CHANGE HEALTHCARE
HEALTH AND WELFARE PLAN

Plan No. 501

SUMMARY PLAN DESCRIPTION
GENERAL PROVISIONS

Effective as of January 1, 2022

Change Healthcare Operations, LLC
5995 Windward Parkway
Alpharetta, GA 30005
615-932-3000

TABLE OF CONTENTS

Page

Extended Plan Deadlines Due to COVID-19 Pandemic

Please note that, due to the hardship caused by the COVID-19 pandemic and in accordance with federal guidelines, Change Healthcare is extending a number of important deadlines that are described in this Summary Plan Description.

These extensions provide extra time for employees and their family members to:

- request a special enrollment right;
- provide notice of a COBRA qualifying event (or request an extension of COBRA coverage due to a second qualifying event or disability);
- elect and pay for COBRA coverage; and
- file benefit claims and appeals.

Specifically, each of these deadlines will be suspended until the **earlier of**: (1) the date that is 1 year from the date the applicable deadline would have first begun to run without this suspension, and (2) 60 days after the federal government announces the end of the COVID-19 national emergency period. In other words, this suspension period will not count for purposes of determining whether you have met these deadlines.

For more information about these extended deadlines, please contact **Alight** at **833-2PEOPLE** or visit **The People Connection** website at **desktop.pingone.com/changehealthcare**.

INTRODUCTION

Change Healthcare Operations, LLC ("**Change Healthcare**") has established the Change Healthcare Health and Welfare Plan (the "**Plan**") for the benefit of eligible employees of Change Healthcare and its participating affiliates (together, the "**Company**"). This document, along with the various third-party administrator booklets and insurance certificates for the Plan's Benefit Programs, provide a description of the Plan that is intended to satisfy the summary plan description requirements of the Employee Retirement Income Security Act of 1974 ("**ERISA**").

Where a term in this document has a Plan-specific meaning, it is capitalized. For your convenience, the "**Index of Defined Terms**" at the end of this document includes page references to the definitions of these important defined terms.

BENEFIT PROGRAMS OFFERED UNDER THE PLAN

The Plan offers the following benefit programs (the "**Benefit Programs**"):

- A "**Medical Benefit Program**" that provides comprehensive major medical and hospitalization benefits through a Preferred Provider Organization or Exclusive Provider Organization established by Aetna, Anthem, or Cigna (whichever you elect). Beginning with the 2021 Plan Year, eligible employees may also enroll in "on-demand" major medical coverage administered by Bind Benefits. More information about each of these options is included in the Plan's enrollment materials and the Benefit Booklets for the Medical Benefit Program.

  If you are eligible for and elect to participate in the Medical Benefit Program, you will automatically participate in the Plan's Prescription Drug Benefit Program, as well.

  Medical Coverage for Hawaii Employees: Employees in Hawaii are eligible for medical coverage through the Hawaii Medical Service Association ("HMSA"). Details about the HMSA Medical Benefit Program, including the eligibility requirements for the program, are included in the HMSA insurance certificate.

- A "**Prescription Drug Benefit Program**" that provides comprehensive prescription drug coverage for name brand and generic medications through participating pharmacies. You will automatically participate in the Prescription Drug Benefit Program if you enroll in the Medical Benefit Program.

- A "**Dental Benefit Program**" that provides preventive dental care and protection against certain dental expenses through a Preferred Provider Organization (the Core and Standard Plan options) or Dental Health Maintenance Organization (the DHMO Plan option).

- A "**Vision Benefit Program**" that provides benefits for eye exams, contact lenses, and prescription eyeglasses through a Preferred Provider Organization.

- A "**Long Term Disability ("LTD") Insurance Benefit Program**" that provides you long-term income replacement benefits should you become totally disabled. The Company pays the entire cost of basic LTD insurance. You may also purchase supplemental LTD insurance.

- A "**Life and Accidental Death and Dismemberment ("AD&D") Insurance Benefit Program**" that provides benefits to your beneficiaries in the event of your death, and benefits for you or your beneficiaries in the event of an accident that directly causes dismemberment (the loss of a hand, foot, or eye). The Company pays the entire cost of basic life and AD&D insurance benefits. You may also purchase supplemental life and AD&D insurance for yourself and dependent life and AD&D insurance for your Eligible Dependents.

- A "**Pre-Tax Payment Benefit Program**" that allows you to pay with pre-tax dollars your share of the cost of certain Benefit Programs that require contributions from you. (See **Appendix A** for a list of the Benefit Programs that you may pay for on a pre-tax basis.) The Pre-Tax Payment Benefit Program also allows you to make pre-tax contributions to a Health and/or Dependent Care FSA or a Health Savings Account.

- A "**Health Care Flexible Spending Account ("Health Care FSA") Benefit Program**" that allows you to pay for certain health care expenses on a pre-tax basis. You may choose to contribute up to $2,750 per Plan Year to your Health Care FSA. (This annual dollar limit may be increased in future years for cost-of-living adjustments, as communicated each year in the annual enrollment materials for the Plan.)

- A "**Dependent Care Flexible Spending Account ("Dependent Care FSA") Benefit Program**" that allows you to pay for certain dependent care expenses on a pre-tax basis, up to an annual maximum of $5,000 per household ($2,500 if you are married, filing separately).

- A "**Wellness Program**" that provides you with access to a variety of wellness resources to help you maintain a healthy lifestyle. If you enroll in the Plan's Medical Benefit Program, you will be eligible to earn wellness rewards, in the form of lower medical premiums, for participating in certain wellness activities.

- An "**Employee Assistance Program ("EAP")**" that provides confidential counseling and referral services for work, family, personal, legal, and financial matters.

- "**Accident, Critical Illness, and Hospital Indemnity Insurance Benefit Programs**" that allow you to purchase accident, critical illness, and hospital indemnity insurance to cover the unexpected costs that may result from an accident, or if you or a family member experiences a serious illness or needs to be hospitalized.

- A "**Legal Services Plan**" that allows you to purchase legal services for assistance with personal legal matters.

- A "**Business Travel Accident Insurance Benefit Program**" that provides benefits to you or your beneficiaries in the event of your death, paralysis, or loss of limbs due to an accident occurring during business travel.

PREFERRED HEALTH CARE PROVIDERS

Benefits under the Medical, Prescription Drug, Dental, and Vision Benefit Programs are offered through a Preferred Provider Organization or Exclusive Provider Organization, depending on which options you elect. The Dental Benefit Program also includes a Dental Health Maintenance Organization option for certain Company locations.

- A "**Preferred Provider Organization**" or "**PPO**" is a group of health care providers, pharmacies, or dentists that contract to provide health, pharmacy, dental, or vision services on a discounted fee-for-service basis. These providers are referred to as network providers, and they have agreed through a contract to accept an approved amount as payment in full for covered services (but you remain responsible for any Deductible, Coinsurance, and/or Copayment required by the Plan). When network providers are used, the levels of coverage under the Plan are higher, and your out-of-pocket expenses are lower. When receiving care from a network provider, you may need to show your Plan identification card.

  The PPO options offered under the Plan may also offer out-of-network coverage. When you receive care from an out-of-network provider, levels of coverage under the Plan are lower, and your out-of-pocket expenses are higher. Out-of-network providers may require you to pay the bill up front and file a claim for reimbursement from the Plan. Also, if you receive services from an out-of-network provider and the out-of-network provider will not accept the amount approved by the Plan as payment in full for covered services (as described in more detail in the Benefit Booklets), you will be responsible for the difference between the approved amount and the provider's charges, in addition to any Deductible, Coinsurance, and/or Copayment required by the Plan.

- An "**Exclusive Provider Organization**" or "**EPO**" is a type of health plan that offers a local network of doctors and hospitals for you to choose from. With the EPO options offered under the Plan, you will have low copays for doctor office visits, even lower copays for virtual office visits, and prescription drug coverage that will bypass the deductible, and that has a maximum cost associated with each prescription filled. You can use the doctors and hospitals within the EPO network but cannot go outside the network for care. This means that if you choose to get care outside of the EPO network, your expenses generally will not be covered by the Plan.

- The "**Dental Health Maintenance Organization**" or "**DHMO**" is a lower-cost dental option that requires you to use dentists within the DHMO option's network. The DHMO option will offer price transparency for services and has no annual maximum benefit but offers no out-of-network benefits. The DHMO option is only available to employees of certain Company locations.

Lists of participating network physicians, hospitals, pharmacies, dentists, and other health care professionals for the Medical, Prescription Drug, Dental, and Vision Benefit Programs are available, without charge, from the applicable third-party administrator's website, or by contacting the third-party administrator directly. Please refer to **Appendix A** for the website and contact information for the third-party administrators and insurers for each of the Plan's Benefit Programs. Before using a particular provider for health care, pharmacy, dental care, or vision services, you should confirm whether they are a participating or a non-participating provider under the Plan.

THIRD-PARTY ADMINISTRATOR BOOKLETS AND INSURANCE CERTIFICATES

Some of the Plan's Benefit Programs are "**Self-funded**" by the Company. This means that the Company pays the benefits from its general assets, and the benefits are not guaranteed by an insurance company. Other Benefit Programs are "**Insured**." This means that the Company's contributions and your contributions (as applicable) are used to pay insurance premiums to an insurance company, and the insurance company pays the benefits under a group insurance policy. **Appendix A** lists whether each Benefit Program offered under the Plan is Self-funded or Insured.

The third-party administrators that administer the Self-funded Medical, Prescription Drug, Dental, and Vision Benefit Programs produce booklets and/or benefit summaries (collectively, "**Benefit Booklets**") that provide a detailed description of the benefits available under those Benefit Programs. The Benefit Booklets prepared by the Plan's third-party administrators, together with this document, are the "**Summary Plan Descriptions**" (or "**SPDs**") for the Plan's Self-funded Medical, Prescription Drug, Dental, and Vision Benefit Programs.

For each Insured Benefit Program, there is a group insurance policy that serves as part of the official Plan document for that Benefit Program. The insurer for each Insured Benefit Program also prepares one or more booklets, summaries, and/or insurance certificates (collectively, "**Insurance Certificates**") that describe in detail the benefits available under that Benefit Program. The Insurance Certificates prepared by the insurance carriers, together with this document, are the Summary Plan Descriptions for the Plan's Insured Benefit Programs. For any Insured Benefit Program, if there is any conflict between the terms of this document and the group insurance policy with respect to the specific benefits offered under the Benefit Program, the terms of the group insurance policy for the Benefit Program will control.

EFFECTIVE DATE

This document describes the Plan as in effect on January 1, 2022. Please read this document, and the Benefit Booklets and Insurance Certificates for each of the Benefit Programs in which you are enrolled, carefully and keep them for future reference. The provisions in this document related to eligibility and participation supersede any provisions stated in the Benefit Booklets and Insurance Certificates, except for the Insured Benefit Programs that have certain state mandated eligibility standards for dependents. If you have any questions about any of the Benefit Programs or the Plan in general, please contact **Alight** at **833-2PEOPLE** or visit **The People Connection** website at **desktop.pingone.com/changehealthcare**.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

You are eligible to participate in each of the Benefit Programs offered under the Plan if you are classified by the Company as a full-time employee that is regularly scheduled to work at least 30 hours per week in a position that is not excluded from eligibility (an "**Eligible Employee**"). The positions that are excluded from eligibility are described below. For purposes of the EAP only, you are also considered an "Eligible Employee" if you are classified by the Company as a part-time employee that is regularly scheduled to work at least 20 hours per week in a position that is not excluded from eligibility.

You are eligible to participate in the Plan beginning on the first day of the month that falls after your date of hire as an Eligible Employee. (For example, if you are hired as an Eligible Employee on March 1, you will be eligible to participate in the Plan on April 1). This is your "**Waiting Period**." To enroll in the Plan, you will need to timely complete the Plan's on-line enrollment process, as described in more detail in the "**Participation**" section below.

You are not eligible to participate in the Plan if you are classified by the Company as:

- An independent contractor, a leased employee, or an employee of a non-participating company, whether or not you are an actual employee of the Company;
- A union employee, unless otherwise required by a collective bargaining agreement;
- A nonresident alien that does not receive U.S. source income;
- An intern;
- A seasonal or temporary employee (other than an intern), unless the Company determines that the individual qualifies as a "full-time employee" under the Patient Protection and Affordable Care Act (the "ACA") and offers the individual coverage under the Plan's Medical and Prescription Drug Benefit Programs in accordance with its policy for implementing the ACA's employer mandate provisions;
- An individual who has waived participation in the Plan by any means; or
- An employee who is covered under a health and welfare benefit plan sponsored by a foreign affiliate of the Company.

For the LTD, Life, AD&D, and Accident, Critical Illness, and Hospital Indemnity Insurance Benefit Programs, you must be "actively at work" during your Waiting Period and when your Waiting Period ends to be eligible to participate. Please see the Insurance Certificates for these Benefit Programs for more information on this requirement, including the definition of "actively at work."

Special Eligibility Rules for the Medical and Prescription Drug Benefit Programs. For the Medical and Prescription Drug Benefit Programs only, the Company uses a special service counting method (called the "look-back" method) to determine whether employees with variable work schedules have sufficient hours of service to obtain full-time employee status

based on rules adopted by the Company to comply with the employer mandate provisions of the ACA. Under the look-back method, the Company calculates the hours of service of the employee in a prior period (called the "measurement period") to determine the status of the employee during a future period (called the "stability period"). Details regarding each of these periods and the rules for counting hours of service are available upon request to the Plan Administrator. Determination of full-time employee status for purposes of the Plan's Medical and Prescription Drug Benefit Programs will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the applicable employer mandate provisions of the ACA and its accompanying regulations.

REHIRED EMPLOYEE ELIGIBILITY

If you terminate employment with the Company and are rehired as an Eligible Employee within the same Plan Year, you will automatically be reinstated in the Benefit Programs you were participating in prior to your termination if you are rehired within 30 days of your termination date (in other words, you will not be permitted to make new benefit elections). However, if you are rehired more than 30 days after your termination date, you will be permitted to make new benefit elections upon your reemployment. The same rule applies if you cease to be an Eligible Employee for reasons other than termination of employment and then return to Eligible Employee status within the same Plan Year.

If you are rehired by the Company within 12 months of your termination date, any prior service as an Eligible Employee will count toward the Plan's Waiting Period. This means that if you completed the Plan's Waiting Period prior to your termination date, any coverage you elect will be effective immediately on your date of rehire, as long as you re-enroll within 31 days of your rehire date. If you are rehired by the Company more than 12 months after your termination date, your prior service as an Eligible Employee will not count toward the Plan's Waiting Period, and you will need to satisfy the Waiting Period again. If you cease to be an Eligible Employee for reasons other than termination of employment and then return to Eligible Employee status, your prior service as an Eligible Employee will count toward the Plan's Waiting Period, regardless of whether you return to Eligible Employee status within 12 months.

DEPENDENT ELIGIBILITY

Certain members of your family are eligible for coverage under the Plan's Medical, Prescription Drug, Dental, and Vision Benefit Programs, and the EAP. You may also elect coverage for your Eligible Dependents under the Life and AD&D Insurance Benefit Programs and the Accident, Critical Illness, and Hospital Indemnity Insurance Benefit Programs.

For purposes of the Medical, Prescription Drug, Dental, and Vision Benefit Programs, an "**Eligible Dependent**" is:

- Your Spouse;
- Your Child until he or she reaches age 26 (although your Child will continue to be an Eligible Dependent, if all other criteria are met, until the end of the month in which your Child turns age 26); and

- Your Child who is age 26 or older who resides with you and who meets all of the following requirements:
    - your Child is incapable of self-sustaining employment due to a severe physical or mental condition that is expected to last indefinitely;
    - your Child is primarily dependent on you for support and maintenance and is indicated as such on your most recent federal tax return;
    - your Child was covered under this Plan or another group health plan immediately prior to reaching age 26; and
    - you provide proof of these facts to the Plan Administrator, and you provide continuing proof as requested by the Plan Administrator.

  For your Child to continue to be an Eligible Dependent after reaching age 26, the Plan Administrator must be notified **within 31 days** of your Child's 26th birthday. Written proof that your Child continues to meet the Plan's eligibility criteria may be requested by the Plan Administrator from time to time.

"**Spouse**" means the one person to whom you are legally married under state law. A divorced former Spouse of an Eligible Employee is not an Eligible Dependent under any circumstances.

"**Child**" means (1) your biological child; (2) your legally adopted child or child placed with you in anticipation of the child's being adopted; (3) your stepchild; (4) a child for whom you or your Spouse has permanent legal guardianship; or (5) a child who must be provided health coverage under the Plan as required by a Qualified Medical Child Support Order.

Please Note: If you and your Spouse or Child both work for the Company as Eligible Employees, your Spouse or Child can be enrolled in the Plan as an Eligible Employee or as your Eligible Dependent, but not both. Similarly, if both parents are Eligible Employees, their Child may be covered as an Eligible Dependent of one parent or the other, but not of both.

For purposes of the EAP, an Eligible Dependent means (1) any member of your household, and (2) your Children up to age 26, whether or not they live at home.

Please refer to the relevant Insurance Certificates to determine who is an Eligible Dependent for purposes of the Life and AD&D Insurance Benefit Programs and the Accident, Critical Illness, and Hospital Indemnity Insurance Benefit Programs.

PROOF OF DEPENDENT STATUS

It is your responsibility to provide accurate information and to make accurate and truthful statements regarding family status, age, relationships, *etc.*, and to update previously provided information and statements as soon as possible, but no later than **31 days** after the relevant event. Failure to do so may be considered an intentional misrepresentation of material fact, and may result in termination of Plan coverage, including a retroactive termination of coverage. At any time, the Plan Administrator may require proof that a person qualifies or continues to qualify as

an Eligible Dependent. Your failure to provide required evidence of eligibility may be considered intentional misrepresentation of material fact and may, as determined by the Plan Administrator, result in disenrollment of the individual for whom such evidence is requested, including a retroactive disenrollment.

