First American Financial Corporation

Group Life, Medical, Dental, Disability Benefit Plan

Health Plan Summary Plan Description

- This summary provides an overview of certain health plans ("Health Plans") of First American Financial Corporation Group Life, Medical, Dental, Disability Benefit Plan ("Master Plan") for eligible employees, and your rights and obligations under the Health Plans. However, because it is only a summary, it does not contain all of the details included in the legal documents governing the Health Plans under the Master Plan. This summary combines with each of Appendices A through E (medical plans), F (dental plan), and G (prescription drug plan) to serve as the summary plan description for each Health Plan for the purposes of ERISA. In case of a conflict between the information in this summary and an appendix hereto, this summary shall govern. In case of a conflict between the information in the summary plan description for each Health Plan and the Master Plan, the Master Plan shall govern.

- If a question arises as to the interpretation of the terms of the Health Plan portions of the Master Plan, the Administrative Benefits Plan Committee as Plan Administrator has the sole discretionary authority to interpret, construe and apply the terms of the Health Plans, and to decide any such question, including but not limited to, a question as to an employee's eligibility to participate in any Health Plan.

DATED JANUARY 1, 2023

Table of Contents

HIGHLIGHTS OF

FIRST AMERICAN FINANCIAL CORPORATION HEALTH PLANS

The Master Plan consists of a number of component plans intended to make certain welfare benefits available to eligible employees and their dependents.

This document is a summary of certain group health benefits available to eligible employees under the Master Plan that provide for medical, prescription drug and dental coverage ("Health Plans"). This summary describes features that are common to most or all of the Health Plans while Appendices A through E (medical plans), F (dental plan), and G (prescription drug plan) contain information specific to each Health Plan. This summary and Appendices A through E, F, and G combine to serve as the summary plan description for the purposes of ERISA. The appendices applicable to the Health Plans in which you enroll will also be provided to you.

The following Health Plans are included in this summary:

HEALTH PLAN	OPTIONS	FUNDING	INSURER OR THIRD PARTY CLAIMS ADMINISTRATOR
MEDICAL (Appendices A – E)	Five medical plan options:[1] • High HSA Plan • Low HSA Plan • High PPO Plan • Low PPO Plan • Out-of-Area HSA Plan	Self-Insured	Medical Management Program Administrator: Accolade, Inc. ("Accolade") Accolade, Inc. 660 W Germantown Pike Suite 500 Plymouth Meeting, PA 19462 (877) 684-4612 member.accolade.com Third Party Administrator for Health Plan Claims and Appeals: Meritain Health, Inc. ("Meritain") Meritain Health, Inc. P.O. Box 853921 Richardson, TX 75085-3921 (800) 925-2272

HEALTH PLAN	OPTIONS	FUNDING	INSURER OR THIRD PARTY CLAIMS ADMINISTRATOR
HEALTH SAVINGS ACCOUNT[2]	Permits contributions into savings account if criteria are met	N/A	Fidelity Investments Fidelity Investments 900 Salem Street Smithfield, RI 02917 1-877-208-0791 www.netbenefits.com/firstamerican
DENTAL (Appendix F)	Two dental plan options:[3] • High Plan • Low Plan	Self-Insured	CIGNA Health and Life Insurance Company ("CIGNA") CIGNA Dental Appeals P.O. Box 188044 Chattanooga, TN 37422-8044 1-800-244-6224 www.mycigna.com
PRESCRIPTION DRUG (Appendix G)	Prescription drug coverage	Self-Insured	CVS Caremark CVS Health One CVS Drive Woonsocket, RI 02895 1-888-543-5920 www.caremark.com

1 If you reside in Hawaii or have enrolled in a Kaiser medical plan, this summary plan description does not summarize the provisions of your coverage. Please see the Insured Health Plan Summary Plan Description for a summary of coverage available in Hawaii or through the Kaiser plans.

2 The Health Savings Account is not a Health Plan, is not a part of this summary plan description, and is not subject to ERISA. It is an account you may establish if you are enrolled in one of the Company's HSA eligible medical plans and is included in this table solely to provide you with contact information in a convenient location.

3 The zip code of your primary residence will determine whether your dental plan coverage is considered "in-area" or "out-of-area" coverage. This determination will be made at the time of your enrollment in the Dental Plan. The network of participating providers and the Contracted Fees for services will vary between in-area and out-of-area coverage. You may contact Cigna by calling toll-free at 1-800-244-6224 or visiting www.mycigna.com for more information about your in-area or out-of-area dental coverage.

The Company shares in the cost of medical, dental, and prescription drug coverage.

Please note that in this summary, references to "First American" refer to First American Financial Corporation and references to the "Company" refer to First American Financial Corporation and/or its affiliates who have adopted the Master Plan. Terms defined and used throughout this summary may also appear in one or more of the attached Appendices A through E, F, and G and will have the same meaning unless specifically noted otherwise. Understanding these terms will also help you understand how your Health Plan(s) works and provide you with useful information regarding your coverage.

This summary does not apply to other component plans included under the Master Plan not listed above. You may obtain a complete list of the Master Plan component plans and any applicable summary plan descriptions by contacting the Plan Administrator.

On January 1, 2021, Meritain replaced Aetna as third-party medical claims administrator for the self-insured Health Plans included under the Master Plan. As the plan's administrator, **Meritain** processes your medical claims and internal appeals, issues payments to providers, provides information about payments you may owe for medical services, and performs other administrative services for the plan. Although Meritain is the administrator, the Master Plan has retained the Aetna network of health care providers and facilities for in-network coverage under the Master Plan through the Plan's administrative services contract with Meritain.

In addition, the Accolade Benefit Navigation Services were added as a resource in 2021. Accolade is your first point of contact for most plan related matters and can help manage your medical benefits needs. Accolade also provides administrative services and manages certain processes under the Master Plan, such as the precertification process (expanded in 2021 to be required for certain services) and various clinical programs. You can work with an Accolade Health Assistant to answer your questions, resolve issues, and find the right care for you and your family. Behind the scenes, Accolade partners with **Meritain** and your providers to manage your medical claims administration needs arising under this plan.

If you have questions about one or more Health Plans that are not answered here, please contact **Accolade** to speak with an **Accolade** Health Assistant. **Accolade** is the Master Plan's medical management program administrator, and can be reached by using the contact information provided on your member ID card and also provided in the table above. You can also visit First American's myFA intranet site at www.myfaportal.com or contact FA Benefits at 1-866-677-2300 for more information.

Wellbeing Program

First American offers a voluntary wellbeing program called FA Wellbeing. The program allows you to earn rewards for the time and effort you invest in completing designated activities. FA Wellbeing offers a variety of simple programs, resources, tools and services focused on helping you and your covered family members improve and maintain your physical, mental, and financial health at no cost to you. You and your dependents are not required to participate in the program, but only employees who do so will earn rewards points. Covered family members are eligible to participate in the FA Wellbeing program but cannot earn or redeem rewards points.

In 2023, you can earn up to 450 ***fantastic*** points (worth a cash value of approximately $450 dollars) for completing a variety of activities with our wellbeing partners. To participate in the program, you must first complete the program's confidential wellbeing assessment, then rewards are earned by completing each of five levels of the program. Level 1: *Commit*, is completed when you reach 1,000 FA Wellbeing Rewards points, at which time you will be awarded 100 ***fantastic*** points (worth a cash value of approximately $100). Level 2: *Strive*, is completed when you reach 2,000 FA Wellbeing Rewards points, at which time you will be awarded an additional 100 ***fantastic*** points (worth a cash value of approximately $100). Level 3: *Achieve*, is completed when you reach 4,000 FA Wellbeing Rewards points, at which time you will be

awarded an additional 125 ***fantastic*** points (worth a cash value of approximately $125). Level 4: *Soar*, is completed when you reach 6,000 FA Wellbeing Rewards points, at which time you will be awarded an additional 125 ***fantastic*** points (worth a cash value of approximately $125). In addition, if you reach 8,000 FA Wellbeing Rewards points you will be inducted into the Hall of Fame and entered in a raffle for prizes. FA Wellbeing Rewards points earned during each year will not roll over into the next year, but you will retain ***fantastic*** points earned during each year according to the company's then-current policy. Your reward points can be redeemed for merchandise and gift cards at firstam.achievers.com.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard to earn the same incentive by different means. You may request such accommodation or alternative standard by contacting Benefits at fawellbeing@firstam.com or 800-854-3643 and we will work with you and, if you wish, your doctor to find a reasonable alternative that is right for you. For more information about specific FA Wellbeing programs and activities visit www.wellbeing.firstam.com.

ELIGIBILITY

Employees Hired on or Before October 3, 2021

If your most recent date of hire or rehire with the Company was on or before October 3, 2021, you are eligible to participate in a Health Plan in 2023 if you meet each of the following requirements:

- You are at least 18 years of age,
- You are employed by First American or an affiliated Company that participates in the Health Plan, and
- You worked, on average, at least 30 hours per week between October 3, 2021 and October 2, 2022.

Employees Hired on or After October 4, 2021

If your most recent date of hire or rehire with the Company was on or after October 4, 2021, you are eligible to participate in a Health Plan on the first day of the calendar month coincident with or following the date you meet the following requirements:

- You are at least 18 years of age,
- You are employed by First American or an affiliated Company that participates in the Health Plan, and
- You are regularly scheduled to work at least 30 hours per week, or you worked an average of at least 30 hours per week during your first 12 months of employment.

For purposes of the requirement to work at least 30 hours per week, your hours of work will include, for example, any hours for which you are entitled to payment due to vacation, holiday, illness, incapacity (including disability), layoff or furlough (for up to 13 weeks), jury duty, military duty, or leave of absence.

Employees Not Eligible

The following employees are not eligible to participate in the Health Plans:

- "Leased employees," as that term is defined under Internal Revenue Code §414(n)(2), and independent contractors providing services to the Company;

- Employees who are nonresident aliens and who receive no earned income from the Company that qualifies as income from United States sources;

- Employees the Company treats as seasonal employees. A seasonal employee is an employee whose employment does not exceed the specific duration of a business unit's pre-determined season. Generally the seasonal hiring period should not exceed 1559 hours or 6 months, whichever comes first; and

- Employees the Company treats as non-employees, even if a court or administrative agency determines that a person is a common law employee (including, for example, independent contractors, contract labor, consultants or advisors, leased employees, directors, and any person whose services are not compensated directly through the Company's payroll department).

