new dependent or if you decline coverage under this Plan for yourself or an eligible dependent while other coverage is in effect and the covered person later loses that other coverage for certain qualifying reasons. Please review

these notices carefully.

## A. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by the Company. The term individually identifiable health information means information that:

- Is created or received by a healthcare provider, health plan, employer or healthcare clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual; and
- Identifies the individual, or there is a reasonable basis to believe that the information can be used to determine the identity of the individual.

This information is known as protected health information ("***PHI***"), and, as illustrated above, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication.

This notice describes the privacy practices of all the Company health plans. Understanding what PHI is and how it is used will help you make more informed decisions if you are asked to sign an authorization to disclose your PHI to others, as required by HIPAA.

**Health information held by your employer in your employment records is not PHI.**

*The privacy policy and practices described in this notice do not apply to health information that your employer or an employer -sponsored employee benefit plan holds in your employment records or in records relating to pre-employment screenings, such as disability benefits or claims, on-the-job injuries, Workers' Compensation claims, medical leave requests, return to work reports, life insurance, retirement benefits, accommodations under the Americans with Disabilities Act, or any other records that do not constitute PHI from the group health plans. These records may, however, be subject to other state and federal law.*

## B. Plan's Duties

The Plan is required by law to maintain the privacy and confidentiality of your ***PHI*** and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your ***PHI***. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not the Company as an employer — that's the way the HIPAA rules work. Different policies may apply to other Company programs that do not address ***PHI*** or to data that is not ***PHI***.

## C. Use of Your PHI

Generally, under HIPAA, the Plan may only use and disclose your ***PHI*** with your authorization, subject to certain exceptions. These exceptions allow the Plan to use and disclose your ***PHI*** without your authorization for purposes of health care treatment, payment activities, and health care operations. Accordingly, the plans covered by this notice may share ***PHI*** with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

Here are some examples of how the Plan may disclose your ***PHI*** in each circumstance:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your ***PHI*** with physicians who are treating you.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of ***PHI*** used, disclosed or requested will be limited as required under HIPAA to the minimum necessary amount to accomplish the intended purposes of such disclosure. If the Plan uses or discloses ***PHI*** for underwriting purposes, the Plan will not use or disclose ***PHI*** that is your genetic information for such purposes.

## D. Sharing Your PHI with the Company

The Plan, or its health insurer or HMO, may disclose your ***PHI*** without your written authorization to the Company for plan administration purposes. The Company may need your ***PHI*** to administer benefits under the Plan. The Company agrees not to use or disclose your ***PHI*** other than as permitted or required by the Plan documents and by law. Certain Human Resources personnel are the only Company Employees who will have access to your ***PHI*** for plan administration functions.

Here's how additional information may be shared between the Plan and Company, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to the

Company if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to the Company information on whether an individual is participating in the Plan or has enrolled or dis-enrolled in an insurance option or HMO offered by the Plan.

## E. Other Allowable Uses or Disclosures

**As Required by Law.** The Plan must allow the U.S. Department of Health and Human Services to audit plan records. The Plan may also disclose your ***PHI*** as authorized and to the extent necessary to comply with workers' compensation or other similar federal laws (e.g., the Family and Medical Leave Act, and the Americans with Disabilities Act) and state law, as applicable.

**To People Involved In Your Care.** In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

**To Business Associates.** The Plan may disclose your ***PHI*** to the Plan's Business Associates. Each Business Associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your ***PHI***. An example of one of our Business Associates is a health insurance company who assists the Plan in plan administration activities.

**To Plan Sponsor.** The Plan may disclose to the Company (the "Plan Sponsor"), in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to the Plan Sponsor the fact that you are enrolled in, or de-enrolled from the Plan. The Plan may disclose your ***PHI*** to the Plan Sponsor for plan administration functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your ***PHI***. The Plan Sponsor must also agree not to use or disclose your ***PHI*** for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor.