Coverage under a Benefit Program will end on the date an individual is no longer eligible for participation in that Benefit Program as an Eligible Dependent, even if the Plan discovers the individual is no longer eligible at a later date. The Plan has the right to recover from you any payments the Plan makes on behalf of an individual who is no longer an Eligible Dependent.

Please Note: For purposes of electing COBRA Continuation Coverage, you have 60 days to provide the Plan with notice of a Qualifying Event, such as a divorce or a Child's loss of Eligible Dependent status. For more information on your COBRA rights under the Plan, please see "**COBRA Continuation Coverage**" below.

PARTICIPATION

INITIAL ENROLLMENT PERIOD

If you are an Eligible Employee, once you have completed your Waiting Period, the Company will automatically enroll you in the Benefit Programs that do not require you to make any elections or Benefit Contributions ("**Default Benefit Programs**"). The Default Benefit Programs offered under the Plan are: Basic LTD Insurance, Basic Life Insurance, Basic AD&D Insurance, and the EAP.

To begin participating in the other Benefit Programs offered under the Plan, you must complete the Plan's on-line enrollment process by logging on to **The People Connection** enrollment site via PingOne (**desktop.pingone.com/changehealthcare**) within **31 days** of becoming an Eligible Employee (this 31-day period is referred to as your "**Initial Enrollment Period**"). On the Plan's enrollment website, you may elect the coverage you prefer for yourself and your Eligible Dependents. You will also agree to have your pay reduced on a pre-tax or after-tax basis (as applicable) for any Benefit Contributions. If you have any questions about enrollment in the Plan, please contact Alight at 833-2PEOPLE for assistance.

After you complete the on-line enrollment process, your Plan coverage will start on the first day of the month following your date of hire as an Eligible Employee. The benefit choices you make during your Initial Enrollment Period will remain in effect for the remainder of the Plan Year, unless you become eligible for a Special Enrollment Period, or you experience another Qualified Change Event (as described below) and you make new benefit elections.

If you do not enroll yourself (and your Eligible Dependents) during your Initial Enrollment Period, you will participate in the Default Benefit Programs only for the remainder of the Plan Year. You will not be able to enroll in any of the Plan's other Benefit Programs until the next Open Enrollment Period, unless you become eligible for a Special Enrollment Period, or you experience another Qualified Change Event (as described below) and you make new benefit elections.

Please Note: For supplemental coverage under the Life and AD&D Insurance Benefit Programs, you may need to provide evidence of insurability if you elect coverage over the guaranteed issue amount or enroll outside of your Initial Enrollment Period. Please refer to the Plan's enrollment materials and the applicable Insurance Certificates for additional information relating to evidence of insurability.

SPECIAL ENROLLMENT RULES FOR HEALTH SAVINGS ACCOUNTS

If you enroll in one of the high deductible health plan ("**HDHP**") options offered under the Medical Benefit Program, the Plan allows you to make pre-tax contributions to a Health Savings Account ("**HSA**") that can be used to pay for qualified health care expenses. The Company, in its discretion, may also contribute to your HSA on your behalf. If you enroll in one of the EPO options offered under the Medical Benefit Program, or in the Bind Benefits "on demand" medical coverage option, you will not be eligible to participate in an HSA.

An HSA is not an employer-sponsored employee benefit plan. It is an individual account that you open with an HSA trustee or custodian to be used primarily for paying your qualified health care expenses. Your HSA belongs to you, even if you leave the Company, and you may use the account to save for your health care expenses, including health care expenses that arise after you retire.

The Company will provide you with the name of the Plan's designated HSA trustee or custodian during your Initial Enrollment Period. To start making HSA contributions, you must:

- Enroll in one of the HDHP options offered under the Medical Benefit Program; and
- Complete the procedures outlined in your enrollment materials for establishing an HSA and electing your contribution amount.

You may prospectively change your HSA contribution election at any time during the Plan Year by changing your election through **The People Connection** enrollment site via PingOne (**desktop.pingone.com/changehealthcare**). Changes made during the Plan Year will be effective on the first day of the month following your election change.

OPEN ENROLLMENT PERIOD

Each year, the Plan Administrator establishes an "**Open Enrollment Period**," usually in November. During the Open Enrollment Period, you can enroll for the first time or make new benefit choices for the upcoming Plan Year by enrolling online through **The People Connection** enrollment site via PingOne (**desktop.pingone.com/changehealthcare**) during the time period stated in the open enrollment materials. The open enrollment materials will provide detailed information about the Benefit Programs available during the upcoming Plan Year and the cost of those Benefit Programs.

The Plan Administrator may choose each year whether to use an Active or Passive Open Enrollment Period. Before the Open Enrollment Period begins each year, you will be notified as to whether the Open Enrollment Period will be Active or Passive.

Active Open Enrollment Period

An "**Active Open Enrollment Period**" requires you to take action to enroll or remain enrolled in the Plan. If you do not enroll or make new benefit choices during an Active Open Enrollment Period, your benefit elections for the previous Plan Year will end. If you would like to continue your Plan coverage or enroll in the Plan for the first time during an Active Open Enrollment Period, you must complete the Plan's online enrollment process during the Open Enrollment Period, as described in the Plan's open enrollment materials. However, as long as you remain an Eligible Employee, the Company will continue your participation in the Default Benefit Programs (as described above) even if you do not actively enroll during the Active Open Enrollment Period.

Passive Open Enrollment Period

During a "**Passive Open Enrollment Period**," if you do not change your existing benefit elections during the Open Enrollment Period, your benefit elections for the previous Plan Year – other than your elections for the Health and Dependent Care FSA Benefit Programs and your HSA contribution election – will remain in effect during the upcoming Plan Year. Please note that you will be responsible for any increased Benefit Contributions required for these Benefit Programs.

If you would like to enroll in a Benefit Program for the first time or make changes to your Plan coverage during a Passive Open Enrollment Period, you must complete the Plan's online enrollment process during the Open Enrollment Period, as described in the Plan's open enrollment materials. You will always need to make new elections each year for the Health and Dependent Care FSA Benefit Programs. You must also make new HSA contribution elections each year. Your Health and Dependent Care FSA and HSA contribution elections do not carry over from year to year, even during a Passive Open Enrollment Period.

For both an Active and Passive Open Enrollment Period, the benefit choices you make (or are deemed to have made) during the Open Enrollment Period will take effect on January 1st and will remain in effect until the next December 31st. You may not change your benefit choices during this period, unless you become eligible for a Special Enrollment Period, or you experience another Qualified Change Event (as described below).

SPECIAL ENROLLMENT PERIOD

In certain circumstances, you and your Eligible Dependents may enroll in the Medical Benefit Program (including the Prescription Drug Benefit Program) outside of your Initial Enrollment Period and the Plan's Open Enrollment Period, during what is referred to as a "**Special Enrollment Period**." For example, the Plan provides you with a Special Enrollment Period if you acquire a new Eligible Dependent through marriage, birth, or adoption, or if you decline coverage under the Medical Benefit Program for yourself or an Eligible Dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

You must request special enrollment by the deadline outlined below (in most cases, this deadline is **31 days** from the event that provides you with a Special Enrollment Period). You

may request special enrollment through **The People Connection** enrollment site via PingOne (**desktop.pingone.com/changehealthcare**) or by calling Alight at 833-2PEOPLE. To obtain more information about your special enrollment rights under the Plan, please contact Alight at 833-2PEOPLE.

You and your Eligible Dependents may enroll in the Medical Benefit Program during a Special Enrollment Period under the following circumstances:

Loss of Other Coverage (Other than Medicaid or a State Children's Health Insurance Program)

If you are an Eligible Employee, you may enroll yourself and your Eligible Dependents in the Medical Benefit Program if you declined coverage for yourself or an Eligible Dependent when it was first available because of other group health plan or health insurance coverage (except Medicaid or a state children's health insurance program, which is described below), and that coverage is later lost because:

- the coverage was provided under COBRA, and the entire COBRA coverage period was exhausted;
- the coverage was non-COBRA coverage and the coverage terminated because of loss of eligibility for coverage; or
- the coverage was non-COBRA coverage and employer contributions for the coverage were terminated.

However, you must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage). If you request special enrollment within this 31-day period, your coverage under the Medical Benefit Program will begin as soon as administrative practicable after the date the Plan receives your request for special enrollment.

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program

If you are an Eligible Employee and you decline enrollment for yourself or your Eligible Dependents while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may enroll yourself and your Eligible Dependents in the Medical Benefit Program if you or your Eligible Dependents lose eligibility for that other coverage.

You must request enrollment within 60 days after coverage ends under Medicaid or a state children's health insurance program. If you request special enrollment due to a loss of coverage under Medicaid or a state children's health insurance program within this 60-day period, your coverage under the Medical Benefit Program will begin as soon as administratively practicable after the date the Plan receives your request for special enrollment.

New Eligible Dependents

If you initially declined coverage under the Medical Benefit Program for yourself or an Eligible Dependent and you later have a new Eligible Dependent because of marriage, birth,

adoption, or placement for adoption, you may enroll yourself and your new Eligible Dependent – including your Spouse if you have a new Eligible Dependent Child – in the Medical Benefit Program.

For example, if you and your Spouse have a Child, you may enroll yourself, your Spouse, and your new Child in the Medical Benefit Program, even if you were not previously enrolled. You will not have a special enrollment right with respect to an existing Eligible Dependent Child for whom coverage has been waived in the past. However, you may enroll that Child in the Plan under the Plan's Qualified Change Event rules, as described below.

You will need to enroll your Eligible Dependents in the Medical Benefit Program within 31 days after the date of the marriage, birth, adoption, or placement for adoption, regardless of whether the enrollment will result in an increase in your Benefit Contributions (*i.e.*, even if you are already enrolled in Employee + Child(ren) or Family coverage).

For a new Spouse or Child acquired by marriage, coverage under the Medical Benefit Program will be effective as soon as administratively practicable after the date the Plan receives your timely request for special enrollment. When a new Eligible Dependent Child is acquired through birth, adoption, or placement for adoption, coverage will be effective retroactively to the date of the birth, adoption, or placement for adoption, as long as the enrollment is requested within 31 days after the birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Through Medicaid or a State Children's Health Insurance Program

If you are an Eligible Employee and you or your Eligible Dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program, you may enroll yourself and your Eligible Dependents in the Medical Benefit Program.

You must request enrollment within 60 days after you or your Eligible Dependent becomes eligible for such assistance. Coverage will begin as soon as administratively practicable after the date the Plan receives your timely request for special enrollment.

QUALIFIED CHANGE EVENTS

You may not change your pre-tax Benefit Program elections (other than your HSA contribution election) during the Plan Year unless you become eligible for a Special Enrollment Period (as discussed above) or you experience another qualified change event ("**Qualified Change Event**"), and the change you want to make is consistent with the Qualified Change Event. The pre-tax Benefit Programs offered under the Plan are listed in **Appendix A** and include the Medical, Prescription Drug, Dental, Vision, Supplemental LTD Insurance, and Health and Dependent Care FSA Benefit Programs.

Note that not all of the Qualified Change Event rules apply to all pre-tax Benefit Programs – applicable exclusions are described under the relevant subheadings below. Note also

that no change can be made with respect to an Insured Benefit Program if the change is not permitted under the Insurance Certificate for that Benefit Program.

For the after-tax Benefit Programs (Supplemental Life and AD&D Insurance; Accident, Critical Illness, and Hospital Indemnity Insurance; and the Legal Services Plan), you may make a mid-year election change only to the extent provided in the applicable Insurance Certificate. Please see the Insurance Certificates for the after-tax Benefit Programs for additional information.

Procedures for Changing Elections Mid-Year

If you would like to change your benefit elections because of a Qualified Change Event, you must provide notice of the event through **The People Connection** enrollment site via PingOne (**desktop.pingone.com/changehealthcare**) or by calling Alight at 833-2PEOPLE within **31 days** after the occurrence of the event. You may be asked to provide documentation of the event (for example, a divorce decree). If you file a request after the required notice period or fail to provide any requested documentation of the event, no changes will be made to your benefit elections, but you may make the necessary changes during the next Open Enrollment Period.

Your request will generally be effective as soon as administratively practicable after your timely request to change your benefit elections. However, when a new Eligible Dependent Child is acquired through birth, adoption, or placement for adoption, coverage will be effective retroactively to the date of the birth, adoption, or placement for adoption, as long as you timely request enrollment.

Please Note: If the change involves your Spouse or Child losing eligibility for benefits under the Plan, then the change will be deemed effective on the date eligibility is lost, even if you do not request it within 31 days. Failure to inform the Plan that an individual is no longer eligible for coverage under the Plan is considered an intentional misrepresentation of material fact entitling the Plan to retroactively cancel the individual's coverage. The Plan will return any Benefit Contributions you made on behalf of the ineligible individual and has the right to recover from you any payments the Plan makes on behalf of the ineligible individual.

Please also note: If you would like to add your Eligible Dependent to the Medical, Dental, or Vision Benefit Program as a result of a Qualified Change Event, you must enroll your Eligible Dependent within 31 days after the date of the Qualified Change Event, regardless of whether the enrollment will result in an increase in your Benefit Contributions (*i.e.*, even if you are already enrolled in Employee + Child(ren) or Family coverage).

In addition, if you would like to elect coverage under the dependent Life and AD&D Insurance Benefit Program, you will need to do so within 31 days after your Qualified Change Event.

You may change your benefit elections under the Plan under the following circumstances:

Change in Status (Applies to All Pre-Tax Benefit Programs)

If one or more of the following change in status events occur, you may revoke your old election and make a new election, provided the changes you make are on account of and correspond with the change in status event (as described below):

- A change in your legal marital status (for example, marriage, divorce, annulment, or death of a Spouse);
- A change in the number of your Eligible Dependents (for example, the birth, adoption, or placement for adoption of a Child);
- Any of the following events that change the employment status of you, your Spouse, or your Child and that affect eligibility under the Plan or under another employee benefit plan of you, your Spouse, or your Child: termination or commencement of employment; a strike or lockout; taking or returning from an unpaid leave of absence; a change in worksite; changing from salaried to hourly paid, union to non-union, or part-time to full-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit plan;
- A change in your, your Spouse's, or your Child's place of residence that affects the individual's eligibility for coverage; or
- An event that causes your Eligible Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (for example, attaining a specific age).

Change in Status: Other Requirements

If you wish to change your election based on a change in status event, you must establish that the change is on account of and corresponds with the event. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a requested change is on account of and corresponds with a change in status event. As a general rule, a desired election change will be found to be consistent with a change in status event if the event affects eligibility for coverage.

In addition, you must satisfy the following specific requirements in order to alter your election based on a change in status:

- *Loss of Spouse or Dependent Eligibility.* For a change in status involving your divorce or annulment from your Spouse, the death of your Eligible Dependent, or your Eligible Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel coverage for the affected Spouse or Child. A change in election for any other individual would fail to correspond with that change in status event.
- *Gain of Eligibility Under Another Employer's Plan.* For a change in status in which you, your Spouse, or your Child gains eligibility for coverage under another employer's plan as a result of a change in your marital status or a change in employment status, your election to drop coverage for that individual under the

Plan would correspond with the change in status event only if coverage for that individual actually becomes effective under the other employer's plan.

- *Dependent Care FSA Benefits.* With respect to the Dependent Care FSA Benefit Program, you may change your election with respect to a change in status event only if (1) the change is made on account of and conforms with a change in status that affects eligibility for coverage under the Dependent Care FSA Benefit Program; or (2) the change is on account of and conforms with a change in status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

Special Enrollment Rights (Applies to the Medical and Prescription Drug Benefit Programs Only)

If you become eligible for a Special Enrollment Period (as described in "**Special Enrollment Period***"* above), you may change your election under the Plan to correspond with the special enrollment right.

Please Note: If you are eligible for a Special Enrollment Period as a result of the acquisition of a new Spouse or Child, you may also change your election to add previously eligible Children (even though those previously eligible Children do not themselves have a special enrollment right).

Certain Judgements, Decrees, and Orders (Applies to the Medical, Prescription Drug, Dental, Vision, and Health Care FSA Benefit Programs)

If a judgment, decree, or order from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requires health coverage for your Child under this Plan, you may change your election to provide coverage for the Child. If the order requires that another individual (such as your former Spouse) cover the Child, then you may change your election to revoke coverage for the Child, but only if that other coverage is, in fact, provided for the Child.

Medicare or Medicaid Entitlement (Applies to the Medical, Prescription Drug, Dental, Vision, and Health Care FSA Benefit Programs)

If you or your Eligible Dependent becomes enrolled in coverage under Medicare or Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines), then you may cancel that person's coverage under the Plan, including your Health Care FSA contributions for that individual. Similarly, if you or an Eligible Dependent who has been entitled to Medicare or Medicaid loses eligibility for that coverage, then you may enroll that individual in coverage under the Plan.

Change in Cost (Applies to All Pre-Tax Benefit Programs Other Than the Health Care FSA Benefit Program)

If the cost charged to you for your benefits coverage significantly increases during the Plan Year, then you may choose to do any of the following:

- make a corresponding increase in your Benefit Contributions;
- revoke your election and receive coverage under another Benefit Program option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or
- drop your coverage, but only if no other Benefit Program option provides similar coverage.

If the cost of coverage significantly decreases during the Plan Year, then you may make the following election changes:

- if you are enrolled in the Benefit Program option that has decreased in cost, you may make a corresponding decrease in your Benefit Contributions;
- if you are enrolled in another Benefit Program option, you may change your election on a prospective basis to elect the option that has decreased in cost; or
- if you are otherwise eligible, you may elect the Benefit Program option that has decreased in cost on a prospective basis, subject to the terms and limitations of that option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your Benefit Contributions to reflect the minor change in cost. The Plan Administrator in its sole discretion, and on a uniform and consistent basis, will determine whether an increase or decrease is significant. The Plan Administrator will notify you of increases or decreases in the cost of coverage.