When Your Spouse or Domestic Partner is Also an Eligible Employee

If you and your spouse or domestic partner are both eligible employees who may enroll in a Health Plan, you both may enroll separately as covered employees. Alternatively, one may enroll as an eligible employee with the spouse or domestic partner as a covered dependent. However, no eligible employee may enroll both as an eligible employee and as another employee's covered dependent. Any eligible dependents may enroll as a covered dependent of either spouse or domestic partner, but may not enroll as a covered dependent of both. Also note that complex tax rules apply for covering domestic partners; if you and your domestic partner are both eligible employees who may enroll, it may be tax advantageous for you each to enroll separately as covered employees rather than one as a dependent of the other. See "Taxation of Domestic Partner Benefits" below.

Change of Employment Status

Once you become eligible for the Health Plans, your eligibility continues until your employment with the Company ends, or until you transfer into an ineligible position (such as switching to seasonal status or failing to maintain the required hours of service in your work schedule). If you are eligible for coverage in 2023 and you switch to an ineligible position (such as switching to seasonal status or failing to maintain the required hours of service in your work schedule) in 2023, you will remain eligible for coverage for the remainder of the year regardless of the

number of hours you work during the year. However, you may be ineligible for coverage in 2024 as a result of your change in status, depending on the number of hours you work in 2023.

If you leave the Company and you are rehired more than 13 weeks later as an employee eligible to participate in the Health Plans, you may become eligible for the Health Plans under the same terms and conditions as for a new hire. If you are rehired no later than 13 weeks after your termination, your former eligibility status will be reinstated on the first of the month following your rehire date.

Transfers

If you transfer from a position that is ineligible for participation in the Health Plans or from a position with an affiliated company that does not participate in the Health Plan to an eligible position with the Company or a participating affiliate, you may become eligible for the Health Plans under the same terms and conditions as for a new hire.

Continuation Coverage and Post-65 Retiree Coverage Through Via Benefits

After your employment ends, you may elect COBRA continuation coverage as described under "Continuation Coverage" in this summary. After your continuation coverage ends, or if you do not elect continuation coverage, you are no longer eligible to participate in a Health Plan. Former employees and retirees are not eligible for Health Plan coverage. Medicare-eligible retirees may purchase individual medical, dental and/or vision coverage through Via Benefits, and retirees who are not yet eligible for Medicare may use the Via Benefits concierge service to shop for individual coverage through state health insurance marketplaces. Via Benefits is not an employer-sponsored health plan and does not provide you with access to employer sponsored health plans, but rather is a resource made available by First American to assist you with your individual health coverage needs in retirement. For more information, please contact Via Benefits at 1-844-686-0477 or email the Via Benefits support team at Via Benefits Support.

Dependent Eligibility

A dependent is:

- Your legally recognized spouse, regardless of sex or gender, as determined in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Internal Revenue Code and other federal laws applicable to the Health Plans;

- Your non-spouse domestic partner (see special rules for non-spouse domestic partners below);

- Your child, until the last day of the month in which the child reaches age 26;

- Your child, regardless of age, if the child has a permanent and total disability (which may be mental or physical) that started prior to the date the child reached the otherwise applicable maximum age for coverage under the Health Plan and the child is eligible for tax-free coverage as either your "qualifying child" or "qualifying relative" as set forth in Section 152

of the Code (but without regard to whether your dependent child's gross income is less than the IRS exemption amount);

- In general, your child is eligible for tax-free coverage if they reside with you for more than half the year and they do not provide more than one-half their own support. However, a child who does not reside with you may still be considered your "qualifying relative" if you provide sufficient support and they are not a qualifying child of any other taxpayer. See IRS Publication No. 501 for additional rules for how to determine whether your disabled adult child qualifies as your tax dependent.

- Proof of such disability must be provided to the claims administrator no later than 31 days after the child reaches the otherwise applicable maximum age for coverage under the Health Plan (or upon enrollment if you become eligible for the Health Plan with an otherwise eligible child);

- Your child's coverage under this special rule will end when the disability ends, when you or your child fail to provide proof that the disability continues when such proof is requested by the Health Plan, when your child fails to have an exam required by the Health Plan, or when your child stops being eligible for coverage for another reason; or

- A child who is the subject of a Qualified Medical Child Support Order/National Medical Support Order as verified by First American.

For purposes of the Health Plans, children include:

- Biological children;

- Legally adopted children;

- Stepchildren who reside with the employee; and

- Children under legal guardianship of the employee as deemed by a court order, including foster children and children placed with the employee for adoption, provided the child resides with the employee.

This definition will not be construed to include an unborn fetus.

A person is not a "dependent" if they are:

- On active duty in the military,

- Receiving coverage as an employee,

- No longer a spouse due to legal separation or divorce, or

- No longer a domestic partner due to termination of domestic partnership.

Your dependent becomes eligible for benefits at the same time as you do. If you do not enroll yourself in a Health Plan, your dependents cannot enroll in that Health Plan. Additionally, a person may only be enrolled as a "dependent" of one employee.

Non-Spouse Domestic Partner Eligibility

Your non-spouse domestic partner is a person eligible for coverage as your dependent provided that you and your domestic partner meet all of the following criteria:

- You have a common residence.
- Neither of you is married to or legally separated from anyone else, or is in a domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
- You are both at least 18 years of age.
- You are both capable of consenting to the domestic partnership.
- You are not related by blood in a way that would prohibit legal marriage in the state in which you legally reside.

Sex or gender is not a factor in determining who is eligible to enroll in a Health Plan as your domestic partner, as long as the above criteria are satisfied.

In order to enroll your domestic partner for coverage, you must do one of the following:

- Execute a domestic partner agreement, or
- Register as domestic partners in a jurisdiction which authorizes such agreements and/or registries, or
- Affirm that at least three of the following are true, in the manner prescribed by the Plan Administrator:
    - You and your domestic partner have lived together continuously for the past 12 months.
    - You have named your domestic partner as a beneficiary under your will, or your domestic partner has named you.
    - You have granted your domestic partner powers under a durable power of attorney, or your domestic partner has granted you such powers.
    - You have previously named your domestic partner as a beneficiary under a life insurance policy, or your domestic partner has named you.
    - You and your domestic partner have a joint bank account.
    - You and your domestic partner are cosigners of a lease or deed.

- You and your domestic partner are named on the same auto or home insurance policy.

Eligibility of Dependents of a Domestic Partner

If your domestic partner is eligible for coverage, you may also elect coverage for the eligible children of your domestic partner. The children of an eligible domestic partner are eligible for coverage if they are:

- Any child of your domestic partner, until the last day of the month in which the child reaches age 26;
- Regardless of age, a child with a permanent and total disability (which may be mental or physical) that started prior to the date the child reached the maximum age for coverage under the Health Plan (based on the same rules that apply for "Dependent Eligibility" above); or
- The subject of a valid Qualified Medical Child Support Order / National Medical Child Support Order as verified by First American.

For purposes of this section, children of your domestic partner include your domestic partner's:

- Biological children;
- Legally adopted children;
- Stepchildren who reside full-time with your domestic partner; and
- Children under legal guardianship of your domestic partner as deemed by a court order, who reside with your domestic partner.

Taxation of Domestic Partner Benefits

Domestic partners and the children of domestic partners generally do not qualify as your tax dependents under federal or state law unless certain criteria are met. If your domestic partner and their children, if any, do not qualify as your tax dependents, the value of Health Plan coverage provided to them must be treated as taxable income to you. This will include both the Company's contribution toward their coverage as well as the portion of your own pre-tax contributions attributable to their coverage, and these amounts will be reflected as taxable income on your Form W-2 and state wage statements.

If you execute the Company's "Certification of Tax-Qualified Dependents form for Domestic Partner Benefits" and certify that your eligible domestic partner and their children, if any, qualify as your tax dependents under federal and applicable state law, coverage may be provided on a pre-tax basis. In other words, the value of the Health Plan coverage provided to your domestic partner and their children will not be treated by First American as taxable income to you.

The tax rules for domestic partner benefits are complex. You should consult with a qualified tax advisor to determine whether you can claim your domestic partner and their children as your tax dependents. You are responsible for notifying FA Benefits within 30 days of the date your domestic partner or their children cease to qualify as tax dependents.

Important Note

States that formally recognize domestic partnerships as a legal relationship may require to you to register as domestic partners or complete some other formal process in order for your domestic partner and their children to qualify as your tax dependents under applicable state law.

Eligibility Due to a Qualified Medical Child Support Order (QMCSO) and National Medical Support Order (NMSO)

A Qualified Medical Child Support Order (QMCSO) is a court order that creates or recognizes the right of a child – referred to as an alternate recipient – to receive benefits while an employee is covered under a Health Plan. A QMCSO, including a National Medical Support Order (NMSO), must meet the requirements of ERISA as described below.

A QMCSO/NMSO must clearly specify the following:

- The names and last known mailing addresses of the covered employee and each alternate recipient covered by the order;
- A reasonable description of the type of coverage to be provided by the Health Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order applies; and
- The name of the Health Plan.

An order need not be recognized as a QMCSO/NMSO if it requires a Health Plan to provide any type or form of benefit or any option not otherwise provided to Participants, except to the extent necessary to meet the requirements of applicable state law relating to medical child support orders, as provided in Social Security Act section 1908.

Upon receipt of a medical child support order, the Plan Administrator will, as soon as administratively possible:

- Send written notice to the covered employee and each alternate recipient covered by the order (at the address included in the order) that the Plan Administrator has received such order and what the Health Plan's procedures are for determining whether the order qualifies as a QMCSO/NMSO;
- Make an administrative determination on whether the order is a QMCSO/NMSO and notify the covered employee and each affected alternate recipient of such determination.

You may obtain a copy of the Master Plan's QMCSO/NMSO procedures at no cost by contacting FA Benefits at 1-866-677-2300.

Important Note

The sections above describe eligibility requirements for dependents, including spouses, non-spouse domestic partners, and children. It is your responsibility to notify the Plan Administrator if you or your dependent have a change that might result in a loss of eligibility under the Health Plans. Failure to do so could result in loss of coverage, including retroactively, additional premium charges, loss of favorable tax treatment, and other consequences. Additionally, the Plan Administrator may perform verification procedures to re-verify that only eligible dependents are enrolled in the Health Plans.

ENROLLING IN THE PLAN

You need to enroll in a Health Plan in order to participate in that Health Plan.