The Plan also is allowed to use or disclose your ***PHI*** without your written authorization for the following activities:

| | |
|---|---|
| Workers' compensation | Disclosures to workers' compensation or similar legal programs that provide benefits for work- related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws |
| Public health activities | Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects |

| | |
|---|---|
| Victims of abuse, neglect, or domestic violence | Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, if: (i) if the disclosure is required by law; (ii) if you agree to the disclosure; (iii) if you do not agree to the disclosure, but the disclosure is authorized by law and the Plan believes, in its professional judgment, that such disclosure is necessary; or (iv) you are not able to agree due to incapacity, and the Plan receives assurances from law enforcement that the disclosure sought will not be used against you, and that waiting to obtain your authorization would significantly impede an ongoing investigation |
| Judicial and administrative proceedings | Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your ***PHI*** that efforts were made to notify you or to obtain a qualified protective order concerning the information) |
| Law enforcement purposes | Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises |
| Decedents | Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties |
| Organ, eye, or tissue donation | Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death |
| Research purposes | Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your ***PHI*** and the confidential treatment of the information during a research project |
| Health oversight activities | Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which ***PHI*** is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws |
| Specialized government functions | Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates |
| HHS investigations | Disclosures of your ***PHI*** to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule |

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those

communications. If we keep psychotherapy notes in our records, we will obtain your authorization before we release those records, subject to few exceptions (e.g., defending ourselves in a legal action). The Plan will never sell your ***PHI*** unless you have authorized us to do so. You may revoke your authorization as allowed under HIPAA. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured ***PHI*** as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your ***PHI*** in a manner that could compromise the privacy of your ***PHI***.

## F. Your Individual Rights

As more fully set forth below, you have the following rights with respect to your ***PHI***.

In many cases, your ***PHI*** is created or maintained by third parties, known as the Plan's Business Associates, and you may be asked to contact them directly regarding the exercise of your rights. To exercise any of these rights, the corresponding request form must be completed, signed and submitted to:

Veronica Miller
Privacy Officer
Benefits Department
veronica.miller@securitasinc.com

Requests that do not follow these guidelines may be denied. Your legal rights include the:

**Right to Access.** With some exceptions, you have the right to review and copy your ***PHI***. We may charge a reasonable fee for the cost of copying, mailing, or other supplies associated with your request.

**Right to Amend.** You have the right to request an amendment of your ***PHI*** when it is incorrect or incomplete. This right exists as long as we keep this information in a designated record set.

**Right to an Accounting of Disclosures.** You have the right to obtain a listing of those to whom we have disclosed your ***PHI***. This right applies to disclosures other than those made for treatment, payment, healthcare operations, and those that you specifically authorized. You can request an accounting for up to six years prior to the date of the request. The first request in a 12-month period is provided at no cost to you. There may be a charge for subsequent requests within the same 12-month period.

**Right to Request Restrictions.** You have the right to request restrictions on the use or disclosure of your ***PHI***. We will comply with all approved requests except for in certain limited situations (e.g., emergencies). We will provide you with a written explanation for denied requests or when we revoke a previously agreed to restriction. You have the right to restrict disclosure related to treatment that has already been paid in full.

**Right to Request Confidential Communications.** You have the right to request that communication with you be conducted in a particular manner or be directed to a certain location. We will attempt to accommodate all reasonable requests.

**Right to a Paper Copy of this Notice**. You may request a paper copy of this Notice at any time.

**Right to Require Written Authorization**. Any uses or disclosures of your ***PHI***, other than those described above will be made only with your advance written authorization, which you may grant or revoke at any time.

### G. Changes to the information in the Privacy Notice

The Plan is required to abide by the terms of this notice as currently in effect. The Plan reserves the right to change the terms of this notice and to make such revised notice provisions effective for all ***PHI*** that the Plan, and/or its business associates, maintains. The Plan will make any revised notices available to you via the Company portal and intranet and distributed during Annual Enrollment.

### H. Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You can send a written complaint to the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. You won't be retaliated against for filing a complaint. You are also permitted to send written complaints to the Securitas Privacy Officer, Benefits Department, Securitas Security Services USA, Inc., 4330 Park Terrace Drive, Westlake Village, CA 91361.

### I. Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Veronica Miller, Privacy Officer, Benefits Department at 1-818-706-6800.