In addition, you may change your benefit elections for the Dependent Care FSA Benefit Program if you experience a significant increase or decrease in your Eligible Dependent Care Expenses. The change in cost provision applies to Dependent Care FSA benefits only if the cost change is imposed by a dependent care provider who is not your relative.

Change in Coverage (Applies to All Pre-Tax Benefit Programs Other Than the Health Care FSA Benefit Program)

You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your benefits coverage is significantly curtailed without a loss of coverage, then you may revoke your election for that coverage and elect coverage under another option that provides similar coverage. If your coverage is significantly curtailed with a loss of coverage (for example, a reduction in benefits for a specific type of medical condition for which treatment is being received), then you may either revoke your election and elect coverage

under another Plan option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the Plan that provides similar coverage.

- *Addition or Significant Improvement of Benefit Program.* If the Plan adds a new Benefit Program option or significantly improves an existing option, Eligible Employees, including those who are not already enrolled in the Plan, may elect to enroll in the new or improved option, subject to any limitations imposed by the applicable Benefit Program.
- *Loss of Other Group Health Coverage.* You may add group health coverage for you or your Eligible Dependents if any of you loses coverage under a group health plan sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of your Spouse's or Child's employer), so long as (1) the other plan permits its participants to make an election change permitted under the cafeteria plan regulations; or (2) the Plan's Open Enrollment Period and Plan Year are different from the annual enrollment period and period of coverage under the other plan.
- *Dependent Care FSA Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change in your dependent care service provider. For example, if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider. Also, if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

Exchange Enrollment (Applies to the Medical and Prescription Drug Benefit Programs Only)

If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual enrollment period, you may prospectively drop coverage under the Medical and Prescription Drug Benefit Programs to enroll in Marketplace coverage, provided that you certify that the Marketplace coverage will be effective no later than the day following the last day of your coverage under the Plan.

Reduction in Hours *(*Applies to the Medical and Prescription Drug Benefit Programs Only)

If you were reasonably expected to average 30 hours of service or more per week, and you experience an employment status change such that you are reasonably expected to average less than 30 hours of service per week, you may prospectively revoke your election for coverage under the Medical and Prescription Drug Benefit Programs, provided that you certify that you and any Eligible Dependents whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under the Patient Protection and

Affordable Care Act that is effective no later than the first day of the second month following the month that includes the date the coverage under the Plan is dropped.

PARTICIPATION DURING A LEAVE OF ABSENCE

If you go on a leave of absence that has been approved by the Company, the Company will continue to maintain your coverage under certain of the Plan's Benefit Programs on the same terms and conditions as if you were still active (that is, the Company will continue to pay its share of the cost of your coverage). Your participation in the Plan's Medical, Dental, Vision, and Healthcare FSA Benefit Programs will continue for up to 52 weeks while you are on a disability or other approved medical leave of absence. Your coverage under the Plan's other Benefit Programs may also be continued to the extent provided under the applicable insurance certificates for those Benefit Programs. Your coverage under the Dependent Care FSA Benefit Program may not be continued during a leave of absence.

Please Note: Special rules apply to a qualified military leave of absence, as described in "**Participation During Military Leave of Absence**" below.

Please also see the "**Health Care Flexible Spending Account Benefit Program**" and "**Dependent Care Flexible Spending Account Benefit Program**" sections below for special rules about how taking a leave of absence impacts your Health Care and Dependent Care FSA benefits.

Paid Leave of Absence. For purposes of the Plan, your leave of absence will be considered a paid leave of absence during the period of your leave (if any) that you receive compensation directly from the Company through payroll. If you are taking a paid leave of absence, the Company will continue to make payroll deductions to collect your Benefit Contributions while you are on paid leave.

Unpaid Leave of Absence. For purposes of the Plan, your leave of absence will be considered an unpaid leave of absence during the period of your leave (if any) that you do not receive compensation directly from the Company through payroll, including periods where you receive compensation solely from an insurance carrier. If you are taking an unpaid leave of absence, you must continue to pay for your Plan coverage (1) through The People Connection with automatic monthly deductions, direct debit from your bank account, or other online payment, or (2) by sending a check or money order via first class mail to the address on your direct billing invoice.

If your approved leave of absence extends beyond the extended coverage period provided for under the applicable Benefit Program (as described above), your participation in that Benefit Program will end. You may, however, be eligible to continue your coverage under the Plan's group health benefit programs at your cost for a limited period of time (see the section titled "**COBRA Continuation Coverage**" for more information).

You should refer to the Company's leave of absence policy and consult with the Company's Human Resources Department before taking any leave.

PARTICIPATION DURING A MILITARY LEAVE OF ABSENCE

If you take a military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("**USERRA**"), you have the right to elect up to 24 months of continuation coverage under the Medical, Prescription Drug, Dental, and Vision Benefit Programs, as well as the Wellness Program and EAP, for you and your Eligible Dependents. You may also continue coverage under the Health FSA Benefit Program through the end of the Plan Year in which you started your qualifying military leave.

A qualifying military leave of absence for this purpose means the voluntary or involuntary performance of duties in the Armed Forces; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty; the corps of the Public Health Service; and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

If you wish to continue participating in the Plan during your military leave, you must call Alight at 833-2PEOPLE (select the "Health and Insurance" option) to make arrangements to pay for the coverage you and your Eligible Dependents wish to maintain. **You have 60 days to elect USERRA continuation coverage, measured from the date your absence from employment for the purpose of performing qualifying military service begins.** If continuation coverage is elected, the coverage is retroactive to the date coverage would otherwise have been lost. If USERRA continuation coverage is not elected within this period, you will lose the right to elect USERRA continuation coverage.

Please Note: Unlike COBRA, USERRA does not give your Eligible Dependents an independent right to elect USERRA continuation coverage. Their coverage may be continued only if you elect USERRA continuation coverage.

You will be required to pay the cost of USERRA continuation coverage. If you perform qualified military service for fewer than 31 days, you will pay the same amount for the coverage that you normally pay as an active employee. If your service exceeds 30 days, the amount charged cannot exceed 102 percent of the cost to the Plan of providing the coverage (including both your Benefit Contributions and the Company's contributions).

USERRA continuation coverage may be terminated before the end of the maximum 24-month continuation period for any of the following reasons:

- the Company no longer provides group health coverage to any of its employees;
- the premium for USERRA continuation coverage is not paid on time;
- you fail to return from qualified military service or apply for a position of employment as required under USERRA; or
- your participation in the Plan or a Benefit Program is terminated for cause under the generally applicable terms of the Plan (*e.g.*, for submission of fraudulent benefit Claims).

The period of coverage available to you and your Eligible Dependents under USERRA runs concurrently with any continuation coverage available under COBRA. Eligibility for TRICARE or active duty military coverage will not terminate USERRA continuation coverage.

Please contact Alight at 833-2PEOPLE for additional information about continuing your Plan coverage during a qualifying military leave of absence (select the "Health and Insurance" option).

END OF PARTICIPATION

Your coverage under the Plan (or a particular Benefit Program, as applicable) will end on the earliest of the following dates:

- The date on which you cease to be an Eligible Employee. This includes termination of employment or moving into an ineligible employment status.
- The last day of the current Plan Year, if you (1) fail to re-enroll during an Active Open Enrollment Period (or during any Open Enrollment Period for the Health and Dependent Care FSA Benefit Programs, and for your HSA contribution election), or (2) voluntarily cancel your participation in the Plan or a Benefit Program during an Open Enrollment Period.
- As soon as administratively practicable after you voluntarily cancel your participation in the Plan or a Benefit Program due to a Qualifying Change Event.
- The last day of the coverage period for which your required Benefit Contributions have been paid if the Benefit Contributions for the next coverage period are not paid when due.
- The date on which your approved leave of absence extends beyond the extended coverage period provided for under the applicable Benefit Program (as explained in "**Participation During a Leave of Absence**" above), if you do not return to Eligible Employee status before that date.
- The date the Company terminates the Plan or a Benefit Program in which you are participating or amends the Plan or Benefit Program to exclude the class of employees to which you belong from coverage. Your participation in the Plan (or the Benefit Program, as applicable) will end on the effective date of the termination or amendment.

Coverage under the Plan (or a particular Benefit Program, as applicable) for an Eligible Dependent will end on the earliest of the following dates:

- The date your coverage under the Plan (or Benefit Program) terminates.
- The date on which the individual is no longer an Eligible Dependent, even if the Plan learns of the ineligibility at a later date (your Child will continue to be an Eligible Dependent, if all other criteria are met, until the end of the month in which your Child turns age 26).

- The last day of the current Plan Year, if you (1) fail to re-enroll during an Active Open Enrollment Period, or (2) voluntarily cancel your Eligible Dependent's participation in the Plan or a Benefit Program during an Open Enrollment Period.
- As soon as administratively practicable after you voluntarily cancel your Eligible Dependent's participation in the Plan or a Benefit Program due to a Qualifying Change Event.
- The last day of the coverage period for which your required Benefit Contributions have been paid if the Benefit Contributions for the next coverage period are not paid when due.
- The date the Company terminates the Plan or a Benefit Program in which your Eligible Dependent is participating or amends the Plan or Benefit Program to exclude your Eligible Dependent from coverage. Your Eligible Dependent's participation in the Plan (or the Benefit Program, as applicable) will end on the effective date of the termination or amendment.

Please Note: If you commit fraud or make an intentional misrepresentation of material fact in applying for or obtaining coverage under the Plan, or in obtaining benefits under the Plan, the Plan may terminate coverage for you and/or any individual you have enrolled in the Plan as of a date to be determined in the Plan Administrator's discretion, consistent with applicable law, including the rules regarding retroactive terminations of coverage.

COBRA CONTINUATION COVERAGE

Under certain circumstances, you or your Eligible Dependents covered by the Plan ("**Covered Dependents**") have the right, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("**COBRA**"), to continue coverage under Plan's group health benefit programs ("**COBRA Continuation Coverage**" or "**Continuation Coverage**"). COBRA Continuation Coverage is available to you and your Covered Dependents when you or they would otherwise lose coverage under the Medical, Prescription Drug, Dental, Vision, or Health Care FSA Benefit Programs, or the Wellness Program or EAP (referred to collectively in this section as the "**Healthcare Benefit Programs**"). This section 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 Plan Administrator has engaged a COBRA Administrator to assist with its COBRA obligations ("**COBRA Administrator**"). You may contact the Plan's COBRA Administrator (Alight) by calling 833-2PEOPLE or visiting http://upointhr.com/thepeopleconnection.

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

QUALIFYING EVENTS

COBRA Continuation Coverage is available if you are enrolled in any of the Healthcare Benefit Programs and you or your Covered Dependent would otherwise lose coverage under a Healthcare Benefit Program on account of a "**Qualifying Event**." COBRA Continuation Coverage is offered to each person who is a Qualified Beneficiary. A "**Qualified Beneficiary**" is someone who will lose coverage under a Healthcare Benefit Program because of a Qualifying Event.

You will become a Qualified Beneficiary if you lose your coverage under a Healthcare Benefit Program because either of the following Qualifying Events occurs:

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

Your Covered Dependent Spouse and Covered Dependent Children will become Qualified Beneficiaries if coverage under a Healthcare Benefit Program is lost because any of the following Qualifying Events occur:

- your hours of employment are reduced;
- your employment ends for any reason other than your gross misconduct;
- you die;
- you become divorced from your Spouse (a Covered Dependent Child will only be a Qualified Beneficiary in this instance if the divorce causes the Child to lose eligibility for coverage under the Healthcare Benefit Program); or
- your Child stops being eligible for coverage under the Healthcare Benefit Program as an Eligible Dependent (only the Covered Dependent Child becomes a Qualified Beneficiary in this instance).

NOTICE OF QUALIFYING EVENT

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the COBRA Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of your employment, a reduction of your hours of employment, or your death, the Plan Administrator will notify the COBRA Administrator of the Qualifying Event. You do not need to notify the COBRA Administrator of any of these Qualifying Events.

For all other Qualifying Events (divorce or your Child's losing eligibility for coverage as an Eligible Dependent), COBRA Continuation Coverage will be available to you only if you notify the COBRA Administrator of the event in writing within **60 days** after the latest of:

- the date of the Qualifying Event; or
- the date on which the Qualified Beneficiary loses (or would lose) coverage under the Healthcare Benefit Program as a result of the Qualifying Event.

You may notify the Plan's COBRA Administrator (Alight) of a Qualifying Event by calling 833-2PEOPLE or visiting http://upointhr.com/thepeopleconnection.

If you do not provide notice to the COBRA Administrator within this 60-day notice period, then all Qualified Beneficiaries will lose their right to elect COBRA, and coverage under the Healthcare Benefit Programs cannot be continued.

ELECTING COBRA CONTINUATION COVERAGE

Once proper notice of a Qualifying Event has been provided, each Qualified Beneficiary will be notified by the COBRA Administrator about his or her right to elect Continuation Coverage. Each Qualified Beneficiary will have an independent right to elect Continuation Coverage. Eligible Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children.

The COBRA election notice provided by the COBRA Administrator will include a 60-day deadline for electing Continuation Coverage. **If you do not elect COBRA Continuation Coverage within the 60-day period specified in the election notice, you will lose your right to elect COBRA Continuation Coverage.**

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

ELECTING MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B. This special enrollment period begins on the earlier of:

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

If you do not enroll in Medicare during your special enrollment period, and elect COBRA Continuation Coverage instead, you may have to pay a late enrollment penalty if you decide to enroll in Medicare Part B later, and you may also have a gap in coverage between when your COBRA Continuation Coverage ends and when your Medicare Part B coverage begins.

If you elect COBRA Continuation Coverage and later enroll in Medicare Part A or B before your maximum COBRA Continuation Coverage period ends, the Plan may terminate your COBRA Continuation Coverage (as described in "**Duration of COBRA Continuation Coverage**" below). Your Covered Dependents, however, will remain eligible for COBRA Continuation Coverage.

If your coverage under Medicare Part A or B is effective on or before the date you elect COBRA Continuation Coverage, your COBRA Continuation Coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA Continuation Coverage. However, it may be more beneficial to purchase a Medicare supplemental contract instead of COBRA Continuation Coverage.

If you are enrolled in both COBRA Continuation Coverage and Medicare, Medicare will generally pay first (primary payer) and the Plan will pay second. Please note that for COBRA participants who are eligible for Medicare, the Plan will pay as if secondary to Medicare, even if you are not actually enrolled in Medicare. For example, the Plan will pay as if the COBRA participant is entitled to benefits under Medicare Part B, even if the COBRA participant is not actually enrolled in Medicare Part B.

For more information, visit https://www.medicare.gov/medicare-and-you and review the Benefit Booklet for the Plan's Medical Benefit Program.

COST OF COBRA CONTINUATION COVERAGE

Each Qualified Beneficiary is required to pay the entire cost of COBRA Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA Continuation Coverage due to a disability, 150 percent) of the cost to the Plan (including both Company and Participant contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA Continuation Coverage. The monthly cost of COBRA Continuation Coverage will be included in your COBRA election notice. COBRA premiums must be paid on an after-tax basis.

For coverage to continue, the first premium must be received by the date stated in the COBRA election notice sent to you. Normally, this date will be 45 days after COBRA Continuation Coverage is elected. Premiums for every following month of Continuation Coverage must be paid monthly on or before the premium due date stated in the COBRA election notice sent to you. There is a 30-day grace period for these monthly premiums. If they are not paid within 30 days after their due date, COBRA Continuation Coverage will end as of the last day of the coverage period for which payment was made in full and cannot be reinstated.

If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and, if the shortfall is not paid within 30 days of the date the notice is received, COBRA Continuation Coverage will end as of the last day of the coverage period for which payment was made in full.

DURATION OF COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage will start on the date of the loss of coverage and may continue until the earliest of the following:

Qualifying Event	Maximum Period of COBRA Continuation Coverage
Your termination of employment or reduction in hours of employment	18 months (29 months if a disability extension applies)
Your divorce, death, or entitlement to Medicare	36 months
Your Covered Dependent Child's loss of Eligible Dependent status	36 months

However, COBRA Continuation Coverage will automatically terminate before the maximum period of coverage if any of the following events occurs:

- Any required COBRA premium is not paid in full on time;
- A Qualified Beneficiary becomes covered under another group health plan after electing COBRA Continuation Coverage;
- A Qualified Beneficiary enrolls in Medicare benefits (under Part A or Part B, or both) after electing COBRA Continuation Coverage;
- The Company terminates all of its group health plans; or
- During a disability extension period (the disability extension is explained below), the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled (COBRA coverage for all Qualified Beneficiaries, not just the disabled Qualified Beneficiary, will terminate).

You must notify the COBRA Administrator in writing within <u>31 days</u> if, after electing COBRA, a Qualified Beneficiary becomes enrolled in Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage.

In addition, for the Health Care FSA Benefit Program, COBRA Continuation Coverage will end on the last day of the Plan Year in which the Qualifying Event occurs (see the paragraph below entitled "**Special Rules for the Health Care FSA Benefit Program**"). COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA (such as fraud or material misrepresentation).

DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE

If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to up to an additional 11 months of COBRA Continuation Coverage, for a maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA Continuation Coverage because of your termination of employment or reduction of hours.

To be eligible for a disability extension, the disability must have started at some time before the 61st day of your COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage that would be available without the disability extension.

The disability extension is available only if you notify the COBRA Administrator in writing of the Social Security Administration's disability determination before the end of the original 18-month period of COBRA Continuation Coverage and within **60 days** after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of your termination of employment or reduction of hours; or
- the date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Eligible Employee's termination of employment or reduction of hours.

If you do not provide the notice to the COBRA Administrator within the time limit explained above, the maximum period for Continuation Coverage will not be extended beyond the original 18-month coverage period.

