Sares Regis Operating Company, L.P. Flexible Benefits Plan

WRAP

SUMMARY PLAN DESCRIPTION

ERISA PLAN NUMBER 501

November 1, 2025

Prepared by

Medcom
BENEFIT SOLUTIONS

Sares Regis Operating Company, L.P. Flexible Benefits Plan
Summary Plan Description

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INTRODUCTION

Sares Regis Operating Company, L.P. (the "Employer") established the Sares Regis Operating Company, L.P. Flexible Benefits Plan (the "Plan") effective December 1, 1988. This Summary Plan Description describes the Plan as amended and restated effective November 1, 2025.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

OTHER SUMMARY PLAN DESCRIPTIONS

This Plan incorporates the terms of all Welfare Benefit Plans listed in Appendix A in addition to the terms of all Welfare Benefit Plans subject to ERISA sponsored by the Employer or any Affiliated Employer who has adopted the Plan (contact your Plan Administrator if you are unsure which welfare benefits plans are subject to ERISA).

You will receive separate Summary Plan Descriptions and/or certificates of coverage from each of the Welfare Benefit Plans that are component parts of this Plan. In the separate Summary Plan Descriptions and/or certificates of coverage you will find information about eligibility, benefits, and employee/employer contributions for each of the separate Welfare Benefit Plans. You are eligible to participate in this Plan if you are eligible to participate in one of the Welfare Benefit Plans that are component parts of this Plan. In addition, in general, all benefits of this Plan are provided by the Welfare Benefit Plans that are component parts of this Plan.

This Summary Plan Description incorporates the terms of the other Summary Plan Descriptions and/or certificates of coverage for each of the Welfare Benefit Plans that are component parts of this Plan.

If applicable, the Employer will pay its contributions/premiums and any employee contributions to the insurance carriers as required for each such coverage. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using the Employer’s contributions to pay for the cost of such benefit. The Employer’s contributions to the Welfare Benefit Plans that are component parts of this Plan shall be made from the general assets of the Employer and on a basis consistent with any regulations that govern such programs and policies. For certain benefit programs, employees may make pre-tax salary reduction elections to pay for benefits through an employer-provided cafeteria plan, if available. For more information, refer to the cafeteria plan governing document. For more information related to contribution shares, refer to subsidiary contract documents or benefit booklets, if available.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is Sares Regis Operating Company, L.P.

   Its address is
   3501 Jamboree Road, Ste 3000, North Tower
   Newport Beach, California 92660

   Its telephone number is 949-809-2508.

   Its Employer Identification Number is 33-0550001.

2. The Plan is a Welfare Benefit Plan which the Plan Sponsor has designated as plan number 501.

3. The Employer's fiscal year and Plan Year each end on December 31.

4. While the Plan Administrator bears primary fiduciary responsibility, insurance companies are responsible for providing the benefits that they insure in accordance with applicable insurance documents.

5. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.

6. The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Plan Administrator.

7. The plan combines self-funded and insured component benefit programs.

ELIGIBILITY AND ENROLLMENT

How to Become a Participant in the Plan

Before you become a Participant, you must meet the eligibility requirements for the Plan, work (or be expected to work) the required number of hours per week on average, and satisfy the applicable Waiting Period or other measurement period as described in this section.

Enrollment

You will become a Participant in this Plan once you have satisfied the requirements and formally elect benefits. If you do not want any or all of the benefits offered under the Plan, you may elect not to receive such benefits in accordance with the procedures established by the Plan Administrator.

Eligibility for Medical Benefits

The Employer offers coverage to Eligible Employees, their Spouses, Domestic Partners and Dependents, including Dependents who have been adopted or placed for adoption with a Participant.

In general, if you regularly work, or are expected to work, 30 hours or more per week on average, and you are not a Seasonal Employee, you will be eligible to become a Participant.

If you were expected to be an Eligible Employee at the time of hire, you may become a Participant following completion of the Waiting Period. If you choose to enroll, participation will begin the first of the month following 60 days after the date of hire.

If you are designated as a Variable Hour Employee at the time of hire, and later become an Eligible Employee, you will be allowed to become a Participant after the Initial Administrative Period. A Seasonal Employee will be treated as a Variable Hour Employee with respect to eligibility.