If you are an eligible new hire, you must enroll before the last day of the month coinciding with your date of hire or within 30 days after your date of hire, whichever is later. If you are an existing employee and you first become eligible for a Health Plan, you must enroll before the last day of the month coinciding with your eligibility date or within 30 days after your eligibility date. If you are already eligible for or enrolled in a Health Plan and you have a qualified status change (life event), you generally must enroll or make changes to your benefits within 31 days of the event.

If you do not enroll by the deadline, you must wait until the next annual enrollment period to enroll or make changes. Annual enrollment occurs in the fall of each year for an effective date of January 1 (but please see "Mid-Year Elections for Benefits" below).

New dependents, such as newborns, also must be enrolled within 31 days after becoming your dependents (e.g., birth in the case of newborns, adoption, or marriage in the case of spouses or stepchildren). You can only enroll your dependents in a Health Plan if you yourself are enrolled in the same Health Plan. In order to enroll in a Health Plan, you must:

- Properly enroll in the Health Plan for yourself and any dependents you wish to enroll, and
- Make any required contributions for coverage or arrange for deduction of the contributions from your payroll. Unless otherwise instructed, payroll deductions will be taken on a pre-tax basis, except where coverage is required to be provided on an after-tax basis.

How to Enroll

To enroll, you need to access FA Benefits at benefits.firstam.net or call 1-866-677-2300.

Effective Date of Coverage

If you enroll yourself or a dependent within the initial enrollment period, you or your dependent will be covered on the first day of the month after your date of hire (or date of transfer, see "Transfers" in the "Eligibility" section above) if you are actively at work on such date. You will be treated as actively at work if you are absent from work due to a health factor. For example, if you commence work on January 1, you are eligible to elect coverage at any time until January 31, and if you elect coverage during this period, your coverage will become effective on February 1. If you commence work on January 16, you are eligible to elect coverage at any time until February 14 (30 days from date of hire or date of transfer), and if you elect during this period, your coverage will become effective on February 1.

If you enroll your new dependent within the 31-day enrollment period after they become an eligible dependent, your dependent will be covered on the date of the event (e.g., birth in the case of newborns, or marriage in the case of spouses or stepchildren). Other coverage changes will take effect as described in elsewhere in this summary. Newborn dependents will automatically be covered for the first 31 days following birth in any Health Plan in which you are covered, excluding the Dental Plan. Coverage will continue beyond 31 days only if you enroll the dependent in timely fashion.

Mid-Year Elections for Benefits

Enrollment of you or your dependents in a Health Plan after the new hire enrollment period and outside of annual enrollment will be permitted only upon the occurrence of a qualified life event, as defined below. In accordance with federal regulations, once you enroll in a Health Plan or decline coverage, that election will remain in force throughout the year unless there is a qualified life event. A qualified life event is defined as one of the following events:

- A change in your legal marital status, including marriage, domestic partnership, divorce, spouse's death, legal separation, or annulment;
- A change in the number of your tax dependents, including birth, adoption, placement for adoption or death;
- Termination or commencement of employment by you, your spouse, your domestic partner, or your dependent;
- A qualifying change in work schedule, such as a reduction or increase in hours by you, your spouse, your domestic partner, or your dependent that results in a change in eligibility for coverage;
- Your dependent satisfies (or ceases to satisfy) dependent eligibility requirements;
- A qualifying change in residence or worksite for you, your spouse, your domestic partner, or your dependent; or

- A significant change in health coverage for you, your spouse, your domestic partner, or your dependent.

Any change you make must be consistent with the qualified life event. In general, you must apply for coverage under a Health Plan within 31 days of the change in status event. Mid-year election changes will be effective as of the date specified in the "Effective Date of Coverage" section above, or as soon as administratively practical thereafter. Please also see "HIPAA Special Enrollment Rights" below.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or group plan coverage, you may be able to enroll yourself or your dependents in medical coverage under the Master Plan at a later date if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage), provided that you request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Finally, if you or your dependent either lose coverage under a Medicaid plan or the state children's health insurance program ("CHIP") or gain eligibility for a state premium assistance subsidy in medical coverage under the Master Plan, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the date of the event.

During the COVID-19 National Emergency period, you were permitted to disregard the 31-day period (or 60-day period for Medicaid/CHIP) special enrollment timeframes stated in this HIPAA Special Enrollment Rights section. This extension could apply for up to 12 months and was made effective for deadlines falling on or after March 1, 2020 and up until July 10, 2023. Effective for any events occurring on or after July 10, 2023, the HIPAA Special Enrollment Rights deadlines have returned to normal.

Please visit the myFA intranet site at www.myfaportal.com or contact FA Benefits at 1-866-677-2300 if you have any questions about your HIPAA special enrollment rights.

Election changes made as a result of a HIPAA special enrollment right will be effective as of the date of your election change or as soon as administratively practical thereafter, except that special enrollments in the case of a birth, adoption, or placement for adoption will be retroactive to the date of the event.

Annual Enrollment

Annual enrollment will be held each year, at a time announced by the Company. If you are then eligible, you and your dependents may enroll in a Health Plan during the annual enrollment period by completing the normal enrollment procedures.

COVERAGE TERMINATION

Your coverage under a Health Plan terminates when the first of the following occurs, except as provided below under "Coverage Continuation":

- The date the Health Plan is terminated or coverage for you or your class of employees is terminated;

- To the extent the Health Plan requires employee contributions and you fail to make any required contributions, the last day of the last month for which the required contribution is made;

- The last day of the month during which your active employment terminates, or you transfer to an affiliated company that does not participate in the Health Plan;

- If you stop working at least 30 hours per week:

    - The last day of the 12-month period measured from your first day of employment if you do not average at least 30 hours per week during that 12-month period; or

    - Following your initial 12 months of employment, the last day of the plan year in which you stop working at least 30 hours per week.

    The Plan Administrator will maintain records and notify you if your eligibility under the Plan will be affected by your hours of service.

The eligibility of your dependents for coverage under a Health Plan terminates when the first of the following occurs:

- The date your eligibility terminates;

- To the extent the Health Plan requires you to make contributions for your dependent's coverage and you fail to make any required contributions, the last day of the last month for which the required contribution is made; or

- The last day of the month in which your dependent no longer satisfies the definition of eligible dependent under the Health Plan, except to the extent that the Health Plan provides for an earlier termination of coverage.

Your coverage and your dependents' coverage under all Health Plans will terminate immediately if you or your dependent commits fraud against a Health Plan, or makes an intentional misrepresentation of a material fact, in either case as determined by the Plan Administrator in its

sole discretion. One example of fraud or an intentional misrepresentation is the enrollment (whether new enrollment or continued enrollment) of an individual who is not eligible for coverage. Depending on the circumstances, coverage may be terminated retroactively, you may be required to return benefits you or your dependents have received from a Health Plan, and the Plan Administrator or employer may take additional action. Please see "Prohibition Against Rescission of Coverage" in this summary for information on any rights you may have to appeal a retroactive termination of medical or prescription drug coverage.

After coverage terminates in a Health Plan, you may be able to elect COBRA continuation coverage for yourself and/or your dependents, as described in more detail below. If COBRA coverage is elected, COBRA coverage will terminate when you (or your dependent) are no longer entitled to COBRA coverage under applicable law, or, if earlier, the last day of the last coverage period for which a required premium for continuation coverage was paid in timely fashion. After your COBRA coverage expires, or if you choose not to elect COBRA coverage, you may be eligible to purchase individual medical, dental and/or vision coverage through the health insurance marketplace. You may visit www.healthcare.gov for more information, including an online application for health insurance coverage and contact information for a health insurance marketplace in your area.

Termination of your or your dependents' Health Plan benefit coverage outside of Annual Enrollment will be permitted only upon the occurrence of a qualified life event (as described in the section on "Mid-Year Elections for Benefits"). You will be permitted to voluntarily terminate your or your dependents' Health Plan benefit coverage outside of Annual Enrollment only upon the occurrence of a qualified life event (as described in the section "Mid-Year Elections for Benefits").

COVERAGE CONTINUATION

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your Health Plan coverage. It can also become available to other members of your family who are covered under a Health Plan when they would otherwise lose their coverage. Although COBRA does not apply to domestic partners (or children of domestic partners), the Health Plans extend continuation coverage comparable to COBRA to domestic partners (or children of domestic partners) in the same manner as provided to spouses (or children) under COBRA.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Health Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, your domestic partner, and your dependent children could become qualified beneficiaries if coverage under a Health Plan is lost because of the qualifying event.

Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you, your spouse, your domestic partner or dependent stop paying for COBRA coverage, COBRA coverage will terminate at the end of the final period for which the required premium is paid (please see "When COBRA Continuation Coverage Ends" for more information).

When is COBRA Coverage Available?

The following chart describes the qualifying events and identifies the potential qualified beneficiaries and applicable maximum COBRA continuation coverage period for each. Remember, the qualifying event must cause a loss of Health Plan coverage for COBRA to apply.

Qualifying Event	Qualified Beneficiaries	Maximum COBRA Continuation Coverage Period
Your hours of employment are reduced, which results in loss of coverage	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	18 months after loss of coverage due to the reduction in hours
Your employment ends for reasons other than gross misconduct	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	18 months after loss of coverage due to your termination
Disability Extension: Can occur if you or an eligible dependent are disabled prior to the 60th day of COBRA continuation coverage and the qualifying event was due to a reduction of hours or your termination of employment.	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	Coverage can be extended for all qualified beneficiaries from the original 18-month period to 29 months if you provide the Plan Administrator with evidence of a Social Security Administration disability determination before the initial 18-month period of COBRA continuation coverage ends and within 60 days of the later to occur of: 1) The date of the disability determination by the Social Security Administration;[1] 2) The date of the qualifying event; 3) The date on which the qualified beneficiary loses or would lose coverage under the Health Plan due to the qualifying event; or 4) The date on which the qualified beneficiary is informed of the obligation and the plan's procedures to provide this evidence to the Plan Administrator

Qualifying Event	Qualified Beneficiaries	Maximum COBRA Continuation Coverage Period
You die	Your covered dependents	36 months after loss of coverage due to your death
Your divorce, legal separation, or termination of domestic partnership[2]	Your spouse and other affected covered dependents	36 months after loss of coverage due to the divorce, legal separation, or termination of domestic partnership
Your dependent child, domestic partner or domestic partner's children no longer meet eligibility requirements	Your affected covered dependent(s)	36 months after loss of coverage due to the loss of dependent eligibility
You fail to return to active employment from a family medical leave of absence (FMLA)	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	18 months after the last day of the leave of absence regardless of whether you continued coverage during FMLA leave
You inform the Company you do not intend to return to active employment from a family medical leave of absence (FMLA)	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	18 months after the last day of the leave of absence regardless of whether you continued coverage during FMLA leave
You become enrolled in Medicare coverage less than 18 months before your initial qualifying event (termination of employment or reduction in hours) and you lost coverage under the Plan due to the initial qualifying event[3]	Your covered dependents	36 months from the date of your enrollment in Medicare

1 You must notify the Plan Administrator within 30 days after the date of any final determination from the Social Security Administration that you or your dependent is no longer disabled. The extension will end with recovery from the disability, and you will be notified of the specific end date.

2 If you cancel coverage for your spouse in anticipation of divorce or legal separation, and a divorce or legal separation later occurs, the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.

3 COBRA continuation coverage can only be continued for qualified beneficiaries (other than the employee) for up to 36 months after the date the covered employee becomes enrolled in Medicare. The covered employee's maximum COBRA continuation coverage period will be 18 months. This COBRA continuation coverage period is available only if the covered employee becomes enrolled in Medicare within 18 months before their termination from employment or reduction in hours.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your spouse, domestic partner or dependent are participating as qualified beneficiaries in an 18-month COBRA continuation coverage period as a result of a qualifying event that is a reduction in your hours of employment which results in loss of coverage or your termination and

experience a second qualifying event during this period, they may be eligible for up to 18 months of additional coverage. This extension for a second qualifying event is only available if the event would have caused the spouse, domestic partner, or dependent child to lose coverage under the Health Plan had the first qualifying event not occurred and you give proper notice of the qualifying event to the Plan Administrator. The maximum COBRA continuation coverage period for a qualified beneficiary including any second qualifying event is 36 months.

An example of a second qualifying event is a dependent losing eligibility under a Health Plan by reaching the Health Plan's dependent age limit while receiving COBRA continuation coverage following your termination of employment.

You Must Give Notice of Some Qualifying Events

COBRA continuation coverage under a Health Plan will be offered to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

You or an affected qualified beneficiary must notify the Plan Administrator of the following qualifying events within 60 days of the date of the event: (i) your divorce, legal separation or termination of domestic partnership; or (ii) your dependent, domestic partner, or domestic partner's child no longer meet the eligibility requirements under a Health Plan. You must provide this notice to:

FA Benefits – First American
P. O. Box 0638
Carol Stream, IL 60132-0638
(866) 677-2300

A failure to timely provide this notice can lead to a loss of the qualified beneficiary's COBRA continuation coverage rights. You are not required to notify the Plan Administrator when one of the other qualifying events occurs. Your Company will notify the Plan Administrator when one of the other qualifying events occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage for each Health Plan for which a qualifying event has occurred. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. In general, COBRA coverage must be elected within 60 days after coverage otherwise would end, or, if later, within 60 days after receiving written notification that COBRA continuation coverage is available.

Cost of COBRA Coverage

Premiums for COBRA coverage may be as much as 102 percent of the total cost of Health Plan coverage without any employer subsidy. If coverage is extended due to disability, COBRA

premiums during the extension period may be as much as 150 percent of the cost of unsubsidized Health Plan coverage.

When COBRA Continuation Coverage Ends

Your COBRA coverage and/or your dependents' COBRA coverage will end prior to the expiration of the 18-, 29-, or 36-month continuation coverage period upon the earliest of the following events:

- You or your covered dependents do not pay required premiums on time.
- You or your covered dependents become covered under a group plan sponsored by a different employer that does not restrict coverage for pre-existing conditions. If the new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The Company no longer offers any group health plan.
- You or your covered dependent becomes enrolled in benefits under Medicare if you or your covered dependent were not enrolled in benefits under Medicare prior to enrolling in COBRA coverage. This does not apply if the termination of COBRA coverage is contrary to the Medicare Secondary Payer Rules or other federal law. However, if you or your covered dependent enroll in COBRA coverage prior to enrolling in benefits under Medicare, your COBRA coverage will end when you enroll in benefits under Medicare.
- You or your dependent dies.

Trade Adjustment Act Recipients

If you become eligible for trade adjustment assistance under the Trade Act of 1974 in connection with your termination of employment from the Company, and if you did not elect continuation coverage when you terminated employment, you may be eligible for a special election period that will last 60 days from the date you become eligible for trade adjustment assistance (but not beyond six months after your initial loss of coverage). Please contact the Plan Administrator if you want more information about this special election period.

Keep Your Plan Informed of Address Changes

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

COVID-19 Related COBRA Deadline Extensions

Certain deadlines under the Master Plan were temporarily extended in connection with the COVID-19 National Health Emergency, to the extent required by applicable law. In particular,

deadlines generally are delayed if they fall during the period from March 1, 2020 up until July 10, 2023. During that period, the following COBRA continuation deadlines for participants are delayed, but for no more than 12 months:

- The 60-day period you have to notify the Plan Administrator of your divorce, separation, termination of domestic partnership, or your dependent, domestic partner, or domestic partner's child no longer meeting the Health Plan's eligibility requirements;

- The 60-day period for electing continued COBRA coverage following the date your coverage otherwise terminated;

- The 45-day period for paying the initial COBRA premiums and the 30-day grace period during which payments are treated as timely for such continued coverage (For example, if your initial COBRA premiums for such coverage were due May 31, 2022, the deadline was extended to May 31, 2023. If your initial COBRA premiums for such coverage were due March 30, 2023, the deadline is extended and must be made no later August 24, 2023, which date is 45 days after the federal government lifted the National Emergency on July 10, 2023); and

- The 30-day or 60-day period you have to notify the Plan Administrator of a change in your disability status.

Effective for any events occurring on or after July 10, 2023 that would trigger one of the COBRA continuation deadlines above, the deadlines have returned to normal.

COVERAGE EXTENSIONS

Leaves of Absence – General

This section provides an overview of how your Health Plan benefits may be affected while you are on a leave of absence. Please review The First American Way employee handbook for additional information on available leaves of absence, your responsibilities, and how you may be affected. A copy of this handbook is available here: The First American Way Employee Handbook, and the most recently updated version can be obtained from your supervisor and/or human resources representative.

Personal Leave of Absence

You continue to be a participant for up to 12 weeks following the date on which you commence an approved personal leave of absence. Your coverage will be subject to you continuing to satisfy the eligibility rules described above (for example, being employed in an eligible position at a full-time status) and to you continuing to pay any required employee contributions in accordance with deadlines and rules established by the Plan Administrator. Personal leave includes an approved absence from work which does not qualify as FMLA leave, disability leave, or military leave. The duration of your coverage on these terms may vary if you have taken a leave of absence within the prior 12-month period.

First American Paid Parental Leave

Effective October 1, 2022, you may continue to be a participant while on paid parental leave (as of October 1, 2022, up to 10 weeks if you are an employee giving birth to a child, and up to 6 weeks for bonding) pursuant to and in accordance with the First American Paid Parental Leave policy (the "FA PPL Policy"). You must pay any required employee contributions in accordance with deadlines and rules established by the Plan Administrator. The duration of your coverage on these terms may vary if you have taken a leave of absence under the FA PPL Policy within the prior 12-month period.

Family and Medical Leave

The Master Plan is intended to comply with the federal Family and Medical Leave Act of 1993 (FMLA). If this summary plan description conflicts with the minimum requirements of FMLA, the minimum requirements of FMLA will govern. For more information about your rights under FMLA, please refer to the First American FMLA Policy.

Your health benefits will continue for the first 12 weeks of FMLA leave (26 in the case of a leave to care for a spouse, child, or parent who is seriously ill or injured as a result of military service) during any rolling 12-month period, provided you continue to pay your employee contributions in accordance with the deadlines and rules established by the Plan Administrator.

You and your dependents are subject to all conditions and limitations of each Health Plan during your leave. For example, if contributions or benefits are changed for active workers, these changes will also apply to you.

If requested, you must submit proof acceptable to the Health Plan that your leave is in accordance with FMLA. The FMLA continuation is concurrent with any other continuation of benefits except for COBRA coverage. (COBRA coverage is described in detail earlier in this summary plan description.) You may be eligible to elect COBRA continuation following the day your FMLA leave ends.

FMLA continuation ends on the earliest of:

- The day you return to work;
- The day you notify your Employer that you are not returning to work;
- The day your coverage would otherwise end under the Health Plan, or
- The day after your FMLA entitlement ends.

If you return to active employment by or before your FMLA coverage expires, your Health Plan coverage will continue automatically or be reinstated if you did not continue coverage during your FMLA leave period. If you return to employment after your FMLA leave period has expired, you will need to re-enroll for Health Plan coverage.

Disability Leave

If you become totally disabled, you may be allowed to continue coverage under a Health Plan for up to 12 weeks, unless benefits continuation governed by state leave regulations allow a greater maximum benefit period. During this benefit period, you must make contributions toward your premiums on the same basis as an active employee. The duration of this continued coverage may be reduced if you have taken a leave of absence within the prior 12-month period.

Please note that if you are disabled, any FMLA leave you may be entitled to may run concurrently with your disability leave. Your coverage will end on the earlier of the end of the maximum benefit period, or the date you are no longer receiving disability benefits, unless you remain eligible for coverage because you return to covered employment.

Military Leave

If you are leaving employment to serve in the uniformed services of the United States, federal law gives you certain rights with respect to medical coverage under the Health Plans. You may choose to "freeze" your eligibility status until your military service ends or you may choose to continue your medical coverage for up to 24 months after your absence begins. In order to continue your coverage, you must provide advance notice of your military leave whenever possible, and you must elect continuation coverage in accordance with rules set forth by the Plan Administrator.

By freezing your eligibility status, you are putting your eligibility status and coverage on hold until you return from military service. When you return from military service, your eligibility status will be reactivated, and your coverage will become effective.

During your military service, you generally have the right to continue coverage for up to 12 weeks at a cost of not more than the cost for a similarly situated active employee. If your military leave is scheduled for longer than 12 weeks, you have taken a leave of absence within the prior 12-month period, or you fail to return to employment within the time allowed by USERRA, the duration of your medical coverage on these terms may vary. If you and your healthcare provider certify by completing the form provided by the Plan Administrator that you are seriously ill or injured, you will be eligible for coverage at the active employee rate for up to 26 weeks.

If your period of military service continues beyond these limits, you must pay for the full cost of coverage plus an administrative fee of up to 2% beginning the month after the month in which you are no longer eligible for coverage at the active employee rate.