If the Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within 31 days after the Social Security Administration's determination. The 11-month disability extension of COBRA Continuation Coverage will end on the first day of the month following the date the Qualified Beneficiary is determined not to be disabled. Continuation Coverage due to the initial employment-related Qualifying Event, or any subsequent Qualifying Event, may still be available if the maximum period for such Continuation Coverage has not expired. Please note that Continuation Coverage will still end during a disability extension for any of the other reasons listed above, such as the failure to pay COBRA premiums when due.

SECOND QUALIFYING EVENT

If COBRA Continuation Coverage was elected by your Covered Dependent because your employment ended or your hours were reduced (including COBRA Continuation Coverage during a disability extension period), and if, during the period of Continuation Coverage, another Qualifying Event occurs, the maximum period of Continuation Coverage for the Covered Dependent may be extended, upon proper notice to the COBRA Administrator, for up to an additional 18 months (for a maximum of 36 months).

This extension may be available to your Covered Dependents receiving COBRA Continuation Coverage in the event of your death or divorce, or if your Covered Dependent Child stops being an Eligible Dependent under the Plan. The extension is only available if the second Qualifying Event would have caused the Covered Dependent to lose coverage under the Plan had the first Qualifying Event not occurred. Continuation Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due.

The extension due to a second Qualifying Event is available only if you notify the COBRA Administrator in writing within 60 days after the date of the second Qualifying

Event. If you do not provide the notice to the COBRA Administrator within this time period, the maximum period for Continuation Coverage will not be extended beyond the original 18-month (or 29-month) coverage period.

NEWBORNS AND ADOPTED CHILDREN

If you elect COBRA Continuation Coverage, any Child born to or placed for adoption with you during the period of Continuation Coverage will also be a Qualified Beneficiary and be entitled to Continuation Coverage for the maximum period of coverage available to any family member, as long as you notify the COBRA Administrator within **31 days** of the birth, adoption, or placement for adoption.

A Child born to or placed for adoption with a Qualified Beneficiary who is not a former Eligible Employee will not be considered a Qualified Beneficiary (*i.e.*, will not have an independent right to elect Continuation Coverage), but may be enrolled in the Plan as an Eligible Dependent of the Qualified Beneficiary pursuant to the Plan's special enrollment rules, as long as the Qualified Beneficiary notifies the COBRA Administrator within **31 days** of the birth, adoption, or placement for adoption.

COVERED DEPENDENTS OF MEDICARE-ELIGIBLE EMPLOYEES

If the Qualifying Event is a termination of employment or reduction of hours, and you enrolled in Medicare benefits (under Part A or Part B, or both) less than 18 months before the Qualifying Event, COBRA Contribution Coverage for your Covered Dependents who lose coverage as a result of the Qualifying Event can last until up to 36 months after the date of your Medicare entitlement.

For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Children who lost coverage as a result of your termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus eight months).

This extended period of Continuation Coverage is available only if you become entitled to Medicare within 18 months before the termination or reduction of hours. **It is your responsibility to notify the COBRA Administrator when electing Continuation Coverage of your Covered Dependent's eligibility for this extension.**

SPECIAL RULES FOR THE HEALTH CARE FSA BENEFIT PROGRAM

The Continuation Coverage you may elect with respect to the Health Care FSA Benefit Program is different from the Continuation Coverage you may elect with respect to the other Healthcare Benefit Programs. First, Continuation Coverage for the Health Care FSA Benefit Program is only available until the end of the Plan Year in which the Qualifying Event occurs. Second, the Plan will not offer you COBRA Continuation Coverage for the Health Care FSA Benefit Program if, at the time of your Qualifying Event, the premium you must pay for this coverage exceeds the remaining coverage available to you for the Plan Year.

If you elect to continue your participation in the Health Care FSA Benefit Program, you will be required to pay for the coverage on an after-tax basis (plus the two percent administrative fee).

FORM AND MANNER OF NOTICE TO THE COBRA ADMINISTRATOR

Any notice to the COBRA Administrator will need to be in writing and must include:

- the name of the Plan (the Change Healthcare Health and Welfare Plan);
- the name, address, and Social Security number of the employee or former employee who is (or was) a Plan participant;
- a brief description of the Qualifying Event and the name(s), address(es), and Social Security number(s) of all Qualified Beneficiaries who lost (or will lose) coverage as a result of the Qualifying Event; and
- for a disabled individual, a copy of the Social Security Administration disability determination, the date of the determination, and a statement of whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

The timely provision of the notice by one Qualified Beneficiary will satisfy the notice requirement on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

QUESTIONS ABOUT COBRA CONTINUATION COVERAGE

If you have questions about COBRA Continuation Coverage, you may contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration in your area or visit its website at https://www.dol.gov/agencies/ebsa. Addresses and phone numbers of Regional and District Employee Benefits Security Administration offices are available through its website.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

It is your responsibility to keep the Plan Administrator and the COBRA Administrator informed of any changes in your address or the addresses of family members to protect your family's rights. If you miss a deadline because your address has not been updated with the Plan, you and your family will lose the right to COBRA Continuation Coverage under the Plan. You should also keep copies, for your records, of any notices you send to the Plan Administrator or COBRA Administrator.

PRE-TAX PAYMENT BENEFIT PROGRAM

The Company may require you to contribute to or pay for some or all of the Plan's Benefit Programs. The amounts you are required to pay for the Benefit Programs are called "**Benefit Contributions**." The Plan, through the Pre-Tax Payment Benefit Program, gives you

the opportunity to make your Benefit Contributions for some of the Plan's Benefit Programs on a pre-tax basis. This means that your contributions will not be subject to federal income tax (or most state and local income taxes) or Social Security taxes. The Pre-Tax Payment Benefit Program is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code.

Appendix A lists the Benefit Programs for which Benefit Contributions can be made on a pre-tax basis. You may participate in the Pre-Tax Payment Benefit Program if you are eligible for any of the pre-tax Benefit Programs listed in **Appendix A**. For all other Benefit Programs, you must make any required Benefit Contributions on an after-tax basis. The Plan Administrator provides a schedule of the applicable Benefit Contributions for each Benefit Program during your Initial Enrollment Period and subsequent Open Enrollment Periods.

HOW THE PRE-TAX PAYMENT BENEFIT PROGRAM WORKS

Under the Pre-Tax Payment Benefit Program, a portion of your taxable compensation is reduced and applied by the Company to pay the Benefit Contributions for certain of the Plan's Benefit Programs on a pre-tax basis.

Because your compensation is reduced, participation in the Pre-Tax Payment Benefit Program may reduce other benefits that are based on your compensation (such as Social Security, life insurance, and disability insurance). For most employees, these benefit reductions are fairly small, particularly compared to the tax savings. In some cases, benefits might not be reduced at all.

REDUCTION OF COMPENSATION

The amount by which the Company will reduce your compensation to make your Benefit Contributions will be stated in the enrollment materials provided to you. The portion of the enrollment materials listing the amount of the Benefit Contributions are considered part of each Benefit Program's SPD only for the purpose of identifying the amount of the Benefit Contributions required each Plan Year.

PRE-TAX HSA CONTRIBUTIONS

If you are enrolled in one of the HDHP options offered under the Medical Benefit Program, you may elect to have a portion of your taxable compensation reduced and contributed to your HSA on a pre-tax basis. For purposes of the Plan, HSA benefits consist solely of the ability to make such pre-tax contributions under the Pre-Tax Payment Benefit Program.

To participate in the HSA benefits, you must be an HSA-eligible individual. This means that (1) you have enrolled in one of the Medical Benefit Program's HDHP options, and (2) you are eligible to contribute to an HSA under the requirements of the Internal Revenue Code. These requirements include such things as not having any other disqualifying coverage – and you should be aware that coverage under a Spouse's plan, including a Spouse's health care flexible spending account, could make you ineligible to contribute to an HSA. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when

you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

The Company will reduce your compensation to make contributions to your HSA by the amount you elect. The amount you elect must not exceed the annual maximum contribution amount applicable to your HDHP coverage option (single or family) for the calendar year in which the contribution is made. The maximum contribution amounts for 2022 are $3,650 for participants enrolled in single HDHP coverage and $7,300 for participants enrolled in family HDHP coverage. An additional catch-up contribution of $1,000 may be made if you are age 55 or older.

HSA contributions will be deposited into your account within a reasonable time period after the payroll period in which your compensation is reduced. You are responsible for ensuring that the total amount of contributions (including both your contributions and any Company contributions) made to your HSA does not exceed the IRS published calendar year limits applicable to your HDHP coverage option (single or family).

An HSA is not an employer-sponsored employee benefit plan. It is an individual trust or custodial account that you open with an HSA trustee or custodian to be used primarily for reimbursement of eligible medical expenses. This means that the HSA trustee or custodian, and not the Company, will establish and maintain your HSA. Your HSA is administered by the HSA trustee or custodian, and the Company's role is limited to allowing you to contribute to your HSA on a pre-tax salary reduction basis and making discretionary Company contributions. The Company has no authority or control over the funds deposited in your HSA. Neither your HSA nor the part of this Plan that allows you to contribute to your HSA on a pre-tax basis is subject to ERISA.

TREATMENT OF BENEFIT CONTRIBUTIONS WHILE ON UNPAID LEAVE

If you take an unpaid leave of absence, you will not be able to participate in the Pre-Tax Payment Benefit Program during your leave. However, you will still be responsible for making Benefit Contributions for any Plan coverage continued during your leave (as described in "**Participation During a Leave of Absence**" above). If you are on a paid leave of absence, you can continue to participate in the Pre-Tax Payment Benefit Program, so long as you remain eligible to participate in the Benefit Programs that require pre-tax Benefit Contributions.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFIT PROGRAM

The Health Care FSA Benefit Program is designed to help you pay for Eligible Health Care Expenses (defined below) by allowing you to pay for these expenses with pre-tax dollars. If you elect Health Care FSA benefits, a Health Care FSA will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health Care FSA is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Company), and it does not bear interest.

AMOUNT THAT YOU MAY CONTRIBUTE TO YOUR HEALTH CARE FSA

You may contribute up to $2,750 each Plan Year to your Health Care FSA. This maximum contribution amount may be adjusted in future years, and any different limit will be stated in the Plan's enrollment materials. The amount that you elect to contribute for a Plan Year is deducted pro rata from each paycheck during the Plan Year on a pre-tax basis.

As described in more detail below, your Health Care FSA election may be for:

- "**General Purpose Health Care FSA**" coverage, if you are not enrolled in one of the HDHP options offered under the Plan's Medical Benefit Program or otherwise contributing to an HSA during the Plan Year; or

- "**Limited Purpose Health Care FSA**" coverage, if you are enrolled in one of the HDHP options offered under the Plan's Medical Benefit Program or are otherwise contributing to an HSA during the Plan Year.

Please note that if you are a highly compensated individual, as defined by law, the Plan Administrator may reduce the amount you may contribute in order to comply with certain nondiscrimination requirements that apply to the Health Care FSA Benefit Program under the Internal Revenue Code.

Please Note: If you elect Health Care FSA benefits, you cannot also elect to make contributions to an HSA unless you elect the Limited Purpose Health Care FSA coverage option.

If you elect the General Purpose Health Care FSA coverage option, you will not be eligible to make HSA contributions, and your Eligible Dependents will also be ineligible to make HSA contributions.

AMOUNT THAT CAN BE REIMBURSED TO YOU

The full amount of Health Care FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for Eligible Health Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submit the Claim.

You generally will have until March 31st of the following Plan Year to submit a Claim for reimbursement for Eligible Health Care Expenses incurred during the previous Plan Year. However, if you end participation in the Health Care FSA Benefit Program before the end of the Plan Year, you will only have until 90 days after the date your participation ends to submit your Claims.

ELIGIBLE HEALTH CARE EXPENSES

The amounts credited to your Health Care FSA may only be used to pay for your or your Eligible Dependent's Eligible Health Care Expenses that are incurred during the Plan Year while you were covered under the Health Care FSA Benefit Program. An expense is "incurred" on the

date that the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense, but the services have not yet been provided, then the expense has not been incurred.

The health care expenses that can be reimbursed from your Health Care FSA are different depending on the type of Health Care FSA coverage you elect (General Purpose or Limited Purpose).

General Purpose Health Care FSA Coverage Option

For purposes of the General Purpose Health Care FSA coverage option, "**Eligible Health Care Expenses**" are expenses for medical care, as defined in Internal Revenue Code Section 213(d) or 106(f) (except for health insurance premiums or qualified long term care expenses), for you and your Eligible Dependents for which you have not been reimbursed through insurance or any other source.

Eligible Health Care Expenses include, for example, amounts paid for:

- hospital bills;
- physician, dental, or vision care bills;
- prescription drugs and over-the-counter medications; and
- insurance deductibles, copayments, and coinsurance.

For a complete list of eligible expenses, please refer to IRS Publication 502 (Medical and Dental Expenses), which contains detailed guidelines on Eligible Health Care Expenses. But use IRS Publication 502 with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (*i.e.*, to figure out their tax deductions), not what is reimbursable under a Health Care FSA. Not all expenses that are deductible are reimbursable under a Health Care FSA, and not all expenses that are reimbursable under a Health Care FSA are deductible.

Limited Purpose Health Care FSA Coverage Option

Under the Limited Purpose Health Care FSA coverage option, you may only be reimbursed for the "**Eligible Health Care Expenses**" listed below:

- Services or treatments for dental care (excluding premiums);
- Services or treatments for vision care (excluding premiums);
- Services or treatments for preventive care;
- For the 2021 Plan Year only, telehealth and other remote care services; and
- Services or treatments for medical care (excluding premiums) after you have met the deductible for the HDHP option in which you are enrolled.

If you are not sure whether an expense qualifies for reimbursement under the Health Care FSA option in which you are enrolled, you may contact the third-party administrator for the Health Care FSA Benefit Program listed in **Appendix A**. Please remember, however, that the third-party administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor

INELIGIBLE HEALTH CARE EXPENSES

The following health care expenses do not qualify for reimbursement under the Health Care FSA Benefit Program:

- expenses paid on behalf of an individual who is not your tax dependent under federal tax law;
- long-term care services;
- expenses that are payable under any other insurance plan or group health plan, or that were paid under another employer's health care spending account program (at the Plan Administrator's request, you are obligated to supply additional information sufficient for the third-party administrator to determine the existence of any duplications of Claims payments);
- expenses for which you have received, or will receive, an itemized deduction on your federal tax return;
- health insurance premiums for any other plan (including premiums for a benefit program sponsored by the Company or premiums paid for your Spouse's insurance);
- expenses in excess of the coverage amount you elect for a Plan Year;
- expenses incurred during a time when you were not covered by the Health Care FSA Benefit Program;
- expenses for which you have not provided satisfactory proof of services;
- expenses incurred during the Plan Year that are claimed later than March 31st following the end of the Plan Year (or later than 90 days after your participation in the Health Care FSA ends, if your participation ends before the end of the Plan Year); and
- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

FORFEITURE OF AMOUNTS REMAINING AT THE END OF THE PLAN YEAR

If the Eligible Health Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for Health Care FSA benefits, you will forfeit any amounts remaining in your Health Care FSA. This is called the use-or-lose rule under applicable tax law.

You generally will have until March 31st of the immediately following Plan Year to submit Eligible Health Care Expenses incurred during the prior Plan Year. However, if your participation in the Health Care FSA Benefit Program ends before the end of the Plan Year, you must submit your claims within 90 days after your participation in the Health Care FSA ends. Any amounts remaining in your Health Care FSA after the end of this Claims run-out period will be forfeited.

Forfeited amounts will be used to offset any losses experienced by the Company as a result of making reimbursements in excess of contributions paid by all participants, and to reduce the cost of administering the Health Care FSA Benefit Program. Also, any Health Care FSA benefit payments that are unclaimed (for example, uncashed benefit checks) within 12 months of issuance will be forfeited and applied as described above.

TERMINATION OF EMPLOYMENT OR OTHER LOSS OF ELIGIBILITY

If you terminate your employment with the Company or otherwise become ineligible to participate in the Health Care FSA Benefit Program before the end of the Plan Year, you may use any amounts remaining in your Health Care FSA for expenses incurred before your termination or other loss of eligibility. However, any expenses incurred after your termination or loss of eligibility may not be paid from your Health Care FSA, unless you are eligible for and elect COBRA Continuation Coverage.

You will have until 90 days after the date you ceased to be eligible to submit Claims for expenses incurred before your termination or other loss of eligibility.

Please Note: COBRA Continuation Coverage under the Health Care FSA Benefit Program will be offered only to Qualified Beneficiaries who have underspent accounts. A Qualified Beneficiary has an underspent account if the annual limit elected by the participant, reduced by the reimbursable Claims submitted at the time of the Qualifying Event, is equal to or more than the amount of the premiums for COBRA Continuation Coverage that will be charged for the remainder of the Plan Year.

See the section entitled "**COBRA Continuation Coverage**" above for additional information on how COBRA Continuation Coverage works with respect to the Health Care FSA Benefit Program.

FILING A CLAIM FOR ELIGIBLE HEALTH CARE EXPENSES

You must file a proper Claim to receive reimbursement for Eligible Health Care Expenses under the Health Care FSA Benefit Program. You may file a Claim online at the Claims Administrator's website listed in **Appendix B** or by using your Debit Card.

All Claims must meet each of the following important requirements:

- The Claim must be for an expense incurred by you or your Eligible Dependent.
- The Claim must be for Eligible Health Care Expenses that are eligible for reimbursement under the Health Care FSA option in which you are enrolled.