If you are an Ongoing Employee who becomes an Eligible Employee following the Standard Measurement Period, you will be allowed to become a Participant after the Standard Administrative Period.

Measurement, Administrative, and Stability Periods

In determining eligibility for the group health plan, the Employer intends to follow IRS regulations and any subsequent guidance when administering the measurement, administrative, and stability periods.

The Initial Measurement Period starts First of Month Following or Coinciding with the employee's date of hire and lasts 12 consecutive months.

The Initial Administrative Period lasts 1 Month.

The Initial Stability Period begins the next day after the end of the Initial Administrative Period and lasts 12 consecutive months.

If you are a Variable Hour Employee, you must first complete an Initial Measurement Period during which you will not be eligible for coverage. At the end of the Initial Measurement Period, if you are determined to be an Eligible Employee, you will be notified by the Plan Administrator and will be eligible to participate in the group health plan after the Initial Administrative Period. The Employer will use the Initial Administrative Period to determine whether you are eligible and to give you the opportunity to enroll if you are determined to be an Eligible Employee. If you choose to enroll, participation will begin on the first day of the Initial Stability Period.

The Standard Administrative Period lasts 2 Months. The Standard Administrative Period starts on November 1 and ends on December 31.

The Standard Measurement Period lasts 12 consecutive months. The Standard Measurement Period starts on November 1 and ends on October 31.

The Standard Stability Period lasts 12 consecutive months. The Standard Stability Period starts on January 1 and ends on December 31.

Ongoing Employee Measurement/Stability Period

Type	*Length*	*Start Date*	*End Date*
Standard Measurement Period	12 Months	November 1	October 31
Standard Administrative Period	2 Months	November 1	December 31
Standard Stability Period	12 Months	January 1	December 31

Eligibility When Rehired

If your employment with the company is terminated and you are later rehired, company policies and complex IRS rules will be used to determine whether you are eligible.

Changes that may Affect Eligibility Status

If your hours of work are reduced, or you move to a different job within the company, your eligibility for benefits may change. Company policies and complex IRS rules will be used to determine whether you are eligible.

Eligibility for Other Benefits

Unless otherwise here stated, the eligibility requirements of each separate welfare benefit can be found in the applicable Summary Plan Descriptions and/or certificates of coverage.

CLAIMS

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Third Party Recovery

If you are paid benefits from any other plan or policy, the Plan may be entitled to reimbursement. In particular, the Plan may be entitled to reimbursement for benefits which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason.

By participating in the Plan, you and your covered dependents consent and agree that a constructive trust, lien, or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. You and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan. And, at that time, you (and your attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

You and your covered dependents consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Coordination of Benefits

If you, your spouse, or dependents are covered by more than one health plan (referred to as an “Arrangement”), detailed rules will be used to determine which Arrangement pays or provides benefits first. If applicable, a secondary Arrangement may reduce the benefits it pays so that payments from all Arrangements do not exceed 100% of the total allowable amount.

The rules for coordination of benefits are further explained in the Summary Plan Descriptions and other documents governing the Arrangements.

Medical Loss Rebates

Under the Patient Protection and Affordable Care Act (ACA), the law requires insurers to issue Medical Loss Ratio (MLR) rebates in certain circumstances. MLR rebates are based upon aggregated market data in each state and not upon a particular group health plan's experience. The portion of the rebate attributable to Participant contributions may be distributed to you, applied towards future premiums, or held in trust for the benefit of Plan Participants. This section applies only for fully insured medical plans.

Claim Procedures - In General

This section applies for any claim for benefits under a Welfare Benefit Plan that is covered by ERISA unless the Welfare Benefit Plan has a claims procedure that is compliant with ERISA section 503. If the Welfare Benefit Plan has a claims procedure that is compliant with ERISA section 503, the claims procedure of the Welfare Benefit Plan will apply. In general, this means that if the claims procedure of the Welfare Benefit Plan has timeframes and procedures that are at least as favorable to you or more favorable than the deadlines provided below, the claims procedure of the Welfare Benefit Plan will apply. In the case of a group health plan, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures are described in the relevant SPD for that plan and incorporated herein.