You may continue coverage for yourself and your eligible family members until the earlier of:

- The end of 24 months from the date on which your absence from work began; or
- The last day of the month in which you fail to return to employment with a participating employer after your military service ends.

If you do not elect to continue coverage, your eligibility status will be frozen as of the date you enter military service, and coverage for you and your dependents will end as of the end of the month in which you enter military service. Coverage for a particular benefit plan may end sooner, as set out in the applicable benefit plan.

These rights are given by the Company and by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If this booklet conflicts with the minimum requirements of USERRA, the minimum requirements of USERRA will govern.

Furlough Leave

You continue to be a participant for up to 12 weeks following the date on which you are placed on furlough. Your coverage will be subject to you satisfying the eligibility rules described above (for example, being employed in an eligible position at a full-time status) and to you continuing to pay any required employee contributions in accordance with deadlines and rules established by the Plan Administrator. The duration of your coverage on these terms may vary if you have taken a leave of absence within the prior 12-month period.

COORDINATION OF BENEFITS

You or members of your family could be covered under more than one health plan. These other plans may include any other group plan (insured or uninsured) providing medical, prescription drug or dental benefits, including company or group-sponsored insurance or group prepayment plans, Medicare or other government-sponsored plans and no-fault automobile insurance to the extent required by law. It does not include any personal health or dental care insurance you might have. Separate coordination of benefits rules apply for purposes of the Dental Plan, as set forth in Appendix F. In the event benefits are available for the same expenses under both a self-insured medical plan under the Master Plan and a Dental Plan under the Master Plan, the medical plan will be the primary plan and the Dental Plan will pay secondary to the medical plan. The charges will be considered for payment under the Dental Plan only if the amount normally paid under the Dental Plan exceeds the amount paid under the medical plan and only up to the excess amount.

The Health Plans will coordinate benefit payments with the other plan you or your dependents may have so that you will receive up to, but not more than, actual expenses for covered benefits. However, in no event will the amount of benefits paid under any Health Plan exceed the amount which would have been paid if there were no other plan involved.

If a Health Plan pays secondary to a managed network health program such as an HMO, benefits payable under the Health Plan are limited to the copayments due under the managed care network. If the covered person does not utilize a provider from the primary plan's network, the benefits payable by the Health Plan are limited to the copayments which would have been due had a network provider been utilized.

Any expense not payable by a primary plan due to the failure to comply with any applicable plan requirements, including utilization review requirements or the failure to properly file a claim for benefits, will not be paid by the Health Plan.

Coordination of benefits will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   -- secondary to the plan covering the person as a dependent; and
   -- primary to the plan covering the person as other than a dependent;

   The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   -- covers the person as other than a dependent; and
   -- is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

   If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. Notwithstanding 1 through 4 above, the Health Plans always pay secondary to any motor vehicle policy including any medical payments, personal injury protection (PIP), no fault coverage, uninsured or underinsured motorist coverage, any policy of insurance from any insurance company or guarantor of a third party, workers compensation or other liability insurance company, any other plan or program that is required by law, or any other source (including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage). Otherwise-eligible expenses will not generally be denied under the Health Plans while the claims administrator coordinates benefits with another plan, program, or coverage, but benefits that are paid are subject to the coordination of benefits provisions described in this section and the subrogation and rights to recovery provisions described below.

   All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer. Regardless of your designation, your automobile no fault coverage is always primary to the Health Plans.

6. If 1, 2, 3, 4 and 5 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   -- laid-off or retired employee; or
   -- the dependent of such person;

   Shall be determined after the benefits of any other plan which covers such person as:

   -- an employee who is not laid-off or retired; or
   -- a dependent of such person.

   If the other plan does not have a provision:

   -- regarding laid-off or retired employees; and
   -- as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

   The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

-- regarding right of continuation pursuant to federal or state law; and
-- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under a Health Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of a Health Plan and an "other plan" both agree that the Health Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, the Master Plan or any Health Plan can release or obtain data. Any person claiming benefits under a Health Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan Administrator such information as may be necessary to implement this provision. The Master Plan or any Health Plan can also, in Plan Administrator's sole discretion, make or recover payments in accordance with this provision. See also "Correction of Errors and Other Adjustments" below.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under a Health Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of the Health Plan.

SUBROGATION AND RIGHT OF RECOVERY

Definitions

As used throughout this section of the summary, the term **Responsible Party** means any party actually, possibly, or potentially responsible for making any payment to a **Covered Person** due to a **Covered Person's** injury, illness, or condition. The term **Responsible Party** includes the liability insurer of such party or any **Insurance Coverage**.

For purposes of this provision, the term **Insurance Coverage** refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage or other liability insurance coverage, no-fault automobile insurance coverage, any first party insurance coverage, or any other source (including but not limited to crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage). For purposes of these subrogation and rights of recovery provisions, however, **Insurance Coverage** does not include benefits you receive from the fully insured critical illness, accident, or hospital indemnity voluntary benefit plans purchased through the Master Plan.

For purposes of this provision, a **Covered Person** includes anyone on whose behalf a Health Plan pays or provides any benefit including, but not limited to, any current or former Health Plan

participant and also the minor child or dependent of any plan member or person entitled to receive any benefits from a Health Plan. A **Covered Person** also includes a decedent, minor, incompetent or disabled person, estate, personal representative of a **Covered Person** or a **Covered Person's** estate, parent, guardian, or anyone else entitled to seek recovery on behalf of a person on whose behalf a Health Plan pays or provides any benefit.

Subrogation

The right of subrogation means a Health Plan is entitled to pursue any claims that a **Covered Person** may have in order to recover benefits paid by the Health Plan. Immediately upon paying or providing any benefit under a Health Plan, the Health Plan shall be subrogated to (stand in the place of) all rights of recovery a **Covered Person** has against any **Responsible Party** with respect to any claim or potential claim against any **Responsible Party**, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Health Plan. The Health Plan may assert a claim or file suit in a **Covered Person's** name and take appropriate action to assert its subrogation claim, with or without the **Covered Person's** consent. The Health Plan is not required to pay a **Covered Person** part of any recovery it may obtain, even if it files suit in the **Covered Person's** name.

Reimbursement

In addition, if a **Covered Person** receives any payment from any **Responsible Party** or **Insurance Coverage** as a result of an injury, illness or condition, the **Covered Person** agrees to reimburse the Health Plan first from such payment for all amounts the Health Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the **Covered Person** receives from any **Responsible Party**.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from a Health Plan, the **Covered Person** agrees that if they receive any payment from any **Responsible Party** as a result of an injury, illness or condition, they will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of the **Covered Person's** fiduciary duty to the Health Plan. No disbursement of any settlement proceeds or other recovery funds from any **Insurance Coverage** or other source will be made until the Health Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, a Health Plan will automatically have a lien to the extent of benefits paid by the Health Plan for the treatment of the illness, injury or condition for which **Responsible Party** is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any **Insurance Coverage,** related to treatment for any illness, injury or condition for which the Health Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Health Plan including, but not limited to, the **Covered Person**; **Covered Person's** representative or agent;

Responsible Party; **Responsible Party's** insurer, representative or agent; and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Health Plan.

Assignment

In order to secure a Health Plan's recovery rights, as a condition of participating in the Health Plan, the **Covered Person** agrees to assign to the Health Plan any benefits or claims or rights of recovery they may have under any automobile policy or other coverage, to the full extent of the Health Plan's subrogation and reimbursement claims. This assignment allows the Health Plan to pursue any claim the **Covered Person** may have, whether or not the **Covered Person** chooses to pursue the claim.

No adult **Covered Person** may assign any rights that they may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of the adult **Covered Person** without the prior express written consent of the Health Plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from a Health Plan, the **Covered Person** acknowledges that the Health Plan's recovery rights are a first priority claim against all **Responsible Parties** and against any payment received by the **Covered Person** and that any payments received by the **Covered Person** are to be repaid to the Health Plan before the **Covered Person** receives any recovery for the **Covered Person's** damages. The Health Plan shall be entitled to full reimbursement on a first-dollar basis from any **Responsible Party's** payments, even if such payment to the Health Plan will result in a recovery to the **Covered Person** which is insufficient to make the **Covered Person** whole or to compensate the **Covered Person** in part or in whole for the damages sustained. The Health Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the **Covered Person** to pursue the **Covered Person's** damage claim, even if the total amount payable to the Health Plan, when added to such court costs and attorney fees, exceeds the amount recovered from the **Responsible Party**.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and a Health Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any **Responsible Party** and regardless of whether the settlement or judgment received by the **Covered Person** identifies the medical benefits the Health Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. A Health Plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Health Plan's claim will not be reduced due to the **Covered Person's** own negligence.

Cooperation and Notice Obligation

The **Covered Person** shall fully cooperate with a Health Plan's efforts to recover its benefits paid. It is the duty of the **Covered Person** to notify the Health Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the **Covered Person's** intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the **Covered Person**. The Covered Person and their agents agree to provide the Health Plan or its representatives notice of any recovery the Covered Person or their agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, the Covered Person and their agents agree to provide notice to the Health Plan prior to settlement, execution of a release or receipt of any applicable funds.

The **Covered Person** and their agents shall provide all information requested by the Health Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Health Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Health Plan in pursuit of its subrogation rights or failure to reimburse the Health Plan from any settlement or recovery obtained by the Covered Person, may result in the denial of any future benefit payments or claim until the Health Plan is reimbursed in full, termination of health benefits for the **Covered Person** or the institution of court proceedings against the **Covered Person**.

The **Covered Person** shall do nothing to prejudice a Health Plan's subrogation or recovery interest or to prejudice a Health Plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Health Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Health Plan's subrogation and reimbursement interest.

The **Covered Person** acknowledges that a Health Plan has the right to investigate the injury, illness, or condition to identify any potential sources of recovery. The Health Plan reserves the right to notify any **Responsible Party** and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The **Covered Person** acknowledges that the Health Plan has notified them that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*., to share their personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator or its designee shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from a Health Plan, the **Covered Person** agrees that any court proceeding with respect to this provision may be brought through arbitration or in any court of competent jurisdiction as the Health Plan may elect. By accepting such benefits, the **Covered Person** hereby submits to each such arbitration or jurisdiction, waiving whatever rights may correspond to them by reason of their present or future domicile. By accepting such benefits, the **Covered Person** also agrees to pay all attorneys' fees the Health Plan incurs in successful attempts to recover amounts the Health Plan is entitled to under this section.

CLAIM PROCEDURES

Claims for Benefits

When you receive care from a network provider, your provider should automatically file a claim for you. Providers and hospitals may submit claims for benefits in accordance with deadlines prescribed by the claims administrator, which includes precertification deadlines for certain services.

If you receive care or treatment from an out-of-network provider (if applicable), you will usually need to pay the provider directly at the time you receive care and then file a claim with the claims administrator for reimbursement of your eligible expenses. Precertification for certain services may be required prior to your receipt of care and filing of a claim for reimbursement. Your claim must include the appropriate paperwork and receipts. If you receive reimbursement from another source, such as your spouse's plan, your claim must include the explanation of benefits from that plan. Be sure to keep a copy of everything for your records.

If you pay for services out of pocket and you believe the services are covered by one of the self-insured medical plans under the Master Plan, you must file a claim for reimbursement within 1 year after the date the services are provided, except with respect to certain changes permitted during the temporary COVID-19 National Health Emergency as described below. The deadlines described in this paragraph apply only to the self-insured medical plans under the Master Plan. Other deadlines may apply to the other Health Plans. Please contact the applicable claims administrator for more information.

Administrative Claims

Claims that do not involve a specific benefit under a Health Plan are called "Administrative Claims" (e.g., you believe that you are being charged too much for the benefit coverage you have elected or you are challenging an eligibility determination). Administrative Claims must be submitted to the Plan Administrator within 90 days from the date you know or should have

known that there is an issue, dispute, problem or other claim with respect to the Health Plan. If a claim involves a Health Plan change or amendment, you are considered to know about your claim when the change or amendment is first communicated to participants in the Health Plan, and the 90-day period for filing a claim begins on the date the change is first communicated, whether or not the change or amendment has become effective by that date.

If you do not file an Administrative Claim by the applicable deadline and in the proper manner, your claim will expire and be automatically denied if it is subsequently filed, unless the Plan Administrator decides, in its sole discretion, to respond to such Administrative Claim. You will not be able to proceed with a lawsuit based on a late-filed Administrative Claim.

Claims and Appeals Administrators

Claims and appeals for the Health Plans are administered by the designated claims administrator:

	Claims Administrator			
Health Plan	**Administrative Claim**	**Initial Claim for Benefits**	**Internal Appeal**	**Voluntary External Review**
Medical	Plan Administrator	Meritain	Meritain	Meritain (at the Plan Administrator's direction) facilitates review by external independent review organization
Prescription Drug	Plan Administrator	CVS Caremark	CVS Caremark	Plan Administrator facilitates review by external independent review organization
Dental	Plan Administrator	CIGNA	CIGNA	N/A

Contact information for claims administrators may be found in the chart under the "Highlights of First American Financial Corporation Health Plans" section of this summary. The Plan Administrator is the First American Financial Corporation Administrative Benefits Plan Committee, and its contact information may be found in the "Other Plan Information" section of this summary.

Authorized Representatives

Another person may submit claims and appeals for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else submit a claim or appeal for you (even if it is your **provider**). You will be required to fill out the

Master Plan's authorized representative form certifying to the claims administrator (e.g., **Meritain**) that you are allowing someone to submit a claim or appeal for you. The claims administrator and the Plan generally will not accept certifications and designations on a **provider's** form, such as those that a **provider** may require you to sign in advance of, as a condition to, or upon receiving treatment. You can get the Master Plan's form by contacting the claims administrator (e.g., **Meritain**) or **Accolade**, or the claims administrator may contact you to request you to certify the appointment of an authorized representative to act on your behalf. Your failure to provide the form or verification in a timely manner can delay the administration of your claim and appeal. You can use an authorized representative at any level of claim or appeal. In the case of a claim involving urgent care, a health care professional, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

Timeframes for Determinations of Claims for Benefits

The timeframes for benefit determination for Health Plan benefits vary depending on the type of claim.

Type of Claim	Initial Deadline for Claims Review	Extensions for Claims Review, if Necessary	Time for You to Provide Additional Information
Urgent	72 hours	None	48 hours
Urgent, concurrent care	24 hours*	None	45 days
Pre-Service	15 days	15 days	45 days
Post-Service	30 days	15 days	45 days

* Applies only when claim is submitted at least 24 hours before end of approved treatment. If the claim is not submitted at least 24 hours before the end of approved treatment, the standard urgent care deadline applies.

- **Urgent claims:** Care is "urgent" if a longer time could seriously jeopardize the participant's life, health or ability to regain maximum function. Also, care may be urgent if, in a doctor's opinion, it would subject the participant to severe pain if care or treatment were not provided. If you require care that is classified as being urgent, but do not submit enough information for the claims administrator to make a determination, the claims administrator will notify you within 24 hours. You have 48 hours after that time to supply any additional information. Until you supply this information, the time limits that apply for the review are suspended (or "tolled").

- **Concurrent care decisions:** These are decisions involving an ongoing course of treatment over a period of time or a number of treatments. If you or your dependent is undergoing a course of treatment, or is nearing the end of a prescribed number of treatments, you may request extended treatment or benefits. If the course of treatment does not involve urgent care, the normal "pre-service" or "post-service" time limits will apply to a request to extend treatment, as described below. If the course of treatment involves urgent care and you request

at least 24 hours before the expiration of the authorized treatments, the claims administrator will respond to your claim within 24 hours. If the treatment involves urgent care and you do not make a claim at least 24 hours before the expiration of the authorized treatments, the standard urgent care deadlines apply.

- **Pre-service determinations:** A "pre-service" determination requires the receipt of approval of those benefits in advance of obtaining the care. If you request a review for pre-service benefits, but do not submit enough information for the claims administrator to make a determination, the claims administrator will notify you within 15 days. You have 45 days after that to supply any additional information. Until you supply this information, the time limits that apply to the claims administrator are tolled.

- **Post-service claims:** A "post-service" determination is made for benefits after you have already received care or treatment. A "post-service" determination does not require advance approval of benefits. If you request a review for post-service benefits, but do not submit enough information for the claims administrator to make a determination, the claims administrator will notify you within 15 days. You have 45 days after that to supply any additional information. Until you supply this information, the time limits that apply to the claims administrator are tolled.

Example #1: If you have an urgent medical situation, the claims administrator must respond to your initial request for benefits within 72 hours, and no extensions are permitted. If the administrator needs more information from you to make a determination, you will have 48 hours from the time you are notified to supply that information. The time period during which you are gathering that additional information does not count toward the time limits that apply to the claims administrator.

If Your Claim for Benefits or Administrative Claim Is Denied

ERISA and the Master Plan govern the process for handling adverse determinations made on claims for benefits under a Health Plan, Administrative Claims, and appeals made for review of such adverse determinations. Under ERISA, if a claimant (*i.e.*, an employee, participant or beneficiary) receives an adverse determination with respect to a claim for benefits or Administrative Claim which results in the claim being denied in whole or in part, the claims administrator will send the claimant a written notice of such denial within a reasonable period of time after such claim is submitted. An adverse determination may be based on eligibility for coverage (including a retroactive termination of coverage under a Health Plan), failure to meet precertification if required, coverage determinations (including plan limitations or exclusions), the results of any utilization review activities, a decision that the service or supply is experimental, investigational, or not medically necessary, or any other reason determined by the claims administrator.

Notice of Denial

If your claim for benefits or Administrative Claim is denied (either in whole or in part), the claims administrator will send you a written explanation of why the claim was denied. In the

case of an urgent claim, this can include oral notification, as long as you are provided with a written notice within three days.

For claims for benefits, this explanation will contain the following information:

- Information that identifies the particular claim, including the date of service, the health care provider, the claim amount (if applicable), and a statement that the diagnosis and treatment codes (along with the corresponding meaning of these codes) are available upon request
- A description of the standard used in denying the claim (e.g., medical necessity)
- The specific reason for the denial
- Specific references to Health Plan provisions on which the denial is based
- A description of additional material or information that you may need to revise the claim and an explanation of why such material or information is necessary
- A statement that you are entitled to receive reasonable access to and copies of all documents, records, and other information relevant to your claim upon request and free of charge
- A specific description of the Health Plan's internal claims and appeals and external review procedures and applicable time limits, including a statement of your rights to appeal and/or bring a lawsuit under ERISA
- Contact information for any state consumer assistance office that can assist you with the internal claims and appeals and external review procedures

Depending on the type of claim for benefits, the explanation will also contain the following information:

- If the denial is based on an internal rule, guideline, or protocol, the denial will say so and state that you can obtain a copy of the guideline or protocol, free of charge upon request
- If the denial is based on an exclusion for medical necessity or experimental treatment, the denial must explain the scientific or clinical judgment for determination, applying the terms of the Health Plan to the medical circumstances, or state that such an explanation will be provided upon request, free of charge
- If the denial involves urgent care, you will be provided an explanation of the expedited review procedures applicable to urgent claims

Appealing a Denied Claim

If your claim for benefits or Administrative Claim is denied, you have the right to make an appeal:

- You may first wish to call the claims administrator for the Health Plan and ask why your claim was denied. You may discover that a simple error was made. If so, you may be able to correct the problem right over the telephone.

- If your claim is denied once again, submit your claim to the Health Plan's claims administrator for an internal appeal. Be sure to explain why you think your claim should be paid and provide all relevant details. For Administrative Claims, this is the only level of appeal.

- If your internal appeal for medical or prescription drug benefits has been denied, your claim may be eligible for external review. Please see "Voluntary External Review" in this summary. External review is not available for Administrative Claims.

You may file an appeal in writing to the applicable claims administrator for your Health Plan using the contact information for claims administrators under the "Highlights of First American Financial Corporation Health Plans" section in this summary. If your appeal is of an urgent nature, you may call the telephone number included in your denial, use the toll-free telephone number on your ID card, or call the telephone number provided for the claims administrator in this summary. Your appeal should include the group name (First American Financial Corporation), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

Timeframes for Your Appeal

If you make a claim for benefits or Administrative Claim, and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can enforce your rights under ERISA.

Appeals are filed with the applicable claims administrator identified in the "Claims and Appeals Administration" section in this summary.

The timeframes applicable to the appeals process for medical, prescription drug, and dental claims are as follows:

	Appeals of			
Step	**Urgent Claims**	**Pre-Service Claims**	**Post-Service Claims**	**Administrative Claims**
Time to appeal denial of initial claim for benefits	180 days from delivery of the denial	180 days from delivery of the denial	180 days from delivery of the denial	90 days from delivery of the denial
Time for decision on Internal Appeal	72 hours from receipt of the appeal[1]	15 days from receipt of the appeal[2,3]	60 days from receipt of the appeal	60 days from receipt of the appeal

1 In the case of an Urgent Claim, the claims administrator will notify you of its decision on appeal as soon as possible.

2 If, due to matters beyond the control of the Health Plan, the claims administrator needs additional time to process a claim, the claims administrator may extend the time to notify you of the Health Plan's benefit determination for up to 15 days provided that the claims administrator notifies you within 15 days after the Health Plan receives the claim, of those special circumstances and of when the claims administrator expect to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

3 Prior authorization is not required under the Dental Plan; however, pre-service review of dental claims will be answered by the claims administrator within 15 calendar days.

Concurrent Care Appeals. You will be provided advanced notice of a termination or reduction in an ongoing course of treatment in order to allow you sufficient time to appeal and receive a decision before your benefit is reduced or terminated.

External review. External review may be available after you have exhausted your appeals for medical or prescription drug claims. External review is described in more detail later in this section.

Administrative Claim Appeals. Administrative Claims are not claims for benefits and may not be subject to the same claim and appeal procedures described elsewhere in this section. However, if your Administrative Claim is denied, you may file an appeal in writing to the Plan Administrator within 90 days from delivery of the denial of your Administrative Claim. Your appeal should include the group name (First American Financial Corporation), your name, member ID or other identifying information shown the documentation you received, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial Administrative Claim. The Plan Administrator will respond within 60 days from receipt of your appeal. If your Administrative Claim is denied on appeal, the Plan Administrator will provide you with notice that will include all applicable required details. Voluntary External Review is not available for denied Administrative Claims.

Additional Information about the Appeals Process

In filing an appeal of a denied claim for benefits, you have the opportunity to:

- Submit evidence and testimony, or written comments, documents, records and other information relating to your claim for benefits

- Receive notice from the claims administrator of any new or additional rationale for denying your claim or appeal, and any new or additional evidence considered, relied upon, or generated by the claims administrator regarding your claim or appeal

- Have reasonable access to and review, upon request and free of charge, copies of all documents, records and other information relevant to your claim, including your claim file

- Have all relevant information considered on appeal, even if it was not submitted or considered in your initial claim

The claims representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal. A review on appeal will not afford deference to the initial denial of your claim and will not be made by the individual who denied your claim or a subordinate of that individual. If benefits are still denied on appeal, you will receive a notice that provides:

- Information that identifies the particular claim, including the date of service, the health care provider, the claim amount (if applicable), and a statement that the diagnosis and treatment codes (along with the corresponding meaning of these codes) are available upon request.

- A description of the standard used in denying the claim (e.g., medical necessity)

- The specific reasons for the denial, including a discussion of the decision

- Reference to the Health Plan provisions on which the decision was based

- A statement that you may receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim

- A specific description of the Health Plan's internal claims and appeals and external review procedures and applicable time limits

- Contact information for any state consumer assistance office that can assist you with the internal claims and appeals and external review procedures

Depending on the type of claim, the notice that you receive from the final review level will also contain the following information:

- If the denial is based on an internal rule, guideline, or protocol, the denial will say so and state that you can obtain a copy of the rule, etc., free of charge upon request

- If the denial is based on an exclusion for medical necessity or experimental treatment, the denial will explain the scientific or clinical judgment for determination, applying the terms of the Health Plan to the medical circumstances, or state that such an explanation will be provided upon request, free of charge

- A statement of your rights to bring suit under ERISA after exhaustion of the appeals process and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Prohibition Against Rescission of Coverage

The Plan Administrator is prohibited from retroactively terminating medical and prescription drug coverage for you or your covered dependents unless you or the covered dependent commits an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact. An example would be providing false information about an individual's eligibility or status as your dependent. Additionally, this prohibition against a retroactive termination of coverage does not apply in the event: (i) a participant fails to timely pay premiums towards the cost of coverage; (ii) you and your ex-spouse fail to timely report a divorce to the Plan Administrator; (iii) there are reasonable administrative delays in terminating coverage; or (iv) of any other circumstance under which retroactive termination would not violate the Affordable Care Act.

The Plan Administrator shall provide a covered individual with 30 days' prior written notice of intent to retroactively terminate coverage and permit the covered individual to appeal the retroactive termination of coverage within the 30-day period. In the event the Plan Administrator retroactively terminates a covered individual's coverage on account of an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact, an adverse determination notice will be provided and such rescission shall not cause the individual to incur a "qualifying event" for COBRA purposes. An external review of this decision may be available to you. Please see "Voluntary External Review" in this summary.

Voluntary External Review

If you receive an adverse benefit determination (including a final internal adverse benefit determination) under your medical or prescription drug plans, you may be entitled to an independent, external (third-party) review pursuant to applicable law. External review is not available for denied Administrative Claims. This section and the sections that follow provide a summary of the external review process. In general, you are eligible for an external review if you satisfy each of the following requirements:

- You were covered under the Health Plan at the time the service was requested or provided;

- The denial of your claim does not relate to your eligibility to participate in the Health Plan;

- The claim involves medical judgment (including, but not limited to, determinations based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the plan's determination that a treatment is experimental or investigational); an adverse determination for **surprise bills** (medical and air ambulance bills), including, but not limited to, determinations of whether an adverse determination is subject to **surprise bill** provisions; or the rescission of coverage;

- You have exhausted the internal appeals process (except in certain cases where the claims administrator failed to follow the process properly or completing an expedited internal appeal would seriously jeopardize the claimant's life, health, or ability to regain maximum function); and

- You have provided all paperwork necessary to complete the external review.

If you choose to request an external review, you must submit your request to **Meritain** (the Plan Administrator's designee) within 123 calendar days of the date you received the final internal adverse benefit determination (or the notice of an adverse benefit determination if exhaustion of the internal appeals process is not required) from the claims administrator. If the last filing date falls on a Saturday, Sunday or Federal holiday, the last filing date will be extended to the next day that is not a Saturday, Sunday or Federal holiday. You must include a copy of the notice and all other pertinent information that supports your request.

For more information regarding this process, please contact the Plan Administrator.

Preliminary Review

Within 5 business days after receiving your request for an external review, the Plan Administrator or its designee must provide you a preliminary review determining whether you are eligible for an external review.

Within one business day after completion of the preliminary review, the Plan Administrator or its designee must issue a written notice to you. If the request is complete but not eligible for external review, the notice will include the reasons your request is not eligible for external review and contact information for the Employee Benefits Security Administration (toll- free number 866-444-EBSA (3272)). If the request is not complete, the notice will describe the information or materials needed to make the request complete, and you will be permitted to complete the request for external review within the 123-calendar day filing period or within 48 hours following the receipt of the notice, whichever is later.

Referral to an IRO

If you are eligible for an external review, the Plan Administrator or its designee will assign an accredited Independent Review Organization (IRO) to conduct the review. The IRO is independent and does not have a financial stake in the outcome of your claim. The IRO will provide you with a written notice indicating that the request has been accepted for external review, and allowing you to submit additional information in writing for the IRO to consider when conducting the external review. In order to be considered by the IRO, this information generally must be submitted within 10 business days after you receive the notice from the IRO.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim and not be bound by any decisions or conclusions reached during the Health Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Health Plan, you, or your treating provider;
- The terms of the Health Plan to ensure that the IRO's decision is not contrary to the terms of the Health Plan, unless the terms are inconsistent with applicable law;
- 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 Health Plan, unless the criteria are inconsistent with the terms of the Health Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

The IRO's Decision

The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim;

- The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching 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 you or the Health Plan;

- 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 established under section 2793 of the Public Health Service Act.

Upon receipt of a notice of a reversing the denial of your claims by the Health Plan's claims administrator, the Health Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

After the decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, the Health Plan, or state or federal oversight agencies upon request, except where such disclosure would violate state or federal privacy laws.

Expedited External Review

The Health Plan must allow you to request an expedited external review at the time you receive:

- A notice of an adverse benefit determination (including a final internal adverse benefit determination) from the Health Plan's claims administrator, if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal with the claims administrator would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A denial of an appeal from the Health Plan's claims administrator, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the denial of your appeal from the Health Plan's claims administrator concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan Administrator or its designee will determine whether the request meets the reviewability requirements set forth

above for standard external review. The Plan Administrator or its designee must immediately send you a notice of this eligibility determination.

Referral of Expedited Review to IRO

Upon a determination that a request is eligible for expedited external review, the Plan Administrator or its designee will assign an IRO. The IRO will issue a decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Health Plan.

Limits on Legal Actions

Decisions made under these claims procedures are final and binding on all parties to the maximum extent permitted by law. If your claim for benefits or Administrative Claim is denied on appeal, you generally may file a lawsuit under ERISA regarding your claim, provided that you comply with the deadlines for filing a lawsuit described in this section. If you wish to file a lawsuit, you must do so by the earlier of the date that is 12 months after the date your claim was denied on appeal or the date that is 24 months from the date a cause of action accrued, unless your Health Plan specifies a different deadline. A cause of action "accrues" when you know or should know that the claims administrator has clearly denied or otherwise repudiated your claim. If you choose to file an external appeal, the deadline for filing a lawsuit will be delayed (tolled) while your appeal is pending. The external appeal is voluntary, and you are not required to undertake it before pursuing legal action.

Deemed Exhaustion

In general, you may not request an external review of your claim or bring a legal action for benefits until you have exhausted the internal claims procedures described in this section. In other words, you must complete the mandatory appeal before you may request external review or bring a legal action for your denied claim. If the claims administrator failed to follow the internal claims process properly, you may be deemed to have exhausted the internal claims procedures. However, the internal claims procedures will not be deemed exhausted based on certain minor violations that do not cause, and are not likely to cause, prejudice or harm to you as the claimant.

If you believe that the claims administrator failed to follow the internal claims procedures properly, you may request an explanation of the violation. You will receive a written explanation from the claims administrator within ten days. If the claims administrator believes that the violation was minor and will not deem the claims procedures to be exhausted, the written explanation will include a specific description of the basis for that assertion.

If you request an external review or file a lawsuit based on your belief that the claims administrator has failed to follow the claims procedures properly, and the court or the external reviewer declines to review your claim until you have exhausted the Health Plan's internal claims procedures, you may resubmit your claim for internal review or appeal. The time period

for filing your claim or appeal will be measured from the date the claims administrator notifies you of your right to resubmit your claim or appeal.