- The Claim must be for an expense that was incurred during the Plan Year and while you were a participant in the Health Care FSA Benefit Program.
- The Claim must be submitted no later than the March 31st following the end of the Plan Year (or no later than 90 days after you end your participation in the Health Care FSA, if you stop participating before the end of the Plan Year).
- If the Claim is submitted online at the Claims Administrator's website (instead of by using your Debit Card), the Claim must be submitted following the instructions on the Claims Administrator's website and must include:
  - the amount, date, and nature of the expense;
  - the name and address of the person, organization, or entity to which the expense was paid;
  - the name of the person for whom the expense was incurred and the relationship of that person to you;
  - the amount recovered or recoverable from any other source with respect to the expense; and
  - written evidence from an independent third party stating that the expense has been incurred and the amount of the expense (for example, bills, invoices, receipts, or other writings showing the amount of the expense).

  Further details about what must be provided are included on the Claims Administrator's website.

Debit Card Claims

When you enroll in the Health Care FSA Benefit Program, you will receive a "**Debit Card**" to pay for Eligible Health Care Expenses. The Debit Card will only be effective at providers with merchant codes (which are verified at the time of use) that relate to health care and is only valid up to the balance of your Health Care FSA. You may use this card to pay for Eligible Health Care Expenses, or you may pay using a different method. Each time you use the card, your Health Care FSA balance will be reduced by the amount of the transaction.

At the time of enrollment, you must agree before receiving a Debit Card that you (1) will only use the Debit Card to pay for Eligible Health Care Expenses for yourself or your Eligible Dependents; (2) will not use the Debit Card for expenses that have already been reimbursed; (3) will not seek reimbursement under any other health plan for expenses paid for with the Debit Card; and (4) will acquire and keep sufficient documentation (for example, invoices and receipts) for expenses paid with the Debit Card. This certification will also be printed on the back of the Debit Card. Each time you pay for an Eligible Health Care Expense by using the Debit Card, you reaffirm this certification. You must also agree to abide by any other terms and conditions of the Debit Card program as set forth in this summary and in any cardholder agreement issued in conjunction with the card, including but not limited to the Plan's right to recoup improper card payments by withholding amounts from your pay and offsetting against other Health Care FSA Claims.

Each time you use the Debit Card, you must obtain and retain a bill, invoice, or other statement from the provider or merchant describing the service or product, the date of the service or sale, and the amount of the expense. For example, if you use your Debit Card to make a Copayment at your doctor's office, you must ask for and retain documents that show the amount, date, and nature of the expense. An explanation of benefits from an insurance company or third-party administrator indicating the date of service and your cost sharing responsibility for that service will also satisfy this requirement. An e-mail or other statement from you describing the service or amount without receipts or an explanation of benefits is insufficient.

Remember to Keep Your Receipts
If you use your Debit Card for Eligible Health Care Expenses, you will need to keep your receipts for one year following the close of the Plan Year in which the expense is incurred to prove that you used the card to pay for an Eligible Health Care Expense.

Many of your Eligible Health Care Expenses will be treated as automatically substantiated without the need for any review beyond the swipe of your Debit Care. However, under certain circumstances, the Claims Administrator will request additional information to substantiate your Debit Card transactions.

You must provide the additional information to the Claims Administrator by the deadline indicated on the Claims Administrator's request for additional information. If you fail to file proof within this time period, or it is determined that you have used your Debit Card for an ineligible expense, your use of the card will be suspended until proof is filed or the Plan is reimbursed by you. In the event of frequent abuse, your Debit Card may be permanently deactivated, whether or not an improper payment is ultimately recouped. You should always obtain and keep a sufficient receipt or invoice so that you can provide it to the Claims Administrator upon request.

Please Note: Participants must repay the Plan for any improper payments that are made with their Debit Cards. Improper payments may be recouped in accordance with applicable IRS guidance, including by withholding amounts from the participant's pay and offsetting against other Health Care FSA Claims.

Your Debit Card will automatically be cancelled if you terminate employment or are otherwise in eligible to participate in the Health Care FSA Benefit Program. You will not be able to use the card during any applicable COBRA Continuation Coverage period, but you may continue to submit online Claims.

MAKING CONTRIBUTIONS DURING A LEAVE OF ABSENCE

If Your Leave of Absence is Paid

If you are taking a paid leave of absence, you will continue making contributions to your Health FSA on a pre-tax basis pursuant to your enrollment elections. In this case, your participation in the Health FSA Benefit Program will continue as if you had remained in active

employment, and Eligible Health Care Expenses incurred during your paid leave will be eligible for reimbursement.

If Your Leave of Absence is Unpaid

If you take an approved unpaid leave of absence, your participation in the Health Care FSA Benefit Program may be continued for up to 52 weeks. To continue your participation during an unpaid leave, you must continue making after-tax contributions to your Health Care FSA through direct billing. If you continue making after-tax contributions to your Health Care FSA during your leave, Eligible Health Care Expenses incurred during your leave will be eligible for reimbursement.

If your approved leave of absence extends beyond 52 weeks, or if you stop making after-tax contributions through direct billing, your participation in the Health Care FSA Benefit Program will end.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT PROGRAM

The Dependent Care FSA Benefit Program is designed to help you pay for Eligible Dependent Care Expenses (as defined below) by allowing you to pay for these expenses with pre-tax dollars. Under the Dependent Care FSA Benefit Program, you may authorize pre-tax contributions through paycheck deductions to a Dependent Care FSA that the Company will establish for you. Your Dependent Care FSA is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Company), and it does not bear interest.

AMOUNT THAT YOU MAY CONTRIBUTE TO YOUR DEPENDENT CARE FSA

The maximum amount you may contribute to your Dependent Care FSA each calendar year is $5,000 if you are:

- married and file a joint federal income tax return;
- married, but your Spouse maintains a separate residence for the last 6 months of the year, you file a separate tax return, and you maintain as your home a household that is a Qualifying Individual's principal place of abode for more than half of the year and furnish more than one-half the cost of maintaining the household; or
- single or the head of household for federal income tax purposes.

If you are married and reside together, but file a separate federal income tax return, the maximum amount that you may contribute to your Dependent Care FSA for a year is $2,500.

Please Note: If you are a highly compensated employee (as defined in IRS guidance), your contributions may be further limited by the Plan's annual nondiscrimination testing. Any such limit will be communicated to you in the Plan's open enrollment materials.

Please Note: These maximums ($5,000 or $2,500, as applicable) are the largest amount that is possible. In addition, the amount of reimbursement that you can receive on a tax-free basis during a calendar year cannot exceed the lesser of your or your Spouse's earned income for the calendar year. If your Spouse has not earned any income from employment during the year and is a full-time student or disabled and unable to care for himself or herself, your Spouse will be assumed to have earned $250 a month if you claim reimbursement for the care of one Qualified Individual, or $500 a month if you claim reimbursement for the care of two or more Qualified Individuals.

Note, also: The maximum amount any one family can elect to contribute to a Dependent Care FSA each year is $5,000. This means if you are married, and your Spouse participates in a dependent care flexible spending account offered through his or her employer, the maximum amount you and your Spouse may contribute to both accounts on a pre-tax basis each year is $5,000.

AMOUNT THAT CAN BE REIMBURSED TO YOU

Unlike the Health Care FSA Benefit Program, you will only be reimbursed for an Eligible Dependent Care Expense up to the current balance in your Dependent Care FSA. If the balance in your Dependent Care FSA is insufficient to pay an Eligible Dependent Care Expense in full, the unpaid remainder will be carried over and paid when the balance in your account is sufficient.

You generally will have until March 31st of the following Plan Year to submit a Claim for reimbursement for Eligible Dependent Care Expenses incurred during the previous Plan Year. However, if you end participation in the Dependent Care FSA before the end of the Plan Year, you will only have until 90 days after the date your participation ends to submit your Claims.

ELIGIBLE DEPENDENT CARE EXPENSES

The amounts credited to your Dependent Care FSA may only be used to pay for the Eligible Dependent Care Expenses of a Qualifying Individual incurred during the Plan Year while you were covered under the Dependent Care FSA Benefit Program. An Eligible Dependent Care Expense is "incurred" when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense, but the services have not yet been provided, then the expense has not been incurred.

"**Eligible Dependent Care Expense**" means an employment-related expense incurred on behalf of a person who meets the requirements to be a Qualifying Individual, as defined below. All of the following conditions must be met for such expenses to be eligible for reimbursement from your Dependent Care FSA:

1. Each person for whom you incur the expenses must be a "**Qualifying Individual**." A Qualifying Individual is defined as:

- your child or a descendant of your child under the age of 13 who: (1) has the same principal place of abode as you for more than one-half of the calendar year, and (2) has not provided over one-half of his or her own support for the calendar year; or

- your mentally or physically disabled Spouse or dependent for federal income tax purposes (regardless of age) who: (1) is physically or mentally incapable to care for themselves, and (2) has the same principal place of abode as you for more than one-half of the calendar year.

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. You may contact the third-party administrator for the Dependent Care FSA Benefit Program (listed in **Appendix A**) for more information on which individuals will qualify as your Qualifying Individuals.

2. No reimbursement will be made to the extent that such reimbursement would exceed the balance in your Dependent Care FSA.

3. The expenses are incurred for services rendered after the date of your election to receive Dependent Care FSA benefits and during the Plan Year to which the election applies.

4. The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expenses can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day.

5. The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.

6. If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least 8 hours per day in your household.

7. If the expenses are incurred for services provided by a dependent care center – that is, a facility (including a day camp) that receives payment for providing care to more than 6 nonresident individuals on a regular basis – the center must comply with all applicable state and local laws.

8. The person who provided care was not your Spouse or a parent of your under-age-13 qualifying child (*e.g.*, a former spouse who is the child's noncustodial parent). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.

9. The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.

10. The expenses can be for any of the following (assuming that the other requirements for reimbursement are met):

- expenses for a day camp or a similar program to care for a Qualifying Individual, even if the camp specializes in a particular activity (*e.g.*, soccer or computers), but

excluding any separate equipment or similar charges (note that summer school and tutoring program expenses do not qualify because they are considered to be primarily for education rather than for care);

- the cost of a Qualifying Individual's transportation to or from a place where care is provided, if furnished by a dependent care provider; and
- expenses such as application fees, agency fees, and deposits that relate to but are not directly for a Qualifying Individual's care, if you must pay the expenses in order to obtain the related care (expenses of this type cannot be reimbursed unless and until the related care is provided, *e.g.*, a deposit that is forfeited because you decide to send your child to a different dependent care provider is not eligible for reimbursement).

For detailed guidelines on Eligible Dependent Care Expenses, see IRS Publication 503 (Dependent Care Expenses). But use Publication 503 with caution, because it was meant only to help taxpayers figure out whether they can claim the household and dependent care services tax credit under Internal Revenue Code Section 21 (the Dependent Care Tax Credit, discussed below), not to explain what is reimbursable under a Dependent Care FSA. In fact, some of the statements in Publication 503 are not correct when determining whether that same expense is reimbursable under your Dependent Care FSA. Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under a Dependent Care FSA.

If you are not sure whether an expense qualifies for reimbursement, you may contact the third-party administrator for the Dependent Care FSA Benefit Program listed in **Appendix A**. Please remember that the third-party administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

FORFEITURE OF AMOUNTS REMAINING AT THE END OF THE PLAN YEAR

If the Eligible Dependent Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for Dependent Care FSA benefits, you will forfeit any amounts remaining in your Dependent Care FSA. This is called the use-or-lose rule under applicable tax law.

You will have until March 31st following the end of the Plan Year for which your Dependent Care FSA election was effective to submit Eligible Dependent Care Expenses for that Plan Year (or until 90 days after you end your participation in the Dependent Care FSA, if you stop participating before the end of the Plan Year). Any amounts remaining in your Dependent Care FSA after the end of this Claims run-out period will be forfeited and will not be returned to you.

Forfeited amounts will be used to reduce the cost of administering the Dependent Care FSA Benefit Program. Also, any Dependent Care FSA benefit payments that are unclaimed (for example, uncashed benefit checks) within 12 months of issuance will be forfeited and applied as described above.

TERMINATION OF EMPLOYMENT OR OTHER LOSS OF ELIGIBILITY

If you terminate your employment with the Company or otherwise become ineligible to participate in the Dependent Care FSA Benefit Program before the end of the Plan Year, any amounts remaining in your Dependent Care FSA will remain available for reimbursement for Claims incurred prior to your termination of employment or other loss of eligibility for a limited period of time. You will have until 90 days after the date on which your participation in the Dependent Care FSA Benefit Program ends to submit Claims for expenses incurred before the date on which you ceased to be eligible.

If you discontinue participation in the Dependent Care FSA Benefit Program during the Plan Year, dependent care expenses incurred after your discontinuation in the Dependent Care FSA Benefit Program will not be eligible for reimbursement, regardless of whether funds remain in your Dependent Care FSA.

TAX TREATMENT OF DEPENDENT CARE FSA BENEFITS

Generally, you will not be taxed on your Dependent Care FSA benefits, up to the limits set forth in "**Amount That You May Contribute to Your Dependent Care FSA**" above. However, the Company cannot guarantee that specific tax consequences will flow from your participation in the Dependent Care FSA Benefit Program. The tax benefits that you receive depend on the validity of the Claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 (Child and Dependent Care Expenses) with your annual tax return (Form 1040) or a similar form. You must list on IRS Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a Claim that is later determined to not be for Eligible Dependent Care Expenses, then you will be required to repay the amount. Alternatively, the Plan Administrator may offset the amount against any other Eligible Dependent Care Expenses submitted for reimbursement or withhold the amount from your pay.

Ultimately, it is your responsibility to determine whether any reimbursement under the Dependent Care FSA constitutes an Eligible Dependent Care Expense that qualifies for the federal income tax exclusion. You may contact the third-party administrator for the Dependent Care FSA Benefit Program if you need further information about which expenses are – and are not – likely to be reimbursable but remember that the third-party administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

FEDERAL DEPENDENT CARE TAX CREDIT

You are not eligible to receive both a federal Dependent Care Tax Credit and reimbursement under the Dependent Care FSA Benefit Program for the same expense. The Dependent Care Tax Credit is a credit against your federal income tax liability under the Internal Revenue Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you.

The credit is calculated as a percentage of your annual Eligible Dependent Care Expenses. In determining what the tax credit would be, you may take into account $3,000 of such expenses for one Qualifying Individual or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage ranges from a minimum of 20 percent of your qualifying expenses (producing a maximum credit of $600 for one Qualifying Individual or $1,200 for two or more Qualifying Individuals) to a maximum of 35 percent of such expenses (producing a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals). The maximum 35 percent rate is reduced by 1 percent (but not below 20 percent) for each $2,000 (or fraction of $2,000) by which your adjusted gross income exceeds $15,000.

Before enrolling in the Dependent Care FSA Benefit Program, you should determine whether reimbursement of Eligible Dependent Care Expenses under the Dependent Care FSA Benefit Program is more advantageous to you than the federal Dependent Care Tax Credits that may be available for the same expenses. For most individuals, participating in a Dependent Care FSA will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a Dependent Care FSA will be only marginally better.) Because the preferable method for treating benefit payments depends on certain factors such as a person's tax filing status (*e.g.*, married, single, head of household), number of Qualifying Individuals, earned income, *etc.*, each participant will have to determine his or her tax position individually in order to make the decision. You may use IRS Form 2441 (Child and Dependent Care Expenses) to help you.

Contact the third-party administrator for the Dependent Care FSA Benefit Program (listed in **Appendix** A) if you need further information about the Dependent Care FSA but remember that the third-party administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor. You can find more information about the federal Dependent Care Tax Credit in IRS Publication 503.

EXPENSES ELIGIBLE UNDER MORE THAN ONE DEPENDENT CARE FSA

If a dependent care benefit is payable under two or more dependent care reimbursement programs, you may submit a Claim for the expenses to either program, but the Dependent Care FSA Benefit Program will not pay any expenses paid by another program. At the Claims Administrator's request, you must supply additional information sufficient for the Claims Administrator to determine if Claim payments have been duplicated.

FILING A CLAIM FOR ELIGIBLE DEPENDENT CARE EXPENSES

You must file a proper Claim to receive reimbursement for Eligible Dependent Care Expenses under the Dependent Care FSA Benefit Program. You must file a Claim by submitting a Claim online at the Claims Administrators' website listed in **Appendix B**.

All Claims must meet each of the following important requirements:

- The Claim must be for Eligible Dependent Care Expenses.

- The Claim must be for a paid expense that was incurred during the Plan Year and during the period for which you were a participant in the Dependent Care FSA Benefit Program.
- The Claim must be submitted no later than March 31st following the end of the Plan Year (or no later than 90 days after you end your participation in the Dependent Care FSA, if you stop participating before the end of the Plan Year).
- The Claim must be submitted following the instructions on the Claim Administrator's website and must include:
  - the amount, date, and nature of the expense;
  - the name, address, and taxpayer identification number of the person, organization, or entity to which the expense was or is to be paid;
  - the name of the person for whom the expense was incurred and the relationship of that person to you;
  - the amount recovered or recoverable from any other source with respect to the expense; and
  - written evidence from an independent third party stating that the expense has been incurred and the amount of the expense (for example, bills, invoices, receipts, or other writings showing the amount of the expense). Further details about what information must be provided are included on the Claims Administrator's website.

MAKING CONTRIBUTIONS DURING A LEAVE OF ABSENCE

If you take a paid or unpaid leave of absence (FMLA or non-FMLA), your participation in the Dependent Care FSA Benefit Program will end. Any Eligible Dependent Care Expenses incurred before your leave will be eligible for reimbursement from your Dependent Care FSA, as long as you timely submit a request for reimbursement. However, any dependent care expenses incurred during your leave are not eligible for reimbursement under the Dependent Care FSA Benefit Program.

When you return from leave, you will have the option to resume participation in the Dependent Care FSA Benefit Program.

WELLNESS PROGRAM

If you are enrolled in the Plan's Medical Benefit Program, the Plan's Wellness Program allows you to save on your medical premiums by completing a number of different activities designed to improve your health and wellbeing. The wellness activities that must be completed in order to earn wellness rewards, and the total amount of wellness rewards available, will be communicated to you each year in the Plan's enrollment materials.