You or any other person entitled to benefits from the Welfare Benefit Plan (a "claimant") may apply for such benefits by completing and filing a claim with the applicable Welfare Benefit Plan provider in accordance with the provider's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable Welfare Benefit Plan provider. Any claim that does not relate to a specific benefit under the plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Welfare Benefit Plan's Plan Administrator. Any claim must include all information and evidence that the Welfare Benefit Plan provider or plan administrator (the "Claim Reviewer") deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. If a claim is received, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable provider identifying such authorized representative. In the case of a claim for

medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

Timing of Notice of Claim

The Claim Reviewer will notify the claimant of any benefit determination within a reasonable period of time but not later than the timeframe specified below depending on the type of claim.

Group Health Plan Claims

Group health plan claims may involve urgent care, concurrent care claims, pre-service care claims or post-service claims. Each has different timeframes that may apply and is described below.

Urgent Care. The Claim Reviewer will notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such a failure, the Claim Reviewer will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. This notification may be made orally, unless you request written notification. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Reviewer will notify the claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the plan's receipt of the specified information, or (B) the end of the period afforded the claimant to provide the specified additional information.

Concurrent care (a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments). The Welfare Benefit Plan will notify a claimant of any reduction or termination of a course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the Claim Reviewer will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service claims. The Claim Reviewer will notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This

period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Reviewer expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service claims. The Claim Reviewer will notify the claimant, of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Disability Claims

In the case of a claim for disability benefits, the Claim Reviewer will notify the claimant, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claim Reviewer notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant will be afforded at least 45 days within which to provide the specified information.

Other Claims

The Claim Reviewer will notify the claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may

be extended one time by the Plan for up to 90 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Content of Notice of Denied Claim

If a claim is wholly or partially denied, the Claim Reviewer will provide the claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the claimant must take if he wishes to appeal the denial including a statement that the claimant may bring a civil action under ERISA.

In addition to the above information, if it is a group health plan or a plan providing disability benefits, the following information must accompany the notice described above:

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

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the denied claim is for a disability benefit under the Plan, the following information will be included in the written notice:

1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration and presented to the Plan.

2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical

circumstances, or a statement that such explanation will be provided free of charge upon request.

3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

4. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for disability benefits.

In addition, in the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims must be included with the notice described above and may be provided to the claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Appeal of Denied Claim

If a claimant wishes to appeal the denial of a claim, he must file an appeal with the Claim Reviewer on or before the 180th day (or the 60th day in the case of a claim other than a group health plan benefit or a disability benefit) after he receives the Claim Reviewer's notice that the claim has been wholly or partially denied. The appeal will identify both the grounds and specific Plan provisions upon which the appeal is based. The claimant will be provided, upon request and free of charge, documents and other information relevant to their claim. An appeal may also include any comments, statements or documents that the claimant may desire to provide. The Claim Reviewer will consider the merits of the claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Reviewer may deem relevant. The claimant will lose the right to appeal if the appeal is not timely made.

In considering the appeal of a group health plan benefit or a disability benefit, the Claim Reviewer will:

1. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

2. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health

care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

3. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

4. Provide that the health care professional engaged for purposes of a consultation under Subsection (2) will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

5. In addition, in the case of a claim involving urgent care, provide for an expedited review process pursuant to which (A) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (B) all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

If the claim is for disability benefits under the Plan, the following will apply:

1. Before the Plan issues any adverse benefit determination, the Claim Reviewer will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or additional rationale must be provided to you as soon as possible and sufficiently in advance of the date on which the Plan must provide you with the notice of final adverse benefit determination so that you have a reasonable opportunity to respond prior to that date.

2. If the determination is based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for you to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until you have had a reasonable opportunity to respond. After you respond or had a reasonable opportunity to respond but failed to do so, the Claim Reviewer will notify you of the Plan's benefit determination as soon as a plan acting in a reasonable and prompt fashion can provide the notice, taking into account the urgency of the medical situation.

Notice of Denied Appeal Review

If a claim is wholly or partially denied, the Claim Reviewer will provide the claimant with a notice identifying all the information identified above, plus a discussion of the decision and available external claims processes and information regarding how to initiate an appeal.

Except as provided below for group health urgent care, pre-service and post-service claims, the Claim Reviewer will notify the claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination (45 days in the case of a claim involving disability benefits). If the Claim Reviewer determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 60-day period (45 days in the case of a claim involving disability benefits). In no event will such extension exceed a period of 60 days from the end of the initial period (45 days in the case of a claim involving disability benefits). The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

Urgent care claims. In the case of a claim involving urgent care, the Claim Reviewer will notify the claimant of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

Pre-service claims. In the case of a pre-service claim, the Claim Reviewer will notify the claimant, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination.

Post-service claims. The Claim Reviewer will notify the claimant of the plan's benefit determination on review within a reasonable period of time. Such notification will be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination.

If an appeal is wholly or partially denied, the Plan Administrator will provide you with a notice identifying (1) the reason or reasons for such denial; (2) the Plan provisions on which the denial is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and (4) a statement describing your right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator will be binding upon all parties.

In the case of a group health plan or a plan providing disability benefits, the notice will also include:

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

2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

3. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

In the case of a claim involving disability benefits, the notice will also include:

1. Any applicable contractual limitations period that applies to your right to bring an action under section 502(a) of ERISA, including the calendar date that the contractual limitations period expires for the claim.

2. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration and presented to the Plan.

3. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.

4. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

You must exhaust all internal remedies before you may file a claim or lawsuit in court.

<u>Legal Action with Respect to Denied Claims</u>

You have the right to bring a legal action against the Plan for benefits you believe are otherwise due to you. Any legal action cannot be brought until you have exhausted your appeal rights under the Plan. In addition, any legal action cannot be brought more than one year after the final determination of your claim under the Plan's claims rules.

No Surprises Act

Prevention of Surprise Bills for Patients Seeking Care from Emergency Room or Freestanding Emergency Care Facility. Any claims paid for emergency care will now be treated as In-network for calculating reimbursement as determined under a methodology set forth in the No Surprises Act, and applicable regulations thereunder, until you are stabilized.

For any emergency services you incurred after you have been stabilized, you will not be balance billed for any services provided by an Out-of-Network Provider provided certain conditions are met, including giving you timely notice and obtaining your written consent in advance to the services.

Such services provided at emergency departments and freestanding emergency care facilities will be paid without requiring any prior authorization by the Plan, and the cost-sharing you must pay shall not exceed the amount that an In-Network provider or facility would charge. Such emergency services shall be provided without regard to any other terms of conditions of coverage, other than plan exclusions or coordination of benefits, a permitted affiliation, a waiting period.

Prevention of Surprise Bills from Out-of-Network Providers Providing Services at In-Network Facilities. Any non-emergency services provided by an out-of-network provider during your visit at an in-network facility shall be paid as in-network and, the non-emergency services provider shall be required to hold you harmless for amounts beyond the in-network cost-sharing requirement unless the out-of-network provider gives you notice and obtains your prior consent.

To meet the notice and consent exception the out-of-network provider must give you:

- written or electronic notice of the provider's out-of-network status,
- a list of in-network providers that the covered individual could see instead, and
- a good faith estimate of your charges at least 72 hours prior to furnishing the out-of-network services.

However, if the services are scheduled less than 72 hours in advance, then you must be given the notice no later than 3 hours before the services are furnished. You must sign a consent to receive the services from the out-of-network provider and acknowledge that you received the written or electronic notice.

Please remember that this notice and consent exception exists for all ancillary services or items, or services furnished to you as a result of unforeseen, urgent medical needs that arise after you consented to the out-of-network non-emergency care at an in-network facility. These

services are subject to the surprise and balance billing prohibitions applicable to emergency services provided by out-of-network health care providers.

The notice and consent exception does not apply to any items and services provided to you by an out-of-network provider when there was no alternative in-network provider at the facility who could furnish the covered item or service. Such services are considered to be "ancillary services." Other services considered to be "ancillary services," and thus always subject to the billing prohibitions by out-of-network providers of amounts beyond the in-network cost-sharing requirement, include:

- Equipment, devices, and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether or not provided by a physician or non-physician practitioner).
- Equipment, devices, and services provided by assistant surgeons, hospitalists, and intensivists.
- Equipment, devices, and services for diagnostics, including telemedicine services, radiology and laboratory services; and
- items and services provided by certain specialty practitioners (which will be specified future rulemaking)."

Prevention of Surprise Bills for Air Ambulance Services. If the Plan covers in-network air ambulance services, then you will be required to pay the in-network cost-sharing amount for an air ambulance, and those amounts paid will be applied to your deductible and OOPM under the Plan. Air ambulance providers shall not be able to balance bill you for the remaining amounts.

Claims from an out-of-network air ambulance claim will count against your in-network deductibles and out of pocket maximum as provided by the Plan. Claim Administrator shall monitor the date on which such emergency claim was received and when the initial and final payments are due.

You and your dependents receiving air ambulance services which are paid for by the Plan, should not be held liable for any amount in excess of their cost-sharing limits under the Plan (deductible, out-of-pocket maximum, co-insurance, or copayments) from an out-of-network air ambulance service provider. These provisions do not apply to ground ambulance services.

Choice of Health Care Provider. If the Plan requires or provides for Primary Care Provider (PCP) designation, you may choose your own PCP, provided the PCP is in-network and available to accept new patients.

You must be allowed direct access to OBGYN care. An OBGYN is required to adhere to all policies and procedures around referrals and authorizations. You must be allowed to select a pediatrician as a PCP. If the Plan requires you to have a primary care provider, you may designate any participating primary care provider who is available to accept you.

For a child you covered under the Plan, you may designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

The Plan may not require authorization or referrals for coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The OBGYN must agree to adhere to the Plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services related to a treatment plan. An OBGYN may refer patients for care or request prior authorization for care similar to a PCP.

Provider Requirements

At a minimum, all providers and healthcare facilities are required to submit provider directory information to an in-network plan or issuer:

- when they begin a network agreement;
- when they terminate a network agreement;
- when there are material changes to their directory information;
- at any other time determined appropriate by the payer, provider, facility, or Secretary of Health and Human Services (HHS).

The following information must be submitted for the provider directory:

- Names, addresses, specialty, telephone numbers, and digital contact information of individual health care providers; and
- Names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or health care facility.

Continuity of Care. You will qualify for protection if you are a continuing care patient and are receiving care from an In-network provider for (1) a serious and complex condition, (2) a course of institutional or inpatient care from a provider or facility, (3) a nonelective surgery from the provider or facility, including receipt of post-operative care with respect to a surgery, (4) pregnancy and is undergoing a course of treatment for the pregnancy, or (5) a determined terminal illness and is receiving treatment for such illness from a provider or facility, and such provider or facility's contract to be a network provider terminates or expires for any reason other than fraud by such provider or facility, then the Plan is required to meet all of the following requirements:

- The Plan must notify you if you are receiving continuing care that you will be protected for continuing care at the time the provider or facility's contract terminates and inform you that it is your right to elect continued transitional care from such provider or facility.
- The Plan shall provide you with an opportunity to notify the Plan or insurer of your need for transitional care.

- The Plan must permit you to elect to continue to have the benefits provided under such Plan or such coverage under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan had the provider or facility's contract not terminated.
- Such transitional coverage shall continue beginning on the date that you receive notice of the contract termination and shall continue until the earlier of 90 days after your receipt of such notice, or the date you are no longer qualified as a continuing care patient under the definition above with respect to that health care provider or facility. The health care provider caring for you is required to accept payment from the Plan for services and items furnished to you as payment in full for such items and services and to maintaining compliance with all policies, procedures, and quality standards imposed by the Plan.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

FMLA

FMLA generally applies if you work at a location where your Employer (or Division) employs 50 or more employees within 75 miles. If your Employer is subject to FMLA, you may generally continue to receive group health plan coverage during an approved leave of absence. FMLA requires that you have worked for your Employer a certain number of hours and number of months to be eligible.

COBRA continuation coverage is available upon the expiration of the FMLA leave, if desired. If you fail to return to active employment following the expiration of the FMLA period, you will be eligible for COBRA coverage up to 18-months starting from the date of your qualifying event (termination of employment or reduction of hours worked).

Your Employer will establish a payment method, should you wish to continue coverage while on FMLA leave, as prescribed for all such FMLA events which will be consistent with every new request for leave. If you do not wish to continue group health plan coverage during FMLA leave, your coverages will be reinstated when you return from FMLA leave.

State Family Medical Leave laws are also considered. Additional leave rights may apply under state law or in accordance with company policies. You should contact your Plan Administrator for further information.

YOUR RIGHTS UNDER ERISA

As a Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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, if the Plan was required by law to file such form), and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

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

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO).

What is a Qualified Medical Child Support Order (QMCSO)?
A "QMCSO" is a medical child support order (from a court or administrative agency) that creates or recognizes the right of an "alternate recipient" to receive benefits for which a Participant or beneficiary is eligible under a group health plan. It is recognized by the group health plan as "qualified" because it includes information and meets other requirements.

Who can be an "alternate recipient"?
Any child of a Participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such Participant is an alternate recipient.

What information must a medical child support order contain to be a "qualified" order?
A medical child support order must contain the following information in order to be qualified:

- The name and last known mailing address of the Participant and each alternate recipient, except that the order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined);
- The period to which the order applies; and
- An order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of certain State laws.

A "National Medical Support Notice" can also be a qualified medical support notice.

The Plan Administrator has established the QMCSO procedures outlined below.

Upon receiving a medical child support order the Plan Administrator will:

1. Determine if the document is a National Medical Support Notice or a judgment order or decree from a court or administrative process.

2. Notify the Participant, each alternate recipient and the issuing court or agency in the case of a National Medical Support Notice of the receipt of the order and provide a copy of these procedures.

3. Review the employment status of the affected employee/parent and review the Plan provisions to determine which, if any, group health plan benefits are available to the alternate recipient.

4. Determine if the document is a qualified medical support order.

5. Notify the Participant and the alternate recipient whether the document is a qualified medical support order within a reasonable time after receipt of the order (not to exceed 40 days in the case of a National Medical Support Notice).

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number provided at the end of this Summary Plan Description.

Newborns' and Mothers' Health Protection

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

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

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires group health plans that provide mental health and substance abuse benefits to cover these services in a manner equal to their coverage of medical and surgical services. For example, separate deductibles may not be applied for treatment of mental health or substance use disorders, as opposed to medical or surgical treatment. The MHPAEA generally applies to employers with more than 50 employees. However, MHPAEA does not apply if your Plan does not currently offer any mental health or substance abuse benefits.

Loss of Benefit

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary.

In the event this Plan offers any self-insured benefit, you may not assign your benefits under this Plan to a non-network provider without the consent of the Plan Administrator. When an assignment is not obtained, the Plan may send the reimbursement directly to you (the Participant and/or beneficiary) for you to reimburse the provider upon receipt of their bill. The Plan may, at its discretion, pay a non-network provider directly for services rendered to you. In the case of any such assignment of benefits or payment to a non-network provider, the Plan reserves the right to offset benefits to be paid to the provider by any amounts that the provider owes to the Plan.

Medicaid

If you obtain Medicaid coverage for treatment that is also covered under this Plan, Medicaid may seek to be made whole from this Plan. Be sure to notify the Plan Administrator if you or a family member receive treatment for the same illness or injury for which you received treatment under Medicaid.

Collective Bargaining

If the Plan Sponsor has entered into a collective bargaining agreement that includes welfare benefits offered under this Plan, the collective bargaining agreement may determine certain coverage provisions, including eligibility, employer and employee contribution amounts, types of benefits offered, and other coverage terms for employees who are members of the collective bargaining group.

Amendment and Termination

The Employer has the right to amend, terminate or merge the Plan at any time, and to change the types of benefits offered from time to time. Any insurers, third party administrators, or other service providers will be selected by the Employer at its sole discretion.

If the Plan is terminated, any remaining plan assets will be used to pay outstanding benefit claims. Following payment of these claims, remaining assets that are not returned to the Plan Sponsor will be refunded to Participants, if allowed by the terms of the applicable subsidiary contracts.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

No warranty or any other representation that any pre-tax premiums or benefits made to you or on behalf of you will be treated as nontaxable for local, state or federal income purposes, is made by the Employer or the Plan Administrator. If it is determined that an amount paid as a benefit is includable in your gross income for income tax purposes, under no circumstances will you have any recourse against the Employer, the Plan Administrator or any Adopting Employer with respect to any increased taxes or any other losses or damages suffered by you as a result. You should consult with a professional tax advisor to determine the tax consequences of your participation.

Domestic Partners and Imputed Income

When employers provide health care benefits for the spouse and/or dependents of their employees, the Internal Revenue Code allows the money paid by the employer for these benefits to be excluded from the employee's gross income. (See, Internal Revenue Code §§105, 106.) No such exclusion exists for benefits given to an employee for their domestic partner, or the

dependents of a domestic partner. Therefore, the money paid by an employer for health care benefits for an employee's domestic partner and/or the dependent of a domestic partner is income that is taxable.

The employee is responsible for paying the tax on domestic partner benefits. To the extent the law requires the employer to withhold tax on the income paid to its employees, the tax on domestic partner benefits must also be withheld.

The IRS also requires that included in the employee's income is the fair market value of the employer provided coverage if the domestic partner is not a qualified relative under the tax code. To be considered a qualified relative you must be a tax dependent on what you claim on your income tax. The IRS requires that an employer withhold tax from their employees' income on the fair market value of the health benefit paid in excess of the amount paid by the employee for that benefit. For example, if the cost of the health insurance premium for a domestic partner is $250.00 per month and the employee pays $50.00 of this premium, and the employer pays $200.00, the fair market value to be included in the employee's gross income in this case would be $200.00 per month. This is called imputed income. Please ask the Plan administrator for the amount of the imputed income.

A domestic partner may be considered a dependent for purposes of the tax laws governing employer-provided health care benefits if the domestic partner is recognized as a common-law spouse, or where the domestic partner meets the following criteria:

- the domestic partner receives over 50% of their support from the taxpayer.
- the domestic partner's principal place of abode is the taxpayer's home; and
- the domestic partner is a member of the taxpayer's household.

Where a domestic partner is considered a tax dependent, the money paid by the employer for health care benefits can be excluded from the employee's gross income.

If the children of a domestic partner satisfy the requirements of being dependent (as outlined above), the money paid by the employer for their health care benefits can be excluded from the employee's gross income. (This assumes that the domestic partner's children have not been adopted by the employee.)

To the extent that the fair market value of domestic partner benefits is considered taxable as income, it also will be treated as wages subject to inclusion in Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA) tax calculations.

(Please note that the information contained in this document is not intended as legal advice and should not be relied on as such. You should always consult your tax professional.)

Wellness

In general, a wellness plan that offers a reward for participating or satisfying a health-based outcome must not offer a reward that exceeds 30 percent of the total premium for employee-only coverage under the plan. An additional 20 percent can be applied to a wellness program designed to prevent or reduce tobacco use (up to 50 percent of the total premium). If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under the program, contact the Plan Administrator to discuss another way to qualify for the reward.

If your employer offers a wellness plan, you will receive additional materials describing the operation of the plan, eligibility to participate, and the amount and conditions for any rewards.

This Summary Plan Description incorporates the terms of the additional materials for the wellness plan herein by reference.

HIPAA Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

Will my health information be kept confidential?

Under HIPAA, group health plans and the third party service providers (where applicable) are required to take steps to ensure that certain "Protected Health Information" is kept confidential.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- If you feel we have violated your rights, you can complain by contacting the Plan Administrator or HIPAA Privacy Officer.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- *Example: We use health information about you to develop better services for you.*

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

COBRA NOTICE

Introduction

This notice applies only to the extent the Employer is subject to COBRA regulations (Code Section 4980B and other applicable state law), and to the extent you are participating in certain Employer-sponsored medical benefits (hereafter within this notice referred to as the "Plan"). Any congressional updates or rule changes by Agencies will also be incorporated into COBRA.

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Continuation Coverage Available?

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

The end of employment or reduction of hours of employment; death of the employee; the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both). or all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notification to the COBRA contact at:

Sares Regis Operating Company, L.P.
3501 Jamboree Road, Ste 3000, North Tower
Newport Beach, California 92660

The telephone number is 949-809-2508.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special

enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

In general, if you 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, beginning on the earlier of

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

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Sares Regis Operating Company, L.P.
3501 Jamboree Road, Ste 3000, North Tower
Newport Beach, California 92660
949-809-2508

APPENDIX A WELFARE BENEFIT PLANS

The following welfare benefits of the Plan Sponsor are subject to ERISA and are covered by the Plan:

WELFARE BENEFIT	FUNDING TYPE
Medical	Self-funded
Medical	Fully-insured
Dental	Fully-insured
Vision	Fully-insured
Group Life	Fully-insured
Accidental Death & Dismemberment	Fully-insured
Voluntary Short-Term Disability	Fully-insured
Employer Long-Term Disability	Fully-insured
Specified Voluntary Worksite Plans	Fully-insured
Voluntary Life/AD&D	Fully-insured
Health Flexible Spending Account (FSA)	Self-funded

GLOSSARY

"Affiliated Employer" means a related company which adopts the Plan and participates in one or more of the benefits offered under the Plan.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, which gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

"Dependent" means any person who qualifies as a dependent under a subsidiary contract for purposes of that contract.

"Domestic Partner" means a person with whom an employee is in a committed relationship. The person may be the opposite sex or same sex as the employee. The domestic partner and the employee:

- must be each other's sole domestic partner and intend to remain so indefinitely;
- maintain a common residence, and intend to continue to do so
- are at least 18 years of age and mentally competent to consent to a contract
- share responsibility for each other's financial obligation
- are not married or joined in a civil union to anyone else
- are not a domestic partner of anyone else
- are not related in a way that would prohibit legal marriage

must provide documentation requested by the employer of proof these requirements have been met.

"Eligible Employee" Is an employee who meets the eligibility requirements for one or more of the benefits offered under this Plan.

"Employer" means the company sponsoring the Plan and any related companies which participate in one or more of the benefits offered under the Plan.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"FMLA" means the Family Medical Leave Act of 1993.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

"Initial Administrative Period"	means the time during which new Variable Hour Employees who have completed the Initial Measurement Period and have been determined to be Eligible Employees can enroll in or waive medical coverage. This period may not last longer than ninety (90) days and may include a partial month prior to the beginning of the Initial Measurement Period. The Initial Administrative Period, or its second part, begins the next day after the end of the Initial Measurement Period.
"Initial Measurement Period"	means the period of time during which a new Variable Hour Employee's hours of service are measured to determine whether the employee will become an Eligible Employee.
"Initial Stability Period"	means the minimum period of time during which medical coverage must be offered to an employee who was previously a Variable Hour Employee and has been determined to be an Eligible Employee. The Initial Stability Period may not be shorter in duration than the Initial Measurement Period.
"Ongoing Employee"	means an employee who was employed with the Employer on the first day of a Standard Measurement Period.
"Participant"	means an employee who participates in benefits that are offered under this Plan.
"PHI"	means Protected Health Information as defined under HIPAA.
"Plan"	means the benefit programs that are described in this document.
"Plan Year"	means each 12-consecutive month period ending on: **December 31**.
"Seasonal Employee"	means an employee who is hired for a position for which the customary annual employment period is six (6) months or less and which begins at approximately the same time of each calendar year. A Seasonal Employee will be treated as a Variable Hour Employee with respect to eligibility.
"Spouse"	means an individual who is lawfully married under any state law or as currently recognized under prevailing Federal law.
"Standard Administrative Period"	means the time during which Ongoing Employees who have completed the Standard Measurement Period can enroll in or disenroll from medical coverage. This period occurs between the Standard Measurement Period and the Standard Stability Period.
"Standard Measurement Period"	means the period during which the Employer counts each Ongoing Employee's hours of service. This period cannot be less than three (3) months nor more than twelve (12) months.

"Standard Stability Period"	means the period of time during which an Ongoing Employee is eligible for medical coverage under the Plan. The Standard Stability Period may not be shorter than the Standard Measurement Period.
"Variable Hour Employee"	means an employee for whom the Employer is not able to determine, at the employee's hire date, whether the employee is reasonably expected to work the required number of hours per week for eligibility.
“Waiting Period”	means the time period during which a newly hired Eligible Employee must be employed by the Employer prior to becoming a Participant.
“Welfare Benefit Plan”	means any plan or program that is offered by the Employer in order to provide ERISA-listed benefits to Eligible Employees, other than pension or retirement programs.