## XV. NOTICE OF SPECIAL ENROLLMENT RIGHTS

### A. Loss of Other Coverage

If you decline enrollment in the Plan for yourself or for an eligible dependent (including your Spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment in the Plan within 30 days after the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

### B. New Dependent by Marriage, Birth, Adoption or Placement for Adoption

In addition, if you have a new dependent as the result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in the Plan due to that event. However, you must request enrollment in the Plan within 30 days after the date of the marriage, birth, adoption or placement for adoption.

### C. Medicaid / State Children's Health Insurance Program

The Plan must allow a HIPAA special enrollment for Employees and Dependents who are eligible but not enrolled if they lose Medicaid or a state Children's Health Insurance Program

(CHIP) coverage because they are no longer eligible, or they become eligible for assistance under Medicaid or CHIP. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan.

### D. For More Information

To request special enrollment or obtain more information about HIPAA special enrollment rights, contact your local Human Resources representative or Veronica Miller, HIPAA Privacy Officer. (See above for contact information.)

## XVI. FEDERAL LAWS PROTECTING WOMEN AND NEWBORNS

### A. Newborns and Mothers Health Protection Act

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

### B. Women's Health and Cancer Rights Act

Group health plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy must provide, in a case of a participant, Spouse, or Dependent who is receiving benefits in connection with a mastectomy, coverage for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of mastectomy, including lymphedemas

in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage must be delivered to the participant upon enrollment and annually thereafter.

## XVII. PLAN ADMINISTRATION

The administration of the Plan and each Program is under the supervision of the Plan Administrator, who has the sole discretion and authority to interpret and administer the Plan and each Program in all of their details. The determination of the Plan Administrator (or its delegate) as to any question involving the administration and interpretation of the Plan is final, conclusive,

and binding on individuals claiming a benefit under the Plan.

## A. Amendment and Termination of the Plan and Programs

The Company intends to continue the Plan and each Program indefinitely. However, the Company reserves the right to modify, amend, or terminate the Plan, or any Program under the Plan, at any time and for any reason. You will be notified of any material changes to the Plan or any Program in which you are enrolled.

## B. Refund of Premium Contributions

For fully insured Programs, the Plan will comply with DOL guidance regarding refunds (e.g. medical loss ratio rebates) of insurance premiums. Where any refund is determined to be plan assets to the extent amounts are attributable to participant contributions, such assets will be: (1) distributed to current plan participants within 90 days of receipt, (2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or (3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

## C. Compliance with Other Applicable Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats and other formats).

The Company provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact Alight at 1-855-896-7455.

If you believe that the Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Name: Rita Moore
Phone: 818-706-4165
Fax: 818-706-5035
Email: Rita.moore@securitasinc.com

If you need help filing a grievance, Rita Moore is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019
TTD: 800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

### D. Non-Assignability of Benefits

Benefits under the Plan are not in any way subject to the debts or other obligations of you, your Dependents, or your beneficiaries. You may not voluntarily or involuntarily sell, transfer, or assign your benefits under the Plan.

## XVIII. LIMITATION OF RIGHTS

The Plan, this SPD, and the Program Documents for each Program describe the benefits for which you may be eligible as a Security Officer. However, neither the establishment of the Plan, nor any amendment thereof, nor the payment of any benefits, will be construed as giving you or any other person any rights against the Company nor the Plan Administrator, except with respect to the benefits provided under the Plan.

Neither the Plan nor any Program is a contract of employment between you and the Company or is to be consideration or an inducement for your employment. Nothing in the Plan or any Program gives you the right to be retained in the service of the Company or any other right with respect to the Company's right to discharge its Employees.

Your rights (and the rights of your Dependents and beneficiaries) to benefits under the Plan are conditioned upon provision to the Company and Plan Administrator of such information, evidence, and signed documents as may reasonably be requested by the Company, the Plan Administrator, and any Claims Administrator (or any delegate thereof) from time to time for the purpose of administration of the Plan.

## XIX. STATEMENT OF ERISA RIGHTS

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

### A. Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report

(Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

## B. Continue Group Health Plan Coverage

Continue health care coverage for your Dependents if there is a loss of coverage under a Program that constitutes a group health plan as a result of a Qualifying Event. You and your Dependents must pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion (but only to the extent such preexisting condition exclusion is permitted under applicable law) for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## C. Prudent Actions by Plan Fiduciaries

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

## D. Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you to up $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are

discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

## E. Assistance with Your Questions

If you have any questions about your Plan, you should contact your Local Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Sponsor, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# XX. IMPORTANT INFORMATION ABOUT THE PLAN

| | |
|---|---|
| Name of Plan | Securitas Security Services USA, Inc. Health and Welfare Benefit Plan<br><br>Securitas Security Services USA, Inc. Flexible Benefits Plan for Security Officers |
| Plan Sponsor | Securitas Security Services USA, Inc. c/o Benefits Department<br><br>4330 Park Terrace Drive<br>Westlake Village, CA 91361 |
| Plan Administrator | *Executive Compensation & Benefits Review Committee of Securitas Security Services USA, Inc.*<br>c/o Benefits Department<br>4330 Park Terrace Drive<br>Westlake Village, CA 91361<br><br>Telephone No.: 818-706-6800 |
| Employer Identification Number | 71-0912217 |
| Plan Number | 502 |
| Type of Plan | Health and welfare benefit plan. |
| Funding | Some Programs offered under the Plan are self-insured by the Company, while others are fully insured. For self-insured Programs, claims are paid from employee contributions from payroll deductions and employer contributions made from the Company's general assets. For fully insured Programs, claims are paid by the insurer. |
| Claims Administration | Claims are processed by a Claims Administrator which may be an insurance company. Detailed information about the services provided by the Claims Administrator may be found in the program materials provided at your site |

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|---|---|
| | by your local Human Resources representative. |
| Type of Administration | Self-administered with certain elements of contract administration and insurer/HMO administration |
| Plan Year | January 1 - December 31 |
| Agent for Service of Legal Process | Securitas Security Services USA, Inc.<br><br>As Sponsor, Securitas Security Services USA, Inc., Health and Welfare Benefit Plan National Registered Agents, Inc.<br>2030 Main St., Suite 1030<br>Irvine, CA 92614 |

# XXI. APPENDIX A – PROGRAM DOCUMENTS

This summary should be read in combination with the Program Documents provided by the Company, insurance companies and service providers. The Program Documents are intended to describe the benefits available to you as an Employee of the Company and, when read with this summary, are intended to meet ERISA's SPD requirements.

The Programs provided under the Plan are either self-insured or fully insured. Self-insured benefits are paid for out of the general assets of the Company and are not guaranteed under a contract or policy of insurance. Fully-insured benefits are provided through contracts with the insurance companies. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

Please refer to the applicable Program Documents for details about specific plan benefits. For additional information or for copies of the Program Documents, please contact the Plan Administrator.

| **Grandfathered Health Plans** | | |
|---|---|---|
| **COVERAGE** | **PROGRAM DOCUMENTS** | **FUNDING** |
| Medical | BlueCross BlueShield of Florida Blue Care HMO Plan | Fully Insured |
| Medical | BlueCross BlueShield of South Carolina PPO Plan | Fully Insured |
| Medical | Priority Health HMO Plan | Fully Insured |

**The Programs in the chart above are grandfathered health plans within the meaning of the Affordable Care Act and therefore are allowed to preserve certain basic health coverage that was in effect when the Affordable Care Act was enacted. This means that the grandfathered health plan may not include certain consumer protections that are required under the Affordable Care Act**

| Non-Grandfathered Health Plans | | |
|---|---|---|
| **COVERAGE** | **PROGRAM DOCUMENTS** | **FUNDING** |
| Medical | Anthem Secure Bronze | Self-Insured |
| Medical | Anthem Secure Silver | Self-Insured |
| Medical | Anthem Secure Care | Self-Insured |
| Medical | Anthem Secure Plus | Self-Insured |
| Medical | Anthem Secure Balance | Self-Insured |
| Medical | Kaiser Hawaii (HMO & POS) | Fully Insured |
| Medical | HMSA | Fully Insured |
| Medical | BlueCross BlueShield of South Carolina PPO Plan | Fully Insured |
| Medical | BlueCross BlueShield of Massachusetts HMO Blue 1000 Deductible | Fully Insured |