You may also be eligible to earn a discount on your medical premiums if you and your enrolled Spouse (if any) are tobacco free or complete a tobacco cessation program. The amount

of the discount, and the deadlines for confirming your tobacco-free status or completing the Plan's smoking cessation program, will be communicated to you in the Plan enrollment materials each year. If you are not able to certify that you and your enrolled Spouse (1) do not use tobacco products, or (2) have completed the Plan's tobacco cessation program by the applicable deadline, you will have a second opportunity to reduce your medical premiums by submitting this information to the Plan by June 30 of the applicable Plan Year. In this case, your discounted medical premiums will begin on July 1 of the same Plan Year.

REASONABLE ALTERNATIVES

Rewards for participating in wellness activities are available to all Eligible Employees who participate in the Medical Benefit Program. If the wellness activities for a Plan Year require you to perform or complete an activity related to a health factor in order to obtain a reward (*e.g.*, walking, diet, or an exercise program) or require you to attain or maintain a specific health outcome (*e.g.*, not using tobacco or attaining specified results on biometric tests), and you think you will be unable to meet the standard for a reward, you may qualify for an opportunity to earn the same reward by different means. Please contact wellness@changehealthcare.com for more information. If a reasonable alternative must be provided for the wellness activity, the Plan will work with you (and, if you wish, with your doctor) to find a wellness activity with the same reward that is right for you in light of your health status.

CLAIM FILING AND APPEAL PROCEDURES

To receive benefits under the Plan, you or your health care provider will need to file a Claim with the Plan in accordance with the Plan's claim procedures. Only those Claims that (1) are properly filed in accordance with the Plan's claims procedures, and (2) are for covered benefits under the Plan will be paid.

This section describes how Claims and appeals are made and decided under the Self-funded Benefit Programs offered under the Plan, and how the Plan will handle Eligibility Claims (as described below). **The Benefit Booklets for the Medical, Prescription Drug, Dental, and Vision Benefit Programs may have additional Claims requirements, so you should carefully review those Benefit Booklets, as well.** The procedures for filing a Claim with respect to the Insured Benefit Programs are explained in the Insurance Certificates provided by the insurance companies.

A "**Claim**" for purposes of these Claim filing and appeal procedures is any request for a Plan benefit, or any grievance, complaint, or claim concerning any aspect of the operation or administration of the Plan, that is made in accordance with these procedures. A communication regarding Plan benefits that is not made in accordance with these procedures will not be treated as a Claim under these procedures. Further, any request for Plan benefits that is not made in accordance with these claims procedures is considered an incorrectly filed claim. The terms "you" and "your" in these Claims procedures apply, where appropriate, to your Eligible Dependents.

Please Note: Time limits apply for filing a Claim, appealing a denied Claim, and requesting

external review (if applicable) or filing a lawsuit in federal court after exhausting the Plan's Claim filing and appeal procedures. Each of these deadlines is described below and has been bolded and underlined for your convenience. **Failure to comply with these important deadlines will cause you to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.**

CLAIMS ADMINISTRATOR

For the Self-funded Benefit Programs, the entity or individual responsible for determining your Claim is referred to in these Claim filing and appeal procedures as the "**Claims Administrator**." This reference applies to the Plan Administrator, or a third party hired by the Plan Administrator to decide initial – and in some cases final – Claims for benefits. Refer to **Appendix B** for a listing of the Claims Administrators for each of the Plan's Self-funded Benefit Programs.

For the Insured Benefit Programs, the Plan Administrator has delegated its responsibilities with respect to benefit claims to the insurance companies identified in **Appendix A**. The insurance companies are responsible for (1) determining eligibility for and the amount of any benefits payable under the Insured Benefit Programs; and (2) providing the claims procedures to be followed and the claims forms to be used under the Insured Benefit Programs.

These Claims Administrators and insurance companies have the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to them. The Claims Administrators responsible for making final Claim determinations under the Self-funded Benefit Programs and the insurance companies for the Plan's Insured Benefit Programs have the necessary discretionary authority and control over the Plan to require deferential judicial review. Therefore, the Claims Administrator's or insurance company's exercise of discretion in its interpretation of the Plan's written terms and its findings of fact in its role as the claims fiduciary for the applicable Benefit Program will not be overturned unless a court determines they are arbitrary and capricious.

AUTHORIZED REPRESENTATIVE

You may appoint an authorized representative to file your Claim, to appeal a denied Claim, and to otherwise represent you for purposes of the Plan's administrative Claim filing and appeal procedures.

An appointment of authorized representative form may be obtained from, and completed forms must be submitted to, the appropriate Claims Administrator listed in **Appendix B**. No person (including a treating health care professional) will be recognized as an authorized representative until the Plan receives an appointment form signed by the claimant, except that for Urgent Care Claims, the Plan will, even in the absence of a signed appointment, recognize a health care professional with knowledge of the claimant's medical condition (*e.g.*, the treating physician) as the claimant's authorized representative unless the claimant provides specific written direction otherwise.

Once you have appointed an authorized representative, the Claims Administrator will communicate directly with your representative, and may not also inform you of the status or outcome of your Claim. You will have to seek such information from your representative. If you have not appointed an authorized representative, the Claims Administrator will communicate with you directly.

ASSIGNMENTS PROHIBITED

No benefit under the Self-funded Benefit Programs shall be subject to alienation, sale, transfer, assignment, pledge, or encumbrance or charge, voluntary or involuntary, by operation of law or otherwise, and any attempt at such transactions shall be void. You may not assign your rights, benefits, or any other interest under a Self-funded Benefit Program to a healthcare provider or any other individual or entity. The applicable Claims Administrator may, however, in its discretion, pay a healthcare provider directly for services rendered to you or your Eligible Dependents. The payment of benefits directly to a healthcare provider, if any, will be done as a convenience to you and your Eligible Dependents and will not constitute an assignment of rights, benefits, or any other interest under the Plan or a waiver of this anti-assignment provision.

REQUIREMENT TO FOLLOW THESE PROCEDURES

No individual may bring any legal action (1) to recover benefits under the Plan; (2) to enforce or clarify any rights under the Plan (including any rights under Section 502 or Section 510 of ERISA); or (3) under any other provision of law, whether or not statutory, until the Plan's administrative Claim and appeal procedures, as explained in this section, have been timely exhausted in their entirety.

You must follow the Plan's Claim and appeal procedures carefully and completely and submit your initial Claim and any required appeals before the deadlines explained below. Failure to do so will cause you to give up important legal rights and will result in the denial of your claim.

The Claims Administrator is also subject to certain deadlines and other procedural requirements under the Plan's Claim and appeal procedures. If the Claims Administrator materially fails to comply with any of the required deadlines or materially fails to adequately inform you of your procedural rights, you may treat the Plan's Claim and appeal procedures as having been exhausted and file a claim in federal court.

You must, however, file your Claim in federal court **within one year** of the date you knew, or should have known, of the Claims Administrator's material failure to comply with these procedures. Any action related to or arising out of or in connection with the Plan may only be brought or filed in the United States District Court, Middle District of Tennessee or, if the District Court declines or lacks jurisdiction, in the Tennessee state courts for Davidson County.

SPECIFIC CLAIM PROCEDURES FOR THE MEDICAL, PRESCRIPTION DRUG, DENTAL, AND VISION BENEFIT PROGRAMS

Types of Claims

There are four categories of Claims that can be made under the Medical, Prescription Drug, Dental, and Vision Benefit Programs, each with somewhat different rules. The primary difference is the timeframe within which Claims, and appeals must be determined. It is very important to follow the requirements that apply to your particular type of Claim. If you have any questions regarding what type of Claim and/or what procedure to follow, contact the relevant Claims Administrator using the contact information listed in **Appendix B**.

A Claim under the Medical, Prescription Drug, Dental, and Vision Benefit Programs may be a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, or a Post-Service Claim.

- ***Pre-Service Claims.*** A "**Pre-Service Claim**" is a Claim for a benefit that is conditioned, in whole or in part, on your obtaining approval for the benefit before obtaining the health care (for example, benefits that require pre-authorization or pre-certification).

  The Benefit Booklets for the Medical, Prescription Drug, Dental, and Vision Benefit Programs will identify any benefits that require advance approval from the Plan. For benefits that do not require advance approval, any request for advance approval will not be treated as a Claim.

- ***Urgent Care Claims.*** Urgent Care Claims are a special type of Pre-Service Claim. An "**Urgent Care Claim**" is any Pre-Service Claim for medical care or treatment with respect to which application of the time periods that otherwise apply to Pre-Service Claims:

  - could seriously jeopardize the claimant's life or health or ability to regain maximum function; or
  - would, in the opinion of a physician with knowledge of the claimant's medical condition, cause the claimant severe pain that cannot be adequately managed without the treatment, service, or procedure that is the subject of the Claim.

  Absent a determination by your physician, the Claims Administrator will determine whether a Claim meets this standard using the judgment of a prudent layperson with average knowledge of health and medicine.

- ***Post-Service Claims.*** A "**Post-Service Claim**" is any Claim that is not a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim.

- ***Concurrent Care Claims.*** A concurrent care decision occurs when the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of "**Concurrent Care Claims**": (1) when reconsideration by the Plan of previously approved care results in

a reduction or termination of the initially approved period of time or number of treatments; or (2) when the claimant wishes to extend the course of treatment beyond the initially approved period of time or number of treatments.

Filing Your Initial Claim

Please refer to the Benefit Booklets for the Medical, Prescription Drug, Dental, and Vision Benefit Programs for detailed instructions on how to submit an initial Claim for benefits under these Benefit Programs.

Claims must be filed with the Claims Administrator as soon as possible and in no event later than 12 months after the date of receipt of the service, treatment, or product to which the Claim relates. Any Claim filed after this Claim filing deadline will be denied automatically for failure to file timely.

Improperly Filed Pre-Service and Urgent Care Claims

As noted above, these Claims procedures generally do not apply to any request for benefits that is not made in accordance with these Claims procedures. However, if you or your health care provider make a mistake in attempting to file a Pre-Service or Urgent Care Claim, the Claims Administrator will notify you of the mistake and describe the proper procedures for filing the Claim.

In the case of an incorrectly filed Pre-Service Claim, you will be notified as soon as possible but no later than 5 days following receipt by the Claims Administrator of the incorrectly filed Claim. In the case of an incorrectly filed Urgent Care Claim, you will be notified as soon as possible but no later than 24 hours following receipt by the Claims Administrator of the incorrectly filed Claim. The notice may be oral unless you specifically request written notice.

Incomplete Claims

If you have properly filed your Claim, but have not provided sufficient information about the treatment, service, or procedure to be authorized, as determined by the Claims Administrator, your Claim will be treated as an incomplete Claim.

If an Urgent Care Claim is incomplete, the Claims Administrator will notify you as soon as possible, but no later than 24 hours following receipt of the incomplete Claim. The notice may be made orally unless you specifically request written notice. The notice will describe the information necessary to complete the Claim and specify a reasonable time, no less than 48 hours, within which the Claim must be completed. The Claims Administrator will decide the Claim as soon as possible but not later than 48 hours after the earlier of (1) receipt of the specified information; or (2) the end of the period of time provided to submit the specified information.

If a Pre-Service or Post-Service Claim is incomplete, the Claims Administrator may deny the Claim or may take an extension of time, as described in "**Extensions of Time**" below. If the Claims Administrator takes an extension of time, the extension notice will include a description of the missing information and specify a period, of no less than 45 days, within which the

necessary information must be provided. The timeframe for deciding the Claim will be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is timely provided to the Claims Administrator. If the requested information is provided, the Claims Administrator will decide the Claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the Claim may be decided without that information.

Standard Timeframes for Deciding Initial Claims

Pre-Service Claims. The Claims Administrator will decide an initial Pre-Service Claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the Claim.

Urgent Care Claims. The Claims Administrator will decide an initial Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the Claim.

Concurrent Care Extension Request. If a Claim is a request to extend a concurrent care decision (as described above) involving urgent care, and if the Claim is made at least 24 hours before the end of the initially approved period of time or number of treatments, the Claim will be decided within 24 hours after receipt of the Claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for Pre-service, Urgent Care, or Post-Service Claims.

Concurrent Care Early Termination. A decision by the Plan to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the claimant under these Claims procedures. Notification to the claimant of a decision by the Plan to reduce or terminate an initially approved course of treatment will be provided sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

Post-Service Claim. The Plan will decide an initial Post-Service Claim within a reasonable time, but no later than 30 days after receipt of the Claim.

Extensions of Time

Despite the specified timeframes, nothing prevents you from voluntarily agreeing to extend the above timeframes. In addition, if the Claims Administrator is not able to decide a Pre-Service or Post-Service Claim within the above timeframes due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that you are notified in writing before the expiration of the initial timeframe applicable to the Claim. The extension notice will include a description of the matters beyond the Claims Administrator's control that justify the extension and the date by which a decision is expected. No extension is permitted for Urgent Care Claims.

Notice of Initial Claim Decision

For Pre-Service, Urgent Care, and Concurrent Care Claims, the Claims Administrator will notify you in writing of the initial Claim decision, whether or not the decision is adverse. For Post-Service Claims, the Claims Administrator may only notify you if the decision is adverse.

A decision on a Claim is "adverse" if it is (1) a denial, reduction, or termination of a Plan benefit; or (2) a failure to provide or make payment (in whole or in part) for a Plan benefit. A rescission of coverage under the Medical and Prescription Drug Benefit Programs is also treated as an adverse benefit determination (whether or not the rescission has an adverse effect on any particular benefit at that time). A rescission is a retroactive cancellation of coverage under the Medical and Prescription Drug Benefit Programs, other than for failure to pay premiums.

In all cases where the decision on your Claim is adverse, you will receive a written notice of the decision. For Urgent Care Claims, you may be notified orally first, and then a written notice will be sent within three days of the oral notice.

The notice of the Plan's adverse benefit decision will include all of the following information:

- the specific reasons(s) for the denial of your Claim;
- a reference to the Plan provisions on which the denial is based;
- a description of any additional material or information necessary to perfect your Claim, and an explanation of why such information is necessary;
- a description of the Plan's Claim review procedures, including any internal or external appeals available, how to initiate the review, the applicable time limits and an explanation of the expedited review procedure for certain types of Claims (for example, certain Urgent Care Claims);
- a statement that you have a right to bring a civil action in federal court if your Claim has been denied after you have exhausted the Plan's Claim review procedures;
- a statement disclosing any rule, guideline, protocol, or similar document or criteria relied on in making the decision (or a statement that such information will be provided free of charge upon request); and
- if the adverse benefit determination is based on a matter of scientific or clinical judgement (for example, it was determined that your treatment was experimental or was not medically necessary), either an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or a statement that a copy of that explanation can be obtained at no charge upon request.

For Claims under the Medical and Prescription Drug Benefit Programs, the Plan's notice will also include:

- information sufficient to identify the Claim involved (*i.e.,* the date of service, the health care provider, and the Claim amount when applicable);

- a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings; and
- any denial code and its meaning and a description of any Plan standard used in denying the Claim.

Internal Appeal of an Adverse Benefit Determination

If you receive a notice of an adverse benefit decision and you disagree with that decision, you must file an internal appeal of the decision by submitting your request for review to the Claims Administrator listed in **Appendix B**. The Benefit Program in which you are enrolled may have one or two levels of internal appeal, depending on the type of Claim. If two levels of internal appeal are provided, the second level may be mandatory (meaning that you must file the second level of internal appeal before you will be considered to have exhausted the Plan's Claim and appeal procedures) or voluntary (meaning that you do not have to file a second level internal appeal to exhaust the Plan's Claim and appeal procedures). Please see the applicable Benefit Booklet for additional information.

Your internal appeal of an adverse benefit determination must be filed within 180 days following your receipt of the notification of the adverse benefit decision. Failure to comply with this important deadline will cause you to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

For Urgent Care Claims, a request for an expedited internal review may be submitted orally or in writing, and all necessary information may be provided by telephone, fax, or any other similarly expeditious method. Certain Urgent Care Claims under the Medical and Prescription Drug Benefit Programs may be eligible for expedited external review in lieu of internal review. (See "**External Claim Review for Medical and Prescription Drug Claims**" below for additional information).

For Pre-Service, Post-Service, and Concurrent Care Claims, your internal appeal must be in writing. Your request should include an explanation of why you think your Claim should not have been denied and any additional information, materials, or documentation supporting your Claim.

Please see the Benefit Booklets for the Medical, Prescription Drug, Dental, and Vision Benefit Programs for additional details on how to file an internal appeal of an adverse benefit determination under the Plan. The Benefit Booklets will also explain whether the benefit option in which you are enrolled provides one or two levels of internal appeal for your Claim, and whether the second level of internal appeal is mandatory or voluntary.

How Internal Appeals Will be Decided

Upon request and free of charge, you will be provided reasonable access to and copies of all of the documents, records, and other information relevant to your Claim. In addition, if the advice of a medical or vocational expert was obtained in connection with the initial Claim decision, the names of each expert will be provided to you on request, regardless of whether the advice was relied on by the Claims Administrator. You may also present evidence and written

testimony and submit written comments, documents, records, and other information relating to your Claim to the Claims Administrator.

For Claims under the Medical and Prescription Drug Benefit Programs, if the Claims Administrator has considered, relied upon, or generated any new or additional evidence in deciding the Claim, you will be provided with such evidence sufficiently in advance of the due date for filing the appeal so that you have an opportunity to respond to the additional evidence. In addition, before issuing a decision on your appeal that is based on a rationale that was not included in the initial decision, the Claims Administrator for the Medical or Prescription Drug Benefit Program will provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the appeal decision to give you a reasonable opportunity to respond.