COVID-19 Related Claims Deadline Extensions

Certain deadlines under the Master Plan were temporarily extended in connection with the COVID-19 National Health Emergency, to the extent required by applicable law. In particular, deadlines generally were delayed during the period from March 1, 2020 up until July 10, 2023. During that period, the following claims deadlines for participants were delayed, but for no more than 12 months:

- The deadline for filing a claim for benefits under the Health Plans (For example, the deadline for 2021 Plan Year claims was extended by 12 months to March 31, 2023.);

- The 180-day period by which a claimant must file an appeal of an adverse benefit determination under the Health Plans; and

- The deadline by which a claimant must request external review, or provide additional information to perfect a request for external review, of a denied appeal of an adverse benefit determination under the Health Plans.

Effective for any events occurring on or after July 10, 2023 that would trigger one of the deadline extensions above, the deadlines have returned to normal.

THE FUTURE OF THE PLAN

Plan Amendment and Termination

First American expects to continue making the Master Plan and the Health Plans available to eligible employees and their dependents. However, First American reserves the right to modify, amend or terminate the Master Plan or any Health Plan, in whole or in part, in its sole discretion, at any time and in any manner, but subject to requirements of law. Such a modification, amendment, or termination may be either prospective or retroactive and may apply to any benefit, benefit structure, condition for or method of payment, or rate of contribution, either to all participants or to a category of individuals. Furthermore, eligible affiliates may, with the written approval of the First American Board of Directors ("Board") or its duly authorized representative, adopt the Master Plan or any Health Plan or discontinue future participation in the Master Plan or any Health Plan.

If the Company terminates, modifies or amends the Master Plan or any Health Plan at any time, with or without notice, any claims requested after the effective date of termination, modification or amendment are payable in accordance with the respective plan documents, as terminated, modified, or amended. However, no amendment or termination can reduce or otherwise affect any claim for a benefit you became entitled to before the date of amendment or termination. For more information contact the Plan Administrator.

In the event the Master Plan or a Health Plan terminates, you will be informed of any termination rights you may have.

OTHER PLAN INFORMATION

The following is additional information you should have about the Master Plan.

No Employment Contract

Neither the Master Plan nor any Health Plan is a contract between the Company and you or anyone else. The fact that the Company offers the Master Plan and any Health Plan or that you participate in the Master Plan or any Health Plan, does not give you or anyone else the right to Company employment. The Master Plan and the Health Plans also do not interfere with the Company's right to discharge you at any time.

No Assignment of Benefits

Health Plan benefits payable to you or your dependents cannot be voluntarily or involuntarily assigned, alienated, sold, transferred, pledged, encumbered, or charged. Neither the Master Plan nor any Health Plan will recognize any attempt to do any of these things. Moreover, payments from the Master Plan or a Health plan are not directly subject to the debts, contracts, or other liabilities of the person entitled to the payment. However, benefits under the Health Plan may be offset for any amounts required to be paid to the Health Plan by you or on your behalf.

The Master Plan or a Health Plan may make payment on your behalf directly to a provider or other third party; such payment is not an assignment of benefits but is made purely for participants' convenience. The Master Plan and Health Plan is not obligated to follow any direction you or a provider may give or attempt to give as to the payment recipient. Instead, the Master Plan and Health Plan reserves the right to make payment to you directly, in which case it is your responsibility to remit payment to the relevant provider. In some cases, an excess payment may have been made to a provider on behalf of the Master Plan or a Health Plan; the Master Plan or the affected Health Plan reserves the right to recover this payment and/or deem any prior overpayment to be partial or full satisfaction of a later payment to be made on your behalf. See also "Correction of Errors and Other Adjustments" below.

Except as described above and in the case of certain judgments involving crimes against the Master Plan or any Health Plan, no person has or may create a lien, other than a federal tax lien, on any funds, securities or other property held under the Master Plan or any Health Plan.

Payments in Case of Incompetency

If the Plan Administrator determines that anyone entitled to Health Plan benefits is either a minor or is incompetent to receive payment because of mental or physical disability, the Plan Administrator may make the payment to someone else for that person's benefit. Payments made under these conditions completely satisfy the obligations of the Company, the Master Plan, any Health Plan, and the Plan Administrator.

Source of Benefit Payments

The Company is the only source of money for Health Plan benefits. Anyone entitled to benefits can claim payments only from the Company.

Final Authority Governing the Terms of the Plan

This summary plan description summarizes the main features of the Health Plans. The summary plan description is not intended to cover every plan detail.

Complete details are in the legal documents that govern the operation and administration of the Master Plan and the Health Plans. If there should ever be any difference between the summary in this summary plan description and the provisions of the Master Plan, the Master Plan would be the final authority.

Copies of the legal plan documents are on file in the Plan Administrator's office. You can arrange to read them by emailing First American's benefits department at benefitservices@firstam.com or contacting **Accolade**.

Correction of Errors and Other Adjustments

If the Plan Administrator determines, in its sole discretion, that the Master Plan or any Health Plan has made an overpayment, the Plan Administrator may recover the amount of the overpayment by requiring the payee to return the excess payments to the Master Plan or the affected Health Plan, reducing any future payments to the payee, reducing any future payments

made on your behalf, or any other method deemed reasonable by the Plan Administrator. Overpayments made under a self-insured medical plan within the Master Plan may also be recovered from a network provider by reducing future payments to the network provider by the amount of the overpayment. This right does not affect any other right of recovery the Master Plan may have with respect to overpayments.

If the Plan Administrator determines, in its sole discretion, that the Master Plan or any Health Plan has made an underpayment to any individual, the Plan Administrator may correct the underpayment by making a lump-sum payment to the payee, increasing any future payments to the payee, or any other method deemed reasonable by the Plan Administrator.

ADMINISTRATIVE INFORMATION

The following is additional important information about the administration of the Master Plan.

Official Plan Name

The official name of the Master Plan is First American Financial Corporation Group, Life, Medical, Dental, Disability Benefit Plan.

Plan Identification Numbers

Two numbers identify the Master Plan for IRS and Department of Labor records:

- The employer identification number assigned to First American Financial Corporation by the IRS, is 26-1911571 and

- The plan number assigned by First American Financial Corporation is 502.

Plan Sponsor

The sponsor of the Master Plan (including all of the Health Plans) is:

First American Financial Corporation
1 First American Way
Santa Ana, California, 92707

First American Financial Corporation was established on June 1, 2010, when it was spun off from First American Corporation as a separate legal entity. The Master Plan was spun off from its predecessor plan on April 1, 2010, and was transferred to First American Financial Corporation pursuant to the spin-off that established First American Financial Corporation.

Upon written request to the Plan Administrator, participants and beneficiaries may receive information as to whether an affiliate participates in the Master Plan and, if so, that affiliate's address.

Type of Plan

The Master Plan is a welfare benefit plan, as defined in ERISA Section 3(1).

Plan Financial Year

The Master Plan's financial records are kept on the basis of a plan year that begins on January 1 and ends on December 31.

Plan Administrator

The official Plan Administrator of the Master Plan, including all Health Plans, is a committee appointed by the Board, which is known as First American Financial Corporation Administrative Benefits Plan Committee. The Plan Administrator may be contacted at this address and phone number:

First American Financial Corporation
Administrative Benefits Plan Committee
1 First American Way
Santa Ana, CA 92707
1-866-677-2300

The Plan Administrator is responsible for the operation and administration of the Master Plan (including all Health Plans), including:

- Making all decisions and factual determinations needed to carry out plan provisions;
- Requiring information needed for administration of the plan and payment of benefits;
- Making and carrying out rules and determining the use of forms needed for administration;
- Deciding the eligibility of employees to participate based on plan provisions and enrollment materials;
- Determining benefit amounts payable, based on plan provisions;
- Interpreting the terms of the Master Plan and the Health Plan in a manner that is consistent with the Plan Sponsor’s intent; and
- Delegating administrative duties (including the duties listed above) to internal or external parties (including outside professionals) as needed to carry out plan provisions or comply with legal requirements for the plan.

The Plan Administrator is entitled to rely on the advice of outside professionals. Members of the Administrative Benefits Plan Committee are protected against the consequences of any action they take while they are relying, in good faith, on those professionals or on any information the professionals provide. To the extent permitted by law, no member of the Administrative Benefits

Plan Committee is responsible for any action taken by another member, the Company, or the Company's officers and directors.

The Plan Administrator has the discretionary authority to interpret, construe, and apply the terms of the Health Plans. All interpretations, determinations and decisions made by the Plan Administrator with respect to any questions or other matters arising under the Master Plan (including all Health Plans) are final, conclusive and binding.

Funding

The Health Plans are self-insured by the Company, and all benefits are paid from the Company's general assets. No one has any right to any plan assets except as specifically provided in the Master Plan or any Health Plan.

Agent for Service of Legal Process

The agent for service of legal process for the Master Plan (including all Health Plans) is CSC. Any legal process related to the Master Plan or any Health Plan may be served on CSC at the following address:

CSC – Lawyers Incorporating Service
2710 Gateway Oaks Dr., Suite 150N
Sacramento, CA 95833-3505
(888) 690-2882

Claims Administrator

Please refer to the Claim Procedures section of this summary for a description of the claims administrator for each type of claim.

COBRA Administrator

FA Benefits– First American
P. O. Box 0638
Carol Stream, IL 60132-0638
(866) 677-2300

STATEMENT OF YOUR LEGAL RIGHTS UNDER ERISA

As a participant in First American Financial Corporation Group Life, Medical, Dental, Disability Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office at 1 First American Way, Santa Ana, CA 92707, all documents governing the Master Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) filed by the Master Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration;

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

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

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, your spouse, and your dependents if there is a loss of coverage under the Master Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Master Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Master Plan documents or the latest annual report from the Master Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after following the administrative procedures described in the *Claims Procedures* section. In addition, if you disagree with the Plan

Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court after following the administrative procedures described in the *Claims Procedures* section. If it should happen that plan fiduciaries misuse the Master Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Master Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the 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, D.C. 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.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact the Plan Administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under the Health Plans, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

(1) reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact **Accolade** by using the contact information provided on your member ID card and also provided above.

For more information, you can visit this U.S. Department of Health and Human Services website, https://www.cms.gov/cciio, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

- **The Company has not authorized anyone to give you any information that conflicts with the rules in the Master Plan document. If you receive any different information, you should not rely on it.**

SUMMARY PLAN DESCRIPTION

FIRST AMERICAN FINANCIAL CORPORATION

DATED JANUARY 1, 2023