| | | |
|---|---|---|
| Medical | BlueCross BlueShield of Massachusetts HMO Options Tiered Deductible | Fully Insured |
| Medical | Highmark Blue Cross of Western Pennsylvania PPO Plan (*plan terminated effective 5/1/2017*) | Fully Insured |
| Medical | Kaiser California HMO Plan | Fully Insured |
| Medical | Kaiser Southern California Traditional HMO for Healthcare Division | Fully Insured |
| Medical | Kaiser Southern California Traditional HMO for Non-Healthcare Division | Fully Insured |
| Medical | Kaiser Southern California Deductible HMO | Fully Insured |
| Medical | Kaiser Northern California Traditional HMO for Healthcare Division | Fully Insured |
| Medical | Kaiser Northern California Deductible HMO for Non-Healthcare Division | Fully Insured |
| Medical | Kaiser Colorado HMO Plan | Fully Insured |
| Medical | Kaiser Group Puget Sound HMO Plan | Fully Insured |
| Medical | Kaiser Northwest (Oregon) HMO Plan | Fully Insured |

| | | |
|---|---|---|
| Medical | Medica | Fully Insured |
| Medical | MVP Health Care HMO Plan | Fully Insured |

**The Programs in the chart above are non-grandfathered health plans within the meaning of the Affordable Care Act. As a non-grandfathered health plan, these Programs must comply with all of the applicable provisions of the Affordable Care Act**

| **Other Plans** | | |
|---|---|---|
| **COVERAGE** | **PROGRAM DOCUMENTS** | **FUNDING** |
| Dental | Aetna Secure T | Self-Insured |
| Dental | Aetna DMO | Fully Insured |
| Dental | Delta Dental of California | Fully Insured |
| Dental | Hawaii Dental Service | Fully Insured |
| Vision | Vision Service Plan | Fully Insured |
| Long Term Disability | The Hartford Long Term Disability Insurance | Fully Insured |

| | | |
|---|---|---|
| Short Term Disability | The Hartford Short Term Disability Short Term Disability Insurance | Fully Insured |
| Basic Accidental Death & Dismemberment | The Hartford Basic Accidental Death and Dismemberment Insurance | Fully Insured |
| Basic Term Life Insurance | The Hartford Basic Term Life Insurance | Fully Insured |
| Voluntary Supplemental Life Insurance for Employee | The Hartford Supplemental Life Insurance | Fully Insured |
| Voluntary Supplemental Life Insurance for Spouse | The Hartford Supplemental Life | Fully Insured |
| Voluntary Supplemental Dependent Life Insurance | The Hartford Supplemental Dependent Life Insurance | Fully Insured |
| Business Travel Accident Insurance | Business Travel Accident Insurance | Fully Insured |

## XXII. APPENDIX B – CLAIMS ADMINISTRATOR OR INSURER

Below is a list of the claims administrators in charge or processing claims under the terms of the Plan. Please refer to applicable Program Documents for further information regarding the filing of a claim.

| MEDICAL PROGRAMS | |
|---|---|
| **CLAIMS ADMINISTRATOR/CARRIER** | **CONTACT INFORMATION** |
| Anthem Blue Cross Life and Health Insurance Company | 21555 Oxnard Street<br>Woodland Hills, CA 91367<br>1-855-593-8122<br>www.anthem.com/ca |
| Blue Cross and Blue Shield of Florida | 4800 Deerwood Campus Parkway<br>Jacksonville, FL 32246<br>1-800-352-2583<br>www.floridablue.com |
| Blue Cross and Blue Shield of Illinois | P.O. Pox 2401<br>Chicago, IL 60690-1364<br>1-800-541-2768<br>www.bcbsil.com/coverage |
| Blue Cross Blue Shield of Massachusetts | P.O. Box 9134<br>North Quincy, MA 02171-9134<br>1-800-358-2227<br>www.bluecrossma.com |
| BlueCross BlueShield of South Carolina | P.O. Box 100300<br>Columbia, SC 29202-3300<br>1-800-760-9290<br>www.southcarolinablues.com |
| Group Health Cooperative | P.O. Box 34585<br>Seattle, WA 98124-1585<br>1-888-901-4636<br>www.ghc.org |
| Highmark Blue Cross Blue Shield | P.O. Box 226<br>Pittsburgh, PA 15222<br>1-800-241-5704<br>www.highmarkbcbs.com |
| HMSA | P.O. Box 2001<br>Honolulu, HI 96805-2001<br>1-800-776-4672<br>www.hmsa.com |

| | |
|---|---|
| Kaiser Foundation Health Plan, Inc. (Northern California Region) | P.O. Box 12923<br>Oakland, CA 94604-2923<br>1-800-464-4000<br>www.my.kp.org/securitas |
| Kaiser Foundation Health Plan, Inc. (Southern California Region) | P.O. Box 7004<br>Oakland, CA 94604-2923<br>1-800-464-4000<br>www.my.kp.org/securitas |
| Kaiser Foundation Health Plan of Colorado | P.O. Box 373150<br>Denver, CO 80237-3150<br>1-800-249-5005<br>www.my.kp.org/securitas |
| Kaiser Foundation Health Plan, Inc. (Hawaii) | P.O. Box 378021<br>Denver, CO 80237<br>1-800-249-5005<br>www.my.kp.org/securitas |
| Kaiser Foundation Health Plan of the Northwest | P.O. Box 370050<br>Denver, CO 80237-9998<br>1-800-813-2000<br>www.my.kp.org/securitas |
| Medical Health Plans | P.O. Box 9310<br>Minneapolis, MN 55440-9310<br>1-800-952-3455<br>www.medica.com |
| MVP Health Plan | P.O. Box 2207<br>Schenectady, NY 12301-2204<br>1-888-687-627<br>www.mvphealthcare.com |
| Priority Health | P.O. Box 269<br>Grand Rapids, MI 49501-0269<br>1-800-446-5674<br>www.priorityhealth.com |

| DENTAL PROGRAMS | |
|---|---|
| **CLAIMS ADMINISTRATOR/CARRIER** | **CONTACT INFORMATION** |
| Aetna | 151 Farmington Avenue<br>Hartford, CT 06156<br>1-800-872-3862<br>www.aetna.com |
| Hawaii Dental Service (HDS) | 700 Bishop Street, Suite 700<br>Honolulu, HI 96813-4196<br>1-800-232-2533<br>http://www.HawaiiDentalService.com |
| Delta Dental | P.O. Box 537007<br>Sacramento, CA 95853-7007<br>800-765-6003<br>www.deltadental.com |

| VISION PROGRAM | |
|---|---|
| **CLAIMS ADMINISTRATOR/CARRIER** | **CONTACT INFORMATION** |
| Vision Service Plan (VSP) | 3333 Quality Drive<br>Rancho Cardova, CA 95670<br>1-800-877-7195<br>www.vsp.com |

| LIFE/AD&D/STD/LTD PROGRAMS | |
|---|---|
| **CLAIMS ADMINISTRATOR/CARRIER** | **CONTACT INFORMATION** |
| Hartford | P.O. Box 2999<br>Hartford, CT 06104-2999<br>1-888-523-2233<br>www.thehartford.com |

| EMPLOYEE ASSISTANCE PROGRAM | |
|---|---|
| **CLAIMS ADMINISTRATOR/CARRIER** | **CONTACT INFORMATION** |
| MHN | P.O. Box 10697<br>San Rafael, CA 94912<br>1-800-722-2922<br>www.mhn.com |

| BUSINESS TRAVEL ACCIDENT INSURANCE | |
|---|---|
| **CLAIMS ADMINISTRATOR/CARRIER** | **CONTACT INFORMATION** |
| Vision Service Plan (VSP) | 3333 Quality Drive<br>Rancho Cardova, CA 95670<br>1-800-877-7195<br>www.vsp.com |

| OTHER CLAIMS ADMINISTRATORS | |
|---|---|
| **CLAIMS ADMINISTRATOR** | **CONTACT INFORMATION** |
| COBRA Administrator | Alight<br>1-855-596-7455<br>www.yoursecurebenefitssolutions.com |
| Human Resources Representatives | Please contact your local human resources representative at your site. |