The review by the Claims Administrator will take into account all information you submit, whether or not that information was presented or considered in the initial benefit decision. All necessary information in connection with an appeal of an Urgent Care Claim will be transmitted between the Plan and the claimant by telephone, fax, or e-mail. The person(s) reviewing your Claim will grant no deference to the original Claim denial but will assess the information you provide as if they were looking at the Claim for the first time. The person(s) reviewing your Claim will not be the same person(s) who made the initial decision, nor will they be subordinate(s) of those individuals.

Timeframes for Deciding Internal Appeals

You will be notified in writing of each decision on appeal, whether favorable or adverse, within the timeframes listed in the chart below. Notice of the decision on an appeal of an adverse Urgent Care Claim determination may be provided orally, as long as a written or electronic notice is sent within three days.

Type of Claim	Timeframe for Providing Notice of Decision on Internal Appeal

Pre-Service Claim	• If the Benefit Program provides for one required level of internal appeal *(including any Benefit Program where the second level of internal appeal is voluntary)*, within 30 days after receipt by the Claims Administrator of the request for review
	• If the Benefit Program provides for two required levels of internal appeal:
	  • First-Level Internal Appeal: Within 15 days after receipt by the Claims Administrator of the first-level internal appeal
	  • Second-Level Internal Appeal: Within 15 days after receipt by the Claims Administrator of the second-level internal appeal

Type of Claim	Timeframe for Providing Notice of Decision on Internal Appeal
Urgent Care Claim	As soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt by the Claims Administrator of the request for review

Post-Service Claim	• If the Benefit Program provides for one required level of internal appeal *(including any Benefit Program where the second level of internal appeal is voluntary)*, within 60 days after receipt by the Claims Administrator of the request for review
	• If the Benefit Program provides for two required levels of internal appeal:
	  • First-Level Internal Appeal: Within 30 days after receipt by the Claims Administrator of the first-level internal appeal
	  • Second-Level Internal Appeal: Within 30 days after receipt by the Claims Administrator of the second-level internal appeal

Concurrent Care Claim	• For an appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment, before the proposed reduction or termination takes place • For an appeal of a denied request to extend any concurrent care decision, in the appeal timeframes for Pre-Service, Urgent Care, or Post-Service Claims described above, as appropriate to the request

Notice of Adverse Appeal Decision

If your appeal is denied, in whole or in part, the notice of the Plan's adverse benefit decision will include all of the following information:

- the specific reasons(s) for the appeal decision;
- a reference to the Plan provisions on which the denial is based;
- an explanation of any remaining levels of internal appeal under the Plan, including whether the internal appeal is mandatory or voluntary and the applicable deadline for filing such an appeal;
- a statement that you have a right to bring a civil action in federal court after exhausting the Plan's internal appeal procedures;
- a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the decision;

- a statement disclosing any rule, guideline, protocol, or similar document or criteria relied on in making the decision (or a statement that such information will be provided free of charge upon request); and
- if the decision is based on a matter of scientific or clinical judgement (for example, it was determined that your treatment was experimental or was not medically necessary), either an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or a statement that a copy of that explanation can be obtained at no charge upon request.

For Claims under the Medical or Prescription Drug Benefit Programs, the Plan's notice will also include the following information:

- information sufficient to identify the Claim involved (*i.e.*, the date of service, the health care provider, the Claim amount when applicable);
- a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
- the specific reasons(s) for the appeal decision, including any denial code and its meaning and any Plan standard used in denying the Claim, including a discussion of the decision; and
- a description of the external review process, as described below, to the extent applicable to your Claim.

Second Level Internal Appeals

The Benefit Program in which you are enrolled may have one or two levels of internal appeal, depending on the type of Claim. If two levels of internal appeal are provided, the second level may be mandatory (meaning that you must file the second level of internal appeal before you will be considered to have exhausted the Plan's Claim and appeal procedures) or voluntary (meaning that you do not have to file a second level internal appeal to exhaust the Plan's Claim and appeal procedures). Please see the applicable Benefit Booklet for additional information. The Benefit Booklet will explain whether the benefit option in which you are enrolled provides one or two levels of internal appeal for your Claim, and whether the second level of internal appeal is mandatory or voluntary.

Mandatory Second Level Internal Appeal. If the benefit option in which you are enrolled provides for two required levels of internal appeal, and you are dissatisfied with the Claims Administrator's initial internal appeal decision, then you must complete the Plan's second level of internal appeal to exhaust the Plan's administrative Claims and appeal procedures with respect to your Claim.

Your second level internal appeal must be filed within a certain period of time, which will be specified in the Benefit Booklet applicable to the benefit option in which you are enrolled, following your receipt of the notification of the initial internal appeal decision. Failure to comply with this important deadline will cause you to forfeit any right to any further review of an adverse decision under the Plan's external review procedures or in a

court of law. Please see the Benefit Booklet for the applicable benefit option for additional information.

You will be notified in writing of the Claim's Administrator's decision on your second level internal appeal, whether favorable or adverse, within the time frames listed below.

- *Pre-Service Claims.* The Claims Administrator will decide the second level internal appeal of a Pre-Service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt by the Claims Administrator of the request for review.

- *Post-Service Claims.* The Claims Administrator will decide the second level internal appeal of a Post-Service Claim within a reasonable period, but no later than 30 days after receipt by the Claims Administrator of the request for review.

- *Concurrent Care Claims.* The Claims Administrator will decide the second level internal appeal of a denied request to extend any concurrent care decision in the appeal timeframe for Pre-Service or Post-Service Claims described above, as appropriate to the request.

Voluntary Second Level Internal Appeal. If the benefit option in which you are enrolled provides a voluntary second level of internal appeal with respect to your Claim, and you are dissatisfied with the Claims Administrator's initial internal appeal decision, then you may file a second level of internal appeal. This second level of internal appeal is completely voluntary, which means that you are not required to complete the Plan's second level of internal review to exhaust the Plan's administrative Claims and appeal procedures with respect to your Claim.

Your second level internal appeal must be filed within a certain period of time, which will be specified in the Benefit Booklet applicable to the benefit option in which you are enrolled, following your receipt of the notification of the initial internal appeal decision. Failure to comply with this important deadline will cause you to forfeit any right to a second level of internal review. You may, however, pursue additional review under the Plan's external review procedures (if your Claim is eligible for external review, as described in "**External Claim Review for Medical and Prescription Drug Claims**" below) or in federal court (subject to the Plan's limitations period and forum selection provision, as described in "**Judicial Review**" below).

If you decide to pursue a voluntary second level of internal appeal, the Plan's limitation periods for filing a request for external review or filing a lawsuit in federal court will be tolled during the time that your voluntary appeal is pending. These limitations periods will not be tolled until you file a written request for a second level of internal review with the applicable Claims Administrator listed on **Appendix B**. The limitations periods will begin to run again when the Claims Administrator issues its decision on your second level internal appeal.

You will be notified in writing of the Claims Administrator's decision on your second level internal appeal, whether favorable or adverse, within a reasonable time appropriate to the medical circumstances. Notice of the decision on a second level internal appeal of an adverse Urgent Care Claim determination may be provided orally, as long as a written or electronic notice is sent within three days.

If the benefit option in which you are enrolled provides for a voluntary second level of internal review, the Plan will not assert that you have failed to exhaust your administrative remedies under the Plan if you elect to pursue a claim through external review (if eligible) or in federal court, rather than through the voluntary level of appeal. Also, no fees or costs will be imposed as part of the voluntary review process. Your decision as to whether or not to a voluntary second level internal appeal will have no effect on your rights to any other benefits under the Plan. For additional information on the internal appeal procedures applicable to the benefit options in which you are enrolled, please review the applicable Benefit Booklet or contact the applicable Claims Administrator listed in **Appendix B**.

Right to Request External Review or Judicial Review

If your Claim is denied, in whole or in part, after you have completed the Plan's internal appeal procedures, you have the right (1) to seek an external review (if your Claim is eligible for external review, as described below), or (2) file a civil action in federal court under ERISA.

Important deadlines apply for filing a request for external review or a federal lawsuit, as explained in "**External Claim Review for Medical and Prescription Drug Claims**" and "**Judicial Review**" below. Failure to comply with these important deadlines will cause you to forfeit any right to any further review of an adverse decision under the Plan's external review procedures or in a court of law.

External Claim Review for Medical and Prescription Drug Claims

For the Medical and Prescription Drug Benefit Programs only, if your internal appeal is denied and your Claim is eligible for external review (as explained below), you may file a request for external review within **4 months** after the date you receive notice that your appeal has been denied under the Plan's final level of required internal review. The request for external review must be made in writing to the Claims Administrator at the address listed in **Appendix B**. If you do not file a written request for external review within this timeframe, you will waive your right to external review.

You generally must complete the Plan's internal appeal procedures before you can request external review. However, as described in more detail in "**Requesting Expedited Eternal Review**" below, an expedited external review may be requested before exhausting the Plan's internal claim and appeal procedures if the timeframe for completing these procedures would seriously jeopardize your life, health, or ability to regain maximum function.

Claims Eligible for External Review. Claims eligible for external review are only those brought under the Medical or Prescription Drug Benefit Program that involve (1) medical judgment, as determined by the external reviewer; (2) a rescission of coverage (whether or not

the rescission has any effect on any particular benefit at the time); or (3) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the federal No Surprises Act.

Claims brought under the Dental and Vision Benefit Programs are not eligible for external review. Furthermore, a Claim is not eligible for external review if:

- the claimant was not covered under the Plan at the time the health care item or service was requested, or, in the case of a retrospective review, the claimant was not covered under the Plan at the time the health care item or service was provided;
- the adverse benefit determination is based on the fact that the claimant was not eligible for coverage under the Plan (except where the Claim relates to a rescission of coverage);
- the claimant has not exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); or
- the claimant has not provided all the information and forms required to process an external review.

Requesting Standard External Review. Within five business days of receiving your request for external review, the Claims Administrator will determine whether your Claim is eligible for external review. The Claims Administrator will notify you if your Claim is eligible for external review within one business day after completing the preliminary review.

If your request for external review is incomplete, the notice will describe the information or materials needed to make the request complete and set forth the time limit for you to provide the additional information needed. If your request for external review is approved, the Claims Administrator will assign your external review to an independent review organization ("**External Reviewer**").

Requesting Expedited External Review. The Plan also provides an expedited external review process for qualifying medical conditions and circumstances. If a Claim is otherwise eligible for external review (as described above), an expedited external review may be requested at the time the claimant receives:

- an initial Claim denial, if (1) completing the Plan's internal appeal process would seriously jeopardize the claimant's life, health, or ability to regain maximum function, and (2) the claimant has filed a request for an expedited internal appeal under the Plan; or
- a final denial of the claimant's internal appeal, if completing a standard external review process would pose a similar risk, or if the denial 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.

In either of these cases, the Claims Administrator will conduct the preliminary review of your request and immediately provide you notice as to whether your Claim is eligible for expedited external review. If your request for external review is approved, an External Reviewer will be assigned.

External Review by Independent Review Organization. If your request for external review is approved, the Claims Administrator will transmit all information considered in making the adverse benefit determination to the External Reviewer.

The External Reviewer will then notify you of your acceptance for external review and your right to submit additional information to the External Reviewer within 10 business days following your receipt of the External Reviewer's notice. The External Reviewer will not be bound by any decisions or conclusions reached by the Claims Administrator and must consider any additional information that you timely submit.

Notification of External Review Decision. The External Reviewer will provide written notice of the final external review decision to you and to the Plan within 45 days after the External Reviewer receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for the External Reviewer's decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the Plan's decision, the Plan will follow the final external review decision of the External Reviewer (but may initiate judicial review).

In the case of an expedited external review, the External Reviewer will provide the notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the External Reviewer receives the request for an expedited external review. If the External Reviewer's notice of decision is not in writing, the External Reviewer will provide written confirmation of the decision within 48 hours.

Judicial Review

All decisions made by the Claims Administrator at the Benefit Program's final level of internal appeal are final and binding for purposes of the Plan's internal Claim and appeal procedures. If no appeal is made, the initial Claim decision of the Claims Administrator is final and binding upon the expiration of the time period for seeking review.

If your Claim is denied in whole or in part after you have exhausted the Plan's internal appeal procedures, you have the right to seek an external review (if your Claim is eligible for external review, as described above) or file a civil action in federal court under ERISA.

If you wish to file an action in court, you must do so <u>within one year of completing the Plan's Claim filing and appeal procedures (including, if applicable, any required second level of internal appeal or external review)</u>. Any action related to or arising out of or in connection with the Plan may only be brought or filed in the United States District Court, Middle District of Tennessee or, if the District Court declines or lacks jurisdiction, in the Tennessee state courts for Davidson County.

SPECIFIC CLAIM PROCEDURES FOR THE HEATH CARE FSA BENEFIT PROGRAM AND WELLNESS PROGRAM

Filing a Claim

Health Care FSA Benefit Program. Please refer to "**Filing a Claim for Eligible Health Care Expenses**" under the "**Health Care Flexible Spending Account Benefit Program**" section of this summary for a description of how to submit a claim for reimbursement under the Health Care FSA Benefit Program.

Wellness Program. You do not need to file a specific Claim for benefits under the Wellness Program. Once you are eligible, the benefits automatically follow. If for any reason, however, you believe you have been improperly excluded from participation or otherwise been denied a benefit under the Wellness Program, you may file a formal Claim in writing to the Claims Administrator for the Wellness Program listed in **Appendix B**. Be sure to state:

- why you think you should receive the benefits available under the Wellness Program;
- why you think you have not been getting the benefit; and
- your name and work location.

A Claim related to the Wellness Program must be made within <u>one year</u> after the date on which the events giving rise to the Claim occurred.

Decision on Your Initial Claim

The Claims Administrator will review all Claims submitted.

For Claims submitted under the Health Care FSA Benefit Program, the Claims Administrator reserves the right to deny ineligible or improperly documented expenses and require additional verification of expenses. Deliberate submission of ineligible Claims may result in your removal from the Health Care FSA Benefit Program.

Notice of the decision on your Claim will be issued within a reasonable time period, but no later than 30 days after receipt of the Claim. This time period may be extended for an additional 15 days if the Claims Administrator needs more time to resolve your Claim due to matters beyond its control, including if your Claim is incomplete.

Claim Review

If your initial Claim is denied and you disagree with this decision, you must make a written request for a review of that decision to the relevant Claims Administrator using the contact information listed in **Appendix B**. Your request should include an explanation of why you think your Claim should not have been denied, as well as any additional information or documentation that you believe supports your Claim.

Your request for review must be filed within 180 days following your receipt of the notice that your Claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your Claim.

Decision on Review

Your appeal will be reviewed and decided by the Claims Administrator in a reasonable time, but not later than 60 days after the Claims Administrator receives your request for review. The person(s) reviewing your Claim will grant no deference to the original Claim denial and will assess the information you provide as if they were looking at your Claim for the first time. Also, the person(s) reviewing your Claim will not be the same person(s) who made the determination on your initial Claim, nor will they be subordinates to those individuals.

If the initial Claim denial was based on a medical judgment, the Claims Administrator will consult with an expert in the appropriate field when reviewing the Claim. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim and will be available to your upon request.

If the decision on review affirms the initial denial of your Claim, you will be provided with a written notice explaining the specific reason for the denial, including the specific Plan provisions on which the decision is based.

Judicial Review

Any lawsuit related to the Health Care FSA Benefit Program or Wellness Program must be brought within **one year** after the date of a final decision on the Claim in accordance with the Claim and appeal procedures described above. Any action related to or arising out of or in connection with the Plan may only be brought or filed in the United States District Court, Middle District of Tennessee or, if the District Court declines or lacks jurisdiction, in the Tennessee state courts for Davidson County.

ELIGIBILITY CLAIMS

Generally, any questions and claims you may have regarding eligibility for participation in the Plan (including enrolling in the Plan or changing your benefit elections) can be handled informally by Alight. However, if the informal question or claim is not resolved, and you still want to pursue the matter regarding your eligibility to participate in the Plan, you must submit a formal written "**Eligibility Claim**" to the Company's Benefits Department using the contact information listed in **Appendix B**.

All eligibility claims must be submitted within 90 days of the date the action complained of occurred. If your Eligibility Claim is denied, you will be provided with written notice of the denial within 30 days after the date you submit your Eligibility Claim (or 45 days if you are notified of an extension).

If you disagree with the Eligibility Claim denial and wish to challenge or otherwise appeal it, you must submit a written request for an appeal of that decision to the Plan Administrator **within 180 days** of receiving the Eligibility Claim denial, using the contact information listed in **Appendix B**. The Plan Administrator will make its determination on your appeal within 60 days of the date you submit your appeal. The decision by the Plan Administrator will be final and binding on all parties.

The claim and appeal procedures outlined above are mandatory. The failure to exhaust the required claim and appeal procedures will bar any subsequent remedies you might have, including, but not limited to, a lawsuit.

PLAN ADMINISTRATION

The Plan Administrator has sole responsibility for the administration of the Plan, with full discretionary authority to: interpret the Plan; determine eligibility for and the amount of benefits available under the Plan; determine the status and rights of participants, beneficiaries, and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; employ or appoint persons to help or advise in any administrative functions; exercise all of the power and authority contemplated by ERISA and the Internal Revenue Code with respect to the Plan; and generally do anything needed to operate, manage, and administer the Plan. The Plan Administrator has the necessary discretionary authority and control over the Plan to require deferential judicial review. Therefore, the Plan Administrator's exercise of discretion in its interpretation of the Plan's written terms and its findings of fact in its role as the Plan Administrator will not be overturned unless a court determines they are arbitrary and capricious.

The Plan has other fiduciaries, advisors, and service providers. For the Insured Benefit Programs, the Plan Administrator has delegated its fiduciary duties with respect to benefit claims to the insurance companies identified in **Appendix A**. The insurance companies are therefore responsible for (1) determining eligibility for and the amount of any benefits payable under the Insured Benefit Programs; and (2) providing the claims procedures to be followed and the claims forms to be used under the Insured Benefit Programs. For the Self-funded Benefit Programs, the Plan Administrator has delegated its responsibilities and fiduciary duties with respect to initial – and in some cases, final – Claims determinations to the Claims Administrators listed in **Appendix B**. These delegates have the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to them.

OTHER IMPORTANT INFORMATION ABOUT THIS PLAN

PLAN NAME

Change Healthcare Health and Welfare Plan

PLAN NUMBER

501

PLAN SPONSOR

Change Healthcare Operations, LLC
5995 Windward Parkway
Alpharetta, GA 30005

EMPLOYER IDENTIFICATION NUMBER

20-5731067

PLAN ADMINISTRATOR

Fiduciary Benefits Committee for the Change Healthcare Health and Welfare Plan
Change Healthcare Operations, LLC
Attn: Benefits Department
5995 Windward Parkway
Alpharetta, GA 30005
615-932-3000

AGENT FOR SERVICE OF LEGAL PROCESS

Change Healthcare Operations, LLC
Attn: General Counsel
5995 Windward Parkway
Alpharetta, GA 30005

Service of process may also be made on the Plan Administrator.

PLAN YEAR

January 1 to December 31

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan extends group health benefits to an Eligible Employee's non-custodial child as required by any **Qualified Medical Child Support Order** ("**QMCSO**") under ERISA Section 609(a). The Plan has procedures for determining whether an order qualifies as a QMCSO. You can obtain a copy of these procedures, without charge, by contacting Alight at 833-2PEOPLE.

TYPE OF PLAN

The Plan is a welfare benefits plan offering the health and welfare benefit programs listed in **Appendix A**. A portion of the Plan is a cafeteria plan offering pre-tax contributions for medical, prescription drug, dental, vision, and supplemental LTD insurance coverage, as well as pre-tax contributions to health and dependent care flexible spending accounts and health savings accounts.

TYPE OF PLAN ADMINISTRATION

Some of the benefits provided under the Plan are Insured and administered by an insurance company, and some are Self-funded and administered by a third-party administrator. The insurance companies and third-party administrators for each of the Plan's Benefit Programs are listed in **Appendix A**.

PLAN FUNDING

For the Medical, Prescription Drug, and Dental Benefit Programs, the Company pays part of the cost, and you are responsible (through your Benefit Contributions) for paying the rest of the cost for yourself and your family. For all other Benefit Programs, either the Company pays the entire cost of coverage, or you pay the entire cost. **Appendix A** lists the Benefit Programs that require you to make Benefit Contributions, and the Benefit Programs that are entirely paid for by the Company. The Benefit Contributions required for each Plan Year are described in the Plan's enrollment materials. The portion of the enrollment materials listing the amount of the Benefit Contributions for each Benefit Program is considered part of this SPD only for the purpose of identifying the amount of the Benefit Contributions required each Plan Year.

The cost of a Benefit Program is determined as follows: (1) for the Insured Benefit Programs, the cost is based on the premium charged by the insurer; and (2) for the Self-funded Benefit Programs, the cost is based on the claims paid under the Benefit Program, plus administrative expenses. The Company, in its sole discretion, will determine what portion of the cost the Company will cover, if any, for each Benefit Program.

You are also responsible for any Coinsurance, Copayments, and Deductibles that may be required under the terms of the Benefit Programs. "**Coinsurance**" is your cost sharing amount of expenses after you have met the Deductible. A "**Copayment**" is the flat dollar amount of health care expenses you incur that you are responsible for paying. The "**Deductible**" is the amount you must pay each year for healthcare expenses before any benefits are payable under the Plan. See the Benefit Booklets and Insurance Certificates for the Plan's Benefit Programs for more information relating to Coinsurance, Copayments, and Deductibles.

The benefits provided under the Plan will be paid, to the extent permitted under ERISA and the Internal Revenue Code, from the general assets of the Company, employee contributions, and insurance contracts. Nothing in the Plan will be construed to require the Company to maintain any fund for its own contributions or segregate any amount which it is obligated to contribute for the benefit of any participant, and no participant or other person will have any claim against, right to, or security or other interest in, any fund, account, or asset of the Company from which any payment under the Plan may be made.

AMENDMENT OR TERMINATION OF THE PLAN

The Company, acting through the Global Benefits Committee of Change Healthcare Operations, LLC, may amend, modify, or terminate the Plan, or any Benefit Program under the Plan, at any time, in any manner, and with respect to any individual in its sole discretion. Any amendment will be in writing and duly adopted in accordance with the Plan's amendment procedures.

If the Plan or a Benefit Program is terminated, coverage upon termination, including any applicable claims run-out period, will be governed by the terms of each Benefit Program, as described in the Benefit Booklets and Insurance Certificates. If the Plan or a Benefit Program is terminated, the rights of participants will be limited to Claims incurred before the Plan's termination. In connection with the termination, the Plan Administrator may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for covered Claims incurred prior to the termination date and submitted in accordance with the rules established by the Plan Administrator. Nothing in this document, the Benefit Booklets, Insurance Certificates, or the Plan document or its related insurance contracts shall be construed to provide vested, non-forfeitable, non-terminable, or non-changeable benefits or rights thereto.

PLAN NOT A CONTRACT OF EMPLOYMENT

Your participation in the Plan does not guarantee your continued employment with the Company. All employees remain subject to discharge, discipline, or layoff to the same extent as if the Plan had not been put into effect. The benefits offered under the Plan are in no way vested or guaranteed.

PARTICIPATING EMPLOYERS

Affiliates of the Company may adopt the Plan, subject to the Company's consent. Any affiliate of the Company that participates in the Plan cannot amend or terminate the Plan itself but may terminate its participation in the Plan or any of the Plan's Benefit Programs. A list of the affiliates of the Company that have adopted the Plan is available upon request from the Plan Administrator.

OVERPAYMENTS

An "**Overpayment**" occurs if:

- the Plan pays an amount not payable under the Plan;
- the Plan pays a benefit more than once; or

- A benefit is paid by both the Plan and a third party.

A benefit is considered paid if it is paid to you or to someone else on your behalf (for example, to a health care provider).

If an Overpayment is made by the Plan, the Plan has the right to recover the Overpayment. If that Overpayment is made to a health care provider, the Plan may request a refund of the Overpayment from either you or the provider. If the refund is not received from either you or the provider, the Overpayment will be deducted from future Plan benefits available to you or your covered family members, or from your wages to the extent permitted by law, but the amounts withheld will not reduce your pay below the applicable state minimum wage law.

ENTIRE REPRESENTATION

This document, along with the Plan document and any Benefit Booklet, Insurance Certificate, or separate insurance policy that applies to the Plan's Benefit Programs, are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral), including, but not limited to, severance agreements and employment agreements.

ACCEPTANCE AND COOPERATION

If you accept benefits under the Plan, you are considered to have accepted its terms, and you agree to perform any act and to execute any documents which may be necessary or desirable to carry out the terms of the Plan.

ERRORS

An error cannot give a benefit to you if you are not actually entitled to the benefit under the terms of the Plan.

STATEMENT OF ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements,

and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a copy of the Plan's summary annual 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

Continue health care coverage for yourself or your Covered Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You and your Covered Dependents will have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. These time schedules are outlined in the "**Claim Filing and Appeal Procedures**" section above and the Benefit Booklets and Insurance Certificates for each of the Plan's Benefit Programs.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan document or the latest annual report from the Plan Administrator and do not receive it within 30 days, you may file suit in 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 that is denied or ignored, in whole or in part, you may file suit in federal court, but only after you have exhausted (or are deemed to have exhausted) the Plan's claim and appeal procedures.

In addition, if you disagree with the Plan's decision or lack of a decision concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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.

You must file your claim in federal court before the expiration of the Plan's limitations period, as described in the "**Claim Filing and Appeal Procedures**" section above, or your claim will be dismissed. Any action related to or arising out of or in connection with the Plan may only be brought or filed in the United States District Court, Middle District of Tennessee or, if the District Court declines or lacks jurisdiction, in the Tennessee state courts for Davidson County.

ASSISTANCE WITH YOUR QUESTIONS

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

INDEX OF DEFINED TERMS

APPENDIX A

BENEFIT PROGRAM FUNDING, ADMINISTRATION, AND BENEFIT CONTRIBUTIONS

BENEFIT PROGRAM	FUNDING TYPE	THIRD-PARTY ADMINISTRATOR OR INSURER	WHO PAYS FOR COVERAGE*
AETNA MEDICAL OPTIONS	Self-funded	Aetna 866-862-8317 aetna.com	The Company pays part of the cost for coverage. You pay the rest through your *pre-tax* Benefit Contributions. **NOTE: All optional add-on coverages for the Bind option are paid *post-tax*.**
ANTHEM MEDICAL OPTIONS	Self-funded	Anthem 833-585-3156 anthem.com	
CIGNA MEDICAL OPTIONS	Self-funded	Cigna 800-244-6224 cigna.com	
BIND "ON DEMAND" MEDICAL OPTION	Self-funded	Bind Benefits 833-576-6494 MyBind.com	
PRESCRIPTION DRUG	Self-funded	CVS/Caremark 800-758-2075 caremark.com	
TELEHEALTH VIRTUAL HEALTHCARE	Self-funded	Teladoc 855-220-4585 teladoc.com/changehealthcare	
DIGITAL MUSCULOSKELETAL THERAPY	Self-funded	Hinge Health 855-902-2777 hingehealth.com	
DIABETES MANAGEMENT	Self-funded	Livongo 800-945-4355 livongo.com	
MEDICAL AND PRESCRIPTION DRUG FOR HAWAII EMPLOYEES	Insured	Hawaii Medical Service Association 808-948-6111 (Oahu) or 800-776-4672 (toll-free on the Neighbor Islands or Mainland) https://hmsa.com	The Company pays part of the cost for coverage. You pay the rest through your *pre-tax* Benefit Contributions.
MEDICAL AND PRESCRIPTION DRUG FOR PUERTO RICO EMPLOYEES	Insured	Triple-S Salud, Inc. 800-981-3241 ssspr.com	The Company pays part of the cost for coverage. You pay the rest through your *pre-tax* Benefit Contributions.

* You are always responsible for any Coinsurance, Copayments or Deductibles that apply under a Benefit Program.

BENEFIT PROGRAM	FUNDING TYPE	THIRD-PARTY ADMINISTRATOR OR INSURER	WHO PAYS FOR COVERAGE*
DENTAL	Self-funded	Cigna 800-244-6224 cigna.com	The Company pays part of the cost for coverage. You pay the rest through your *pre-tax* Benefit Contributions.
VISION	Self-funded	Cigna 800-244-6224 cigna.com	You pay the entire cost for coverage through your *pre-tax* Benefit Contributions.
BASIC LTD INSURANCE	Insured	Unum 866-779-1054	The Company pays the entire cost of coverage.
SUPPLEMENTAL LTD INSURANCE	Insured	Unum 866-779-1054	You pay the entire cost for coverage through your *pre-tax* Benefit Contributions.
EMPLOYEE BASIC LIFE INSURANCE	Insured	Unum 800-445-0402	The Company pays the entire cost of coverage.
EMPLOYEE SUPPLEMENTAL LIFE INSURANCE	Insured	Unum 800-445-0402	You pay the entire cost for coverage through your *after-tax* Benefit Contributions.
DEPENDENT LIFE INSURANCE	Insured	Unum 800-445-0402	You pay the entire cost for coverage through your *after-tax* Benefit Contributions.
EMPLOYEE BASIC AD&D INSURANCE	Insured	Unum 800-445-0402	The Company pays the entire cost of coverage.
EMPLOYEE SUPPLEMENTAL AD&D INSURANCE	Insured	Unum 800-445-0402	You pay the entire cost for coverage through your *after-tax* Benefit Contributions.
DEPENDENT AD&D INSURANCE	Insured	Unum 800-445-0402	You pay the entire cost for coverage through your *after-tax* Benefit Contributions.
PRE-TAX PAYMENT	N/A	The People Connection Alight 833-2PEOPLE desktop.pingone.com/changehealthcare	You pay certain Benefit Contributions on a *pre-tax* basis through this Benefit Program.
HSA	N/A	Optum Financial 844-881-9745 optumfinancial.com	You decide how much, if any, you want to contribute on a *pre-tax* basis to your HSA. The Company, in its discretion, may also make contributions on your behalf.

BENEFIT PROGRAM	FUNDING TYPE	THIRD-PARTY ADMINISTRATOR OR INSURER	WHO PAYS FOR COVERAGE*
HEALTH CARE FSA	Self-funded	Optum Financial 844-881-9745 optumfinancial.com	You decide how much, if any, you want to contribute on a *pre-tax* basis to your health care FSA.
DEPENDENT CARE FSA	N/A	Optum Financial 844-881-9745 optumfinancial.com	You decide now much, if any, you want to contribute on a *pre-tax* basis to your dependent care FSA. **Please Note:** Neither the Dependent Care FSA Benefit Program nor the part of this Plan that allows you to contribute to a Dependent Care FSA on a pre-tax basis is subject to ERISA.
WELLNESS PROGRAM	Self-funded	Limeade Changehealthcare.limeade.com	The Company pays the entire cost of the coverage.
EAP	Insured	Resources for Living 800-433-3805 resourcesforliving.com Username: Change Healthcare Password: eap	The Company pays the entire cost of the coverage.
ACCIDENT, CRITICAL ILLNESS, AND HOSPITAL INDEMNITY INSURANCE	Insured	Allstate 800-521-3535 allstatebenefits.com/mybenefits	You pay the entire cost for coverage through your *after-tax* Benefit Contributions.
LEGAL SERVICES PLAN	Insured	Hyatt Legal 800-821-6400 info.legalplans.com Access Code: GETLAW	You pay the entire cost for coverage through your *after-tax* Benefit Contributions.

APPENDIX B

CLAIMS SUBMISSION AND APPEAL INFORMATION FOR SELF-FUNDED BENEFIT PROGRAMS AND ELIGIBILITY CLAIMS

BENEFIT PROGRAM	TYPE OF CLAIM OR APPEAL	CLAIMS ADMINISTRATOR
AETNA MEDICAL OPTIONS	Filing a Claim:	Toll-free number or address that appears on your Benefit Identification card or claim form
	Internal Appeal of Denied Claim:	Toll-free number or address that appears on your Benefit Identification card, explanation of benefits, or claim form
	External Review of Denied Claim:	Address listed on adverse benefit determination Please see the Benefit Booklets for the Aetna medical options for additional information.
ANTHEM MEDICAL OPTIONS	Filing a Claim:	Toll-free number or address that appears on your Benefit Identification card or claim form
	Internal Appeal of Denied Claim:	Toll-free number or address that appears on your Benefit Identification card, explanation of benefits, or claim form
	External Review of Denied Claim:	Address listed on adverse benefit determination Please see the Benefit Booklets for the Anthem medical options for additional information.
CIGNA MEDICAL OPTIONS	Filing a Claim:	Toll-free number or address that appears on your Benefit Identification card or claim form
	Internal Appeal of Denied Claim:	Toll-free number or address that appears on your Benefit Identification card, explanation of benefits, or claim form
	External Review of Denied Claim:	Address listed on adverse benefit determination Please see the Benefit Booklets for the Cigna medical options for additional information.

BENEFIT PROGRAM	TYPE OF CLAIM OR APPEAL	CLAIMS ADMINISTRATOR
BIND "ON DEMAND" MEDICAL OPTION	Filing a Claim:	Bind Benefits, Inc. P.O. Box 211758 Eagan, MN 55121
	Internal Appeal of Denied Claim:	Bind Benefits, Inc. Appeals Department P.O. Box 211758 Eagan, MN 55121
	External Review of Denied Claim:	Address listed on adverse benefit determination
PRESCRIPTION DRUG	Filing a Claim:	Toll-free number or address that appears on your Benefit Identification card or claim form
	Internal Appeal of Denied Claim:	Toll-free number or address that appears on your Benefit Identification card, explanation of benefits, or claim form
	External Review of Denied Claim:	CVS Caremark External Review Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax Number: 1-866-443-1172
DENTAL	Filing a Claim:	Toll-free number or address that appears on your virtual Benefit Identification card or claim form
	Appeal of Denied Claim:	Toll-free number or address that appears on your virtual Benefit Identification card, explanation of benefits, or claim form Please see the Benefit Booklets for the Dental Benefit Program for additional information.
VISION	Filing a Claim:	Toll-free number or address that appears on your Benefit Identification card or claim form
	Appeal of Denied Claim:	Toll-free number or address that appears on your Benefit Identification card, explanation of benefits, or claim form Please see the Benefit Booklets for the Vision Benefit Program for additional information.

BENEFIT PROGRAM	TYPE OF CLAIM OR APPEAL	CLAIMS ADMINISTRATOR
HEALTH CARE FSA	Filing a Claim: Appeal of Denied Claim:	Optum Financial Claims Department P.O. Box 622337 Orlando, FL 32862-2337 Online: optumfinancial.com Optum Financial Appeals Department 307 International Circle, Suite 200 Hunt Valley, MD 21030
DEPENDENT CARE FSA	Filing a Claim: Appeal of Denied Claim:	Optum Financial Appeals Department 307 International Circle, Suite 200 Hunt Valley, MD 21030 Optum Financial Appeals Department 307 International Circle, Suite 200 Hunt Valley, MD 21030
WELLNESS PROGRAM	Filing a Claim: Appeal of Denied Claim:	wellness@changehealthcare.com Fiduciary Benefits Committee for the Change Healthcare Health and Welfare Plan 5995 Windward Parkway Alpharetta, GA 30005
ELIGIBILITY CLAIMS	Filing a Claim: Appeal of Denied Claim:	benefits@changehealthcare.com Fiduciary Benefits Committee for the Change Healthcare Health and Welfare Plan 5995 Windward Parkway Alpharetta, GA 30005