HOMEMAKERS UPSTATE GROUP, INC.
HEALTH AND WELFARE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

JANUARY 1, 2018

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APPENDIX A

SECTION 1 - YOUR HEALTH AND WELFARE BENEFITS PLAN

YOUR SUMMARY PLAN DESCRIPTION ("SPD")

Your employer maintains a comprehensive employee benefits program designed to assist you and your dependents in achieving financial security and good health. This summary, the Benefit Program Documents discussed below, and the Plan's initial COBRA notice constitute the Plan's summary plan description ("SPD").

Important

You are responsible for decisions affecting your participation in the Plan. No one else can make these decisions for you. You can't be sure you are receiving all of the Plan benefits for which you are eligible unless you know what those benefits are, and you follow the Plan's rules for obtaining those benefits. The SPD provides a description of the Plan's benefits. We strongly encourage you to study the SPD, any modifications to the SPD, and all other Plan notices that you receive. You should keep handy a paper or electronic copy of each of them. If you fail to learn about the benefits offered by the Plan, or if you fail to follow the Plan's rules for obtaining benefits you could miss out on benefits that could be of great value to you and your family; have substantial health care expenses that are not covered by the Plan; make employment or retirement decisions based on an erroneous understanding about your benefit rights; and take action that may harm other plan participants and beneficiaries.

YOUR COBRA NOTICE

If you or your Dependent loses group health plan coverage due to a "qualifying event" (such as termination of your employment, a reduction in your hours, divorce, death, or a child ceasing to meet the Plan's definition of Dependent), you and your Dependent may have the right to continue coverage for a limited time under a federal law commonly referred to as COBRA.

The Plan Administrator will provide each covered Employee and Spouse with an initial COBRA notice at the time the Employee and Spouse commence coverage under a group health plan. The initial COBRA notice provides a general description of COBRA, the individuals who are eligible for COBRA (referred to as "qualified beneficiaries"), and the kinds of events (referred to as "qualifying events") that give rise to COBRA rights.

Important

Importantly, the initial COBRA notice contains an explanation of the notices qualified beneficiaries must provide to preserve COBRA rights. For example, qualified beneficiaries must notify the Plan Administrator in the event of a divorce or legal separation, or in the event a child ceases to be a Dependent Child. Qualified beneficiaries are also required to notify the Plan Administrator of a determination by the Social Security Administration that a qualified beneficiary is disabled. This notice will explain the procedures for providing notice including when and how the notice must be provided and to whom it must be provided (among other things).

The initial COBRA notice is part of this SPD and should be kept with this SPD for reference. Failure to meet the Plan's COBRA notice requirements could result in the loss of COBRA benefits.

BENEFIT PROGRAM DOCUMENTS

Each Insurer that underwrites and administers a fully-insured Plan benefit maintains a booklet (often referred to as Certificate of Insurance, Member Contract, or Certificate of Coverage). Self-insured benefits are described in separate written documents maintained by the Plan Administrator. These documents, referred to as Benefit

Program Documents, provide a detailed description of the Plan's benefits; when coverage begins and ends; when benefits are payable; and what you must do to preserve the right to coverage and benefits. You can obtain a copy of any of these documents from your employer's human resources representative upon written request. **If you have any questions about your benefits, be sure to carefully review this summary and the Benefit Program Documents.**

PROTECTING YOUR RIGHT TO BENEFITS

You Must Provide Notice of Your Disability

If you have an accident or illness that could lead to disability, you are required to provide notice of your accident or illness as soon as reasonably possible. The Benefit Program Documents that describe the Plan's disability benefits explain when you need to provide notice of a claim; to whom notice must be provided; how to file a claim; and the information you need to present as proof of your claim. **Do not wait to provide notice of a potentially disabling accident or illness. If you do so, you may lose the right to claim disability benefits.**

You Must Notify the Plan of any Change in Your Address

It is critically important for you to keep the Plan Administrator apprised of any change in your name, address, marital status, and any change in the name, address and marital status of your dependents. Important benefits information may be mailed to the address in the Plan Administrator's records. This information may include important changes in benefits, and important notices apprising you of your rights and responsibilities under the Plan. This information also may include passwords and other personal information that, if known to another person, might enable unauthorized access to personal and benefits information.

You Must Provide Notice of Changes in Family Status and Certain Other Events

Section 4 includes a description of some events that impact your rights and obligations under the Plan (e.g., you get married or acquire a new child through birth or adoption). If any family status change or other event should occur that would create an entitlement to a benefit for which you or your dependents are not currently enrolled, or would enable any other election change, you must provide written notice of that change **within 30 days of the date of the event.**

In certain cases when your coverage would otherwise end (e.g., your employment terminates, you or a dependent ceases to be eligible for benefits, your employment status changes such that you are no longer eligible for that benefit, etc.), you may be able to continue your coverage under the Plan (or convert your Plan coverage to individual coverage). These events are summarized in Sections 5 and 7 of this summary. To be eligible for continuation and conversion of group benefits, you must make an application on the forms required by the Insurer or Plan Administrator within specific time frames following the event (**generally 30 days**).

You must also notify your employer and the Plan Administrator of certain events whether or not you believe your employer or the Plan Administrator actually knows (or should know) of the event. For example, you must provide written notice if you or any of your dependents become eligible for or enrolled in Medicare; if you are divorced or legally separated from your Spouse, or your marriage is annulled; or if a child ceases to meet dependent eligibility requirements.

Important

The deadlines for meeting your notice obligations under the Plan will be strictly enforced to ensure that all employees and Members are treated in a uniform fashion. However, the Plan Administrator may extend the applicable notice deadlines if the Plan Administrator determines that notice could not reasonably have been

provided within the notice period. If the deadline relates to an insured program benefit, the Insurer must also approve the extension.

You Must Resolve All Disputes Using the Plan's Disputed Claim Procedures

All disputes concerning the Plan must be adjudicated under the Plan's disputed claim and appeal procedures. See Section 6. A person claiming entitlement to coverage or benefits may not file a legal action to redress an adverse benefit determination unless the claim or dispute is adjudicated using the Plan's required claims and appeal procedure. **Failure to exhaust the Plan's claims and appeal procedures may result in a permanent loss of benefits.**

Legal actions involving the Plan (e.g., legal actions seeking entitlement to Plan benefits) **must** be commenced within 6 months following the date the Claims Administrator renders (or is deemed to have rendered) a final decision regarding a claim. If a Benefit Program Document specifies a longer period, the longer period specified in the Benefit Program Document will apply.

If you fail to meet the deadline for filing a legal action (referred to as a "statute of limitations"), you will permanently forfeit the right to file a lawsuit challenging the decision of the Plan Administrator (or Claims Administrator) as the case may be.

NO RELIANCE ON ORAL STATEMENTS

Your rights and benefits under the Plan are governed by the official plan document, which includes this summary and the Benefit Program Documents attached to this summary. If you have any question about your rights under the Plan, you must read these documents.

You are not entitled to rely on any oral statement from any person, including the Plan Administrator. Oral statements regardless of source cannot alter the terms of the Plan or create benefits that are not provided under the terms of the Plan.

If you have an important question regarding a Plan benefit, you should submit your question, in writing, to the Plan Sponsor's human resources department.

PLAN CHANGES - TERMINATION

Your employer intends to continue the Plan indefinitely, but reserves the right to eliminate benefits and terminate or change the Plan at any time and for any reason. **Your employer makes no promise to continue benefits in the future, and rights to future benefits do not vest.** Any discontinuance or modification of the Plan cannot adversely affect valid claims for benefits incurred by eligible persons to the extent the claims were incurred prior to the date of discontinuance or modification; valid claims will be paid under the terms of the Plan that were in place prior to the modification, amendment or termination.

FUTURE PLAN BENEFITS

As a general rule, Plan changes will not be announced until *after* they have been formally adopted. Until a change has been formally adopted, no final decisions will have been made. Decisions regarding changes to the Plan are generally not discussed or evaluated below the highest levels of management. Employees below these levels do not know whether any change will be made, nor are they in a position to advise any employee or other person on or speculate about future plans. **Until a change has been formally announced no one should assume that any change will be made.**

DRAFTING ERRORS

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted in a fashion consistent with its intent, as determined in the sole and exclusive judgment of the Plan Administrator. The Plan will be amended retroactively to cure any such ambiguity.

ASSIGNMENT OF BENEFITS

Your interest in a Plan may not be assigned, sold or alienated (transferred) unless, and only to the extent, expressly provided in the Benefit Program Documents.

HEALTH CARE DECISIONS

All decisions regarding health care are the sole responsibility of each covered individual in consultation with the health care providers selected by the individual. The Plan contains rules for determining the amount the Plan will pay for any item, treatment or health care service, and whether particular treatments or health care expenses are eligible for reimbursement. The covered individual in accordance with the Plan's claims procedure may dispute any decision with respect to the level of health care reimbursement, or the coverage of a particular health care expense. No one, other than your health care providers, will have any liability for the outcome of the health care that is provided, or as a result of a decision by a covered individual not to seek or obtain care, other than liability under the Plan for the payment of benefits.

SECTION 2 – IMPORTANT TERMS

ACTIVELY-AT-WORK

If you are not "actively-at-work" (a term defined in the Benefit Program Documents) when your benefits are scheduled to commence, your coverage may not become effective unless and until you return to active employment in an eligible class. Generally, you are considered "actively-at-work" on any day that you are performing work in an eligible employment classification, at a designated workplace.

Important

Please review the Benefit Program Documents carefully for a detailed explanation of this requirement, including an explanation of what it means to be "actively-at-work." **If there is a chance that you will not be Actively-At-Work when your coverage is scheduled to begin, you should write the Plan Administrator for clarification of your rights and obligations.**

CLAIMS ADMINISTRATOR

Once you and your Dependents are enrolled for coverage, the Claims Administrator has the authority to determine whether benefits are due, and for managing and administering the Plan's claims and appeal procedures. The Claims Administrator for a benefit that is fully-insured is the insurance company that pays and administers that benefit. The name and contact information for each Claims Administrator is referenced in **Appendix A**.

DEPENDENT

A "Dependent" or "Eligible Dependent" is a reference to a Spouse and Eligible Dependent Child who meets the requirements for dependent coverage under the Plan. This document and your Benefit Program Documents explain who is an Eligible Dependent, what you must do to obtain coverage for the Dependent, and when coverage for a Dependent begins and ends. Dependent eligibility is addressed in Section 3.

EMPLOYEE

The term "Employee" is a reference to an individual whose employment with Homemakers Upstate Group, Inc. (or related participating employer) has not been terminated, and who is on the Homemakers Upstate Group, Inc. (or the related participating employer) W-2 payroll.

EVIDENCE OF INSURABILITY

Evidence of insurability is proof presented to the insurance company through a written statement or medical examination that an individual meets the minimum requirements of good health required by the insurance company. Evidence of insurability is generally required for late enrollments, certain increases in coverage, or for coverage over certain limits.

Important

Review the Benefit Program Documents and enrollment information carefully to determine when these requirements apply and for information about how to provide proof of insurability. **If you or a Dependent has an adverse health condition, you should write the Plan Administrator to determine whether this condition will affect eligibility for benefits.**

INSURER

Certain Plan benefits are administered and paid on a fully-insured basis by an insurance company in accordance with the terms of a group insurance policy issued to your employer. The Plan's insured benefits and the insurance companies that administer and pay those benefits are specified in **Appendix A.**

MEMBER

The term "Member" (referred to as "you" and "your" as the context requires) is a reference to an Eligible Employee or any other eligible individual who is enrolled in the Plan other than as a Dependent such as, for example, a former employee who is enrolled for COBRA coverage.

NONCONFINEMENT PROVISION

A nonconfinement provision is a provision in a benefit program that states that an individual is not eligible for coverage if he or she is confined to his or her home or a health care facility on the date coverage would otherwise become effective. Nonconfinement provisions are often included in life and disability insurance programs; they are not permitted in group health plans that are subject to HIPAA.

PLAN ADMINISTRATOR

The Plan Administrator is responsible for the management and administration of the Plan except for those functions that it delegates, in writing, to others. In carrying out its duties, the Plan Administrator has the authority and discretion to construe the terms of the Plan and to determine all questions that arise in connection with the Plan. The Plan Administrator's name and contact information is referenced in Section 8.

PLAN SPONSOR

The Plan Sponsor is the entity designated in Section 8.

PLAN YEAR

The Plan Year is the 12-consecutive month period designated in Section 8.

SPOUSE

An Employee's "Spouse" is a person to whom an Employee is legally married under applicable state law. The term "Spouse" does not include a common law spouse. In all cases, the Plan Administrator will determine if a person is an Employee's Spouse by referring to (and interpreting, in its discretion, as needed) applicable law.

SECTION 3 - ELIGIBILITY

OVERVIEW

This section of the summary addresses eligibility for participation in the Plan. Eligibility for participation does not mean you or your Dependents are automatically entitled to receive benefits; you and your Dependents must actually be enrolled for coverage to be entitled to the benefits described in this summary. Section 4 of this summary addresses participation rights and duties in more detail. The Benefit Program Documents may also contain important information regarding eligibility and participation. Please review these documents carefully.

Important

Under federal law, the Centers for Medicare and Medicaid Services (CMS) require Social Security numbers for Members and Dependents who seek enrollment for medical coverage to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, you and your Dependents will be required to provide Social Security numbers at the time of enrollment to enable the medical plan to meet these reporting requirements. ***If you do not provide this information, neither you nor your Dependents will be eligible for medical plan coverage.***

EMPLOYEE ELIGIBILITY

To be eligible for coverage under the Plan, an Employee must be in a class of employees who are benefits eligible under your employer's published employment and benefits policies. **Appendix A** to this summary provides important information regarding eligibility. The Benefit Program Documents provided to you with this document provide detailed information regarding eligibility for coverage under the Plan.

DEPENDENT ELIGIBILITY

Your Spouse

As a general rule, your "Spouse" is a person to whom you are legally married under applicable state law. The term "Spouse" does not include a common law spouse. In all cases, the Plan Administrator will determine if a person is your Spouse by referring to (and interpreting, in its discretion, as needed) applicable law. A Spouse will not qualify as a Dependent while on active duty in the armed forces of any country. Also, a Spouse who is not a citizen or national of the United States generally will not qualify as a Dependent unless he or she is a resident of the United States, Canada or Mexico.

Your Dependent Children

The Plan's Benefit Program Documents and enrollment materials address whether dependent child coverage is available to a Member's children; which categories qualify for dependent child coverage; what you must do to obtain coverage for a child; and when coverage for an Eligible Dependent Child begins and ends.

Important

The Plan Administrator may require proof of a child's status as a Dependent. If you do not provide proof satisfactory to the Plan Administrator that a child qualifies as a Dependent, you will lose the right to enroll the child.

If you have any question about Dependent Child eligibility, please review the Benefit Program Documents carefully. If you need additional guidance, you may submit a written request for guidance to the human resources department.

DEPENDENT ELIGIBILITY AUDITS

You are responsible for determining if someone qualifies as your Spouse or Dependent Child for purpose of the Plan's dependent eligibility rules, subject to the Plan Administrator's final approval.

The Plan Administrator may require you to provide proof that an individual satisfies the Plan's eligibility requirements. Also, if at any time during a Plan Year, your Spouse or Dependent Child becomes ineligible for coverage, you are responsible for notifying the Plan Administrator of that change in eligibility.

From time to time, the Plan Administrator may decide to conduct an eligibility audit. If the Plan Administrator finds that you have enrolled an individual for coverage in the Plan who did not meet the dependent eligibility criteria, the coverage will be discontinued.

If it is determined that you acted fraudulently or intentionally misrepresented in a material way the status of the individual as a Dependent, coverage may be retroactively denied and you may be required to repay any benefits paid to or on behalf of the individual. Other employment action may be taken against you in cases involving intentional conduct on your part.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

In general, a QMCSO is a type of court order that gives your natural or legally adopted child the right to participate in your group health plan coverage. For purposes of a QMCSO, your natural or legally adopted son or daughter must meet the requirements to be an eligible child under the terms of the Plan. The court order must satisfy certain specific conditions under federal law in order to qualify as a QMCSO. The Plan Administrator will notify you if a medical child support order that applies to you is received and will provide you with a copy of the Plan procedures for determining whether the order qualifies as a QMCSO. You can obtain a copy of these QMCSO procedures without charge or by calling the Human Resources Department.

SECTION 4 – SUMMARY OF PLAN BENEFITS

OVERVIEW

Certain benefits are provided only if you elect them. These benefits are referred to as "Elective Benefits."

To purchase Elective Benefits for yourself and your Spouse and Eligible Dependent Children, you must satisfy all enrollment requirements established by the Plan Administrator and Insurer. No otherwise eligible person will be enrolled for benefits unless all applicable requirements are satisfied.

The Plan's Elective Benefits are identified in **Appendix A** and in the Plan's enrollment information.

You should carefully read the information pertaining to the Plan's Elective Benefits before enrolling. If you enroll in a plan and are dissatisfied with it, you may not be able to select another plan until the next open enrollment period, unless you experience an election change event.

The Benefit Program Documents provide detailed information regarding the coverage and participation requirements of these benefits. Please review these documents carefully.

HOW TO ENROLL FOR ELECTIVE BENEFITS

All benefit elections must be made in the form and manner prescribed by the Plan Administrator. These procedures will be communicated as part of the Plan's enrollment communications. No otherwise eligible person will be enrolled for any Elective Benefit unless all required enrollment actions are timely and correctly completed in accordance with the enrollment procedures published by the Plan Administrator and insurance companies that underwrite the Plan's insured benefits.

HOW TO PAY FOR ELECTIVE BENEFITS

Elective Benefits have a cost, typically expressly as a monthly premium or premium-equivalent contribution. The amount you are required to contribute toward the cost of your coverage, if any, is determined by your employer and communicated as part of the Plan's enrollment information.

Your employer has the right to alter the portion of the cost of coverage paid by you at any time.

You must agree to pay your required contribution, if any, through payroll deduction, which you must authorize as part of your benefits election. **If you do not give your employer the authority to deduct your contributions from your pay, you will not have coverage for any benefit that requires a contribution from you.**

Your payroll deduction contributions will be automatically increased (or decreased) if there is an insignificant increase (or decrease) in the cost of a Plan benefit. The Plan Administrator will determine whether a cost increase (or decrease) is insignificant after taking into account the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change.

Before-Tax Elective Benefits

Your contributions for certain Elective Benefits may be paid with **before-tax** payroll deduction contributions through your employer's cafeteria plan: These benefits are referred to as Before-Tax Elective Benefits.

The Plan's Before Tax Elective Benefits are identified in **Appendix A** and the Plan's enrollment information.

Your contributions for all other benefits are paid with after-tax payroll deduction contributions.

The Plan Administrator may reduce your before-tax contributions if you are a key employee or highly compensated individual if necessary to prevent this Plan from becoming discriminatory under federal tax law.

Important

Paying for Elective Benefits with before-tax payroll deduction contributions might cause a reduction in your Social Security retirement benefit. For some employees, the tax savings associated with the purchase of benefits with before-tax dollars will outweigh the potential reduction in their Social Security benefit.

Initial Enrollment

New hires and newly eligible employees must enroll for Elective Benefits during their initial enrollment period. An employee's initial enrollment period begins and ends on the dates specified in the enrollment information provided by your employer.

Initial enrollment elections take effect on the dates specified in the enrollment information.

Once made, you may not change these elections unless you and/or your Dependents experience an election change event (addressed below) or you make a new benefit election during the Plan's subsequent open enrollment period.

The Plan Administrator may extend the initial enrollment period if the Plan Administrator determines that the enrollment election could not have been filed by the last day of the initial enrollment period. Extensions will be granted (or denied) in a manner that is uniformly applied to all similarly situated employees. **Extensions that relate to insured benefits must also be approved by the Insurer.**

Important

Be sure to review all enrollment information carefully, and make your benefits selections in accordance with the instructions provided. **Unless an extension is granted (see above), you will have no coverage for an Elective Benefit if you fail to submit a complete election for that benefit by the last day of your initial enrollment period.**

Default Elections

If you fail to enroll in an Elective Benefit when you are initially eligible to do so, you will be deemed to have made a "No Coverage" election with respect to that benefit. **Deemed no coverage elections cannot be changed until the next annual open enrollment period, unless you experience an election change event (addressed below).**

Dependent Coverage

If you do not enroll your eligible dependents during your initial enrollment period, you must wait until the next annual enrollment period, unless you experience an election change event, as described in this section.

Dependents you acquire *after your initial enrollment period* must be added within 30 days following the date the dependent was acquired. See ELECTION CHANGE (below).

****Important****

If this Plan includes employee and dependent life insurance, AD&D insurance, and/or disability insurance, and if you do not elect this coverage during your initial enrollment period, you will be required to submit evidence of insurability and be approved by the insurance company to be enrolled for coverage during a subsequent enrollment period (including an election change event enrollment period). ***If you do not elect the insurance plans designated above during your initial enrollment period and you or a Dependent develop a health condition that renders you (or your Dependent) uninsurable, coverage will not be available to the person who is uninsurable.***

Open Enrollment

Before the beginning of each Plan Year, there is an open enrollment period during which you can make new benefit choices for the next Plan Year. Open enrollment is available to active employees, employees on a disability, family or personal leave of absence, and COBRA qualified beneficiaries.

Existing elections (including deemed elections) that are not revoked during the open enrollment period will rollover into the following Plan Year unless otherwise indicated as part of the open enrollment information.

As a general rule, open enrollment elections become effective on the first day of the following Plan Year, subject to any Benefit Program Document provision that would delay coverage such as, for example, an Actively-at-Work or Evidence of Insurability Requirement.

Mid-Year Election Changes

As noted above, the elections you make under the Plan (including "deemed" and "rollover" elections) may not be modified until the next annual open enrollment period. However, certain mid-year election changes are permitted as more fully discussed below.

*****Important*****

Mid-year election changes are permitted only if the following important requirements are met:

- You or your Dependent has experienced a change in status or other event that, in the judgment of the Plan Administrator, constitutes a qualifying election change event under your employer's cafeteria plan and the terms of the Benefit Program Documents;
- The election change request is submitted in the form and manner prescribed by the Plan Administrator and/or Insurer;
- The Plan Administrator and Insurer approve the election change request; and
- The new election is made within 30 days (60 days for certain events) following the election change event or such longer period of time as may be provided in the Benefit Program Documents.

The Plan Administrator may extend the deadline for requesting an election change if the Plan Administrator determines that the necessary information could not have been filed by the required due date. Extensions will be granted (or denied) in a manner that is uniformly applied to all similarly situated employees. Elections that relate to insured benefits must also be approved by the Insurer.

The Plan Administrator reserves the right to evaluate all requests for election changes for consistency, and to ensure requests are handled in accordance with the terms of the Plan and applicable law. **Furthermore, all election change events are subject to conditions or restrictions that may be imposed by any Insurer providing benefits under the Plan.**

Special Medical Plan Enrollment Periods

In addition to the election change events permitted by your employer's cafeteria plan and Benefit Program Documents, you and your dependents have special enrollment rights under a federal law known as HIPAA. These rights are described in this Section.

The Plan Administrator may extend the deadlines (described below) for requesting special enrollment if the Plan Administrator determines that the necessary information could not have been filed by the required due date. Extensions will be granted (or denied) in a manner that is uniformly applied to all similarly situated employees. Extensions that relate to insured benefits must also be approved by the Insurer.

- **Eligibility for State Premium Subsidy Assistance**

  If you or an Eligible Dependent becomes eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to medical coverage under this Plan, you may be able to enroll yourself and your Dependents in the Plan.

  Important

  An employee seeking special enrollment rights under this provision must request enrollment in the Plan within **60 days** following the determination of eligibility for State assistance. If elected, special enrollment coverage begins on the first day of the month following a completed request for enrollment or, if earlier, the date specified in the applicable Benefit Program Document.

- **Loss of Other Coverage**

  If you did not enroll yourself or a Spouse or Eligible Dependent Child during an initial or annual enrollment period because you (or your Spouse or Eligible Dependent Child, as the case may be) had other health insurance or group health plan coverage (including Medicaid coverage and coverage under a State children's health insurance program), you may be able to enroll yourself and a Spouse or Eligible Dependent Child if the other coverage is lost for one of the reasons set forth in HIPAA regulations.

  Special enrollment under the loss of coverage provision applies to current employees only.

  Under HIPAA, events that give rise to a special enrollment opportunity include legal separation; divorce; death of an employee; exhaustion of the other coverage (in the case of COBRA coverage); termination of the other coverage due to a loss of eligibility (in the case of a change in employment status or other change in health coverage of your Spouse or Eligible Dependent Child); cessation of employer contributions for that other coverage (even if eligibility for that other coverage was not lost); relocation out of a health insurer's service area.

  If the other coverage is lost as a result of a failure to pay required premiums or contributions or for cause (e.g., making a fraudulent claim), this special enrollment right does not apply.

  Current employees who lose other coverage (and become eligible for special enrollment), may enroll themselves, and any of their Eligible Dependents.

A Spouse or Eligible Dependent Child for whom special enrollment is requested can only be enrolled in the Plan if the Member is already enrolled in the Plan, or the Member simultaneously enrolls in the Plan with the Eligible Dependent.

If special enrollment is requested on behalf of an Eligible Dependