



Ninnescah Valley Health Systems, Inc.

Ninnescah Valley Health Systems, Inc.
750 West D Avenue
Kingman, KS 67068

Ninnescah Valley Health Systems, Inc.

Summary Plan Description

Effective January 01, 2023

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INTRODUCTION

This is the Summary Plan Description (the "SPD") for the Ninnescah Valley Health Systems, Inc. HRA Plan, a Health Reimbursement Arrangement (the "HRA"). This SPD summarizes your rights and obligations as a participant (or beneficiary) in the HRA.

Read this SPD carefully so that you understand the provisions of our HRA and the benefits you will receive. You should direct any questions you have to the Plan Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this SPD and the plan document, the plan document will control.

I. ELIGIBILITY

01. What Are the Eligibility Requirements for this HRA?

You will be automatically enrolled in the HRA when you enroll in the Employer's group medical plan, unless you have opted out of the HRA.

02. When is My Entry Date?

Your entry date is the date when following conditions are met:
First of the month following a 60 day waiting period

03. Are There Any Employees Who Are Not Eligible?

Yes, employees who are not eligible to receive medical benefits under the group medical plan, or who are not enrolled in that plan, are not eligible to join the HRA.

II. BENEFITS

01. What Benefits Are Available?

The HRA allows for reimbursement for expenses as described in the Appendices of this document. The expenses that qualify are those permitted by Section 213(d) of the Internal Revenue Code.

The amounts provided to the HRA by your employer will be made available on the first day of the plan year.

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. Any amounts reimbursed under the HRA may not be claimed as a deduction on your personal income tax return or reimbursed by other health plan coverage.

If the maximum amount available for reimbursement for a Coverage Period is not utilized in its entirety, refer to Appendix A for information on how these funds will be handled.

02. What is the "Plan Year"?

The "Plan Year" begins January 01 and ends December 31.

03. What is the "Coverage Period"?

The period of the current "Coverage Period" in which the individual is an eligible employee on or after his or her plan entry date.

04. How are payments made from the HRA?

You may submit requests for reimbursement of expenses you have incurred during the course of a Coverage Period in accordance with the instructions of the Plan Administrator. The Plan Administrator will provide you with further details. However, you must make your requests for reimbursements no later than 90 days after the end of the Coverage Period (that is, no later than 03/30). In addition, you must submit to the Plan Administrator, in accordance with the instructions of the Plan Administrator, proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the HRA has agreed to pay, you will receive a reimbursement payment soon thereafter.

The group Health Plan Carrier will submit requests for reimbursement of expenses you have incurred during the course of a Coverage Period for Qualified Medical Expenses as described in Appendix A. All claims need to be submitted for reimbursements no later than 90 days after the end of the Coverage Period (that is, no later than 03/30). If the request qualifies as a benefit or expense that the HRA has agreed to pay, the claims processor will provide reimbursement directly to you soon thereafter. You are responsible to pay your Provider for any expenses not covered by this HRA.

Remember, reimbursements made from the HRA are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

05. What Happens If I Terminate Employment?

If your employment is terminated during the Plan Year for any reason, your participation in the HRA will cease on the date of your termination, and you will not be eligible to be reimbursed for any expenses incurred past that date. You must submit claims for any expenses incurred prior to your termination of employment within 90 days after you terminate employment. Any unused amounts will be forfeited.

06. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage under these benefits terminates, due to your revocation of the benefits or non-payment of contributions while on leave, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

07. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, the Uniformed Services Employment and Reemployment Rights Act of 1994 may give you special rights to health care coverage under the HRA. These rights can include extended health care coverage. USERRA continuation coverage is concurrent with COBRA continuation coverage. If you may be affected by this law, ask your Plan Administrator for further details.

08. Newborn and Mothers Health Protection Act

Group health plans 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 HRA or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

09. **Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

III. GENERAL INFORMATION ABOUT OUR HRA

This Section contains certain general information, which you may need to know about the HRA.

01. **General HRA Information**

"Ninnescah Valley Health Systems, Inc. HRA Plan" is the name of the Plan.

Your Employer has assigned Plan Number 535 to your Plan.

This HRA is integrated with a group health plan entitled the "Ninnescah Valley Health Systems, Inc. Health", which has been assigned policy number 2314.

The company has adopted this Plan effective January 01, 2023.

Your Plan's records are maintained on the basis of a period of time known as the "Plan Year." The Plan Year begins on January 01 and ends December 31 (the "Plan Year").

02. **Employer Information**

Your Employer's name, address, and identification number are:

Ninnescah Valley Health Systems, Inc.
750 West D Avenue
Kingman, KS 67068
EIN: 48-0761700

03. **Plan Administrator Information**

The name and address of your Plan Administrator are:

Ninnescah Valley Health Systems, Inc.
750 West D Avenue
Kingman, KS 67068

The Plan Administrator will also answer any questions you may have about our HRA. The Plan Administrator has the exclusive right to interpret the appropriate HRA provisions. Decisions of the Plan Administrator are conclusive and binding. You may contact the Plan Administrator for any further information about the HRA.

04. **Agent for Service of Legal Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the HRA. The HRA Agent of Service is:

Ninnescah Valley Health Systems, Inc.
750 West D Avenue
Kingman, KS 67068

Legal process may also be served on the Plan Administrator.

05. **Type of Administration**

The HRA is a health reimbursement arrangement. The HRA is not funded or insured. Benefits are paid from the general assets of the Employer.

06. **Claims Administrator Information**

The name and address of your Claims Administrator are:

Point C
1934 Olney Ave, Suite 200
Cherry Hill, NJ 08003

The Claims Administrator keeps the claims records for the HRA and is responsible for the claims administration of the HRA. The Claims Administrator will also answer any claims-related questions you may have about the HRA.

IV. ADDITIONAL HRA INFORMATION

01. Your Rights Under ERISA

HRA Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

- a. Examine, without charge, at the Plan Administrator's office, all HRA documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the HRA with the U.S. Department of Labor (also, available at the Public Disclosure Room of the Employee Benefits Security Administration).
- b. Obtain copies of all HRA documents and other HRA information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies.
- c. Continue health care coverage for a HRA Participant, Spouse, or other dependents if there is a loss of coverage under the HRA as a result of a qualifying event. Employees and dependents may have to pay for such coverage.
- d. Review this Summary Plan Description and the documents governing the HRA on the rules governing COBRA continuation coverage rights.

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 frames.

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; provided, such suit may be filed only after the plan's review procedures described herein have been exhausted and only if filed within 90 days after the final decision on review is provided, or, if a later date is specified in a booklet, certificate or other documentation for a particular Welfare Program, only if filed by such later date.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the HRA and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to \$112 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 a HRA Participant disagrees with the HRA's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for HRA Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the HRA. The individuals who operate the HRA, called "fiduciaries" of the HRA, have a duty to do so prudently and in the interests of the HRA Participants and their beneficiaries. No one, including the Employer or any other person, may fire a HRA Participant or otherwise discriminate against a HRA Participant in any way to prevent the HRA Participant from obtaining benefits under the HRA or from exercising his or her rights under ERISA.

If it should happen that HRA fiduciaries misuse the HRA'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 HRA, you should contact the Plan Administrator. If you have any questions about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), 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 the 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.

02. How claims are submitted

When you have a Claim to submit for payment, you must:

1. File the claim in accordance with the instructions of the Plan Administrator.
2. Submit copies of all supporting receipts and/or Explanation of Benefits (EOB) from your insurance carrier for which you are requesting reimbursement.

A Claim is defined as any request for a HRA benefit, made by a claimant or by a representative of a claimant that complies with the HRA's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Unless otherwise specified, decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days
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Extension due to matters beyond the control of the Plan	15 days
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Insufficient information on the claim:

Notification of	15 days
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Response by Participant	45 days
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Review of claim denial	60 days
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The Claims Administrator will provide written or electronic notification of any Claim denial. The notice will state:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
2. The specific reason or reasons for the adverse determination.
3. Reference to the specific HRA or Welfare Program provisions on which the determination is based.
4. A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
5. A description of the HRA's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal.
6. Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.
7. In the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.
8. The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision to the Claims Administrator. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the HRA. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the Claim determination;
2. was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with HRA documents and HRA provisions have been applied consistently with respect to all claimants;
4. or constituted a statement of policy or guidance with respect to the HRA concerning the

denied Claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the HRA who is neither the individual who made the adverse determination nor a subordinate of that individual.

After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the HRA a request for an external review. A claimant may request from the Plan Administrator additional information describing the HRA's external review procedure.

V. CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this HRA will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the HRA would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA. The HRA itself can provide group health benefits and may also be used to provide health benefits through insurance.

01. **What is COBRA Continuation Coverage?**

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Arrangement (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

02. **Are there other coverage options?**

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, which coverage began effective January 1, 2014. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. 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. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

03. **Who Can Become a Qualified Beneficiary?**

In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under the HRA by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the HRA under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the HRA as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the HRA under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the HRA due to his or her performance of services for the employer sponsoring the HRA. However, this provision does not establish eligibility of these individuals. Eligibility for HRA coverage shall be determined in accordance with HRA Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by

virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

04. What is a Qualifying Event?

A Qualifying Event is any of the following if the Arrangement provided that the participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's HRA coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. A covered Employee's enrollment in any part of the Medicare program.
5. A Dependent child's ceasing to satisfy the HRA's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Arrangement).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the HRA under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the HRA occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the HRA that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the HRA provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the HRA during the FMLA leave.

05. What Factors Should Be Considered When Determining to Elect COBRA Continuation Coverage?

Enrolling in another Group Health Plan. You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after HRA coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA vs. Marketplace. Other factors to consider when weighing your coverage options include: premium costs, whether a change in coverage will affect your access to certain providers, service areas or drug formularies and whether the coverage change will affect your cost sharing (i.e., new deductibles, etc.). See the discussion above under "Are there other coverage options?" for more information on your options for Marketplace coverage.

06. Election for Obtaining COBRA Continuation Coverage?

The HRA has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

07. What is the Election Period and How Long Does It Last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the HRA. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose

coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

08. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The HRA will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. the death of the employee,
3. commencement of a proceeding in bankruptcy with respect to the Employer, or enrollment of the employee in any part of Medicare.

IMPORTANT:

For the 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 or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Point C
1934 Olney Ave, Suite 200
Cherry Hill, NJ 08003

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives **timely 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 for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the Qualifying event that coverage would otherwise have been lost. The COBRA period begins on the date of the Qualifying Event, even though coverage actually ends at the end of the month. If you or your Spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

09. Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

10. Is COBRA Coverage Available If a Qualified Beneficiary Has Other Group Health HRA Coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

11. When May a Qualified Beneficiary's COBRA Continuation Coverage Be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Arrangement with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other HRA that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - a. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - b. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The HRA can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the HRA can terminate for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the HRA solely because of the individual's relationship to a Qualified Beneficiary, if the HRA's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the HRA is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

12. What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - a. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
3. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage

period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

13. Under What Circumstances Can the Maximum Coverage Period Be Extended?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is extended to 36-months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be extended to more than 36-months after the date of the first Qualifying Event.

The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

14. How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the HRA Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

15. Does the HRA Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the HRA, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any extended period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of any costs. The Arrangement will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

16. Must the HRA Allow Payment for COBRA Continuation Coverage to Be Made in Monthly Installments?

Yes. The health coverage is also permitted to allow for payment at other intervals.

17. What is Timely Payment for COBRA Continuation Coverage?

"Timely Payment" means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the HRA on a later date is also considered Timely Payment if either (i) under the terms of the HRA covered employees or Qualified Beneficiaries are allowed to pay for their coverage for the period on that later date, or (ii) under the terms of an arrangement between the Employer and the entity that provides benefits on the Employer's behalf the Employer is allowed to pay for coverage of similarly situated non-COBRA beneficiaries for the period on that later date.

Notwithstanding the above paragraph, the HRA does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the HRA.

If Timely Payment is made to the HRA in an amount that is not significantly less than the amount the HRA requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the HRA's requirement for the amount to be paid, unless the HRA notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

18. Must a Qualified Beneficiary Be Given the Right to Enroll in a Conversion Health HRA at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the HRA will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of

enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the HRA. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee.

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

Appendix A - HRA Plan Benefit

BENEFITS

Employees and dependents who satisfy the financial criteria of this Plan are eligible to submit a claim under this Plan for reimbursement of prescription expenses that would have been covered under the Group Plan in existence on December 31, 2022, provided the prescription claim was incurred after January 1, 2023.

ANNUAL LIMIT

No individual enrolled in this Plan shall be entitled to reimbursement if this Plan has paid benefits in excess of \$1,000,000 during any twelve-month period after January 1, 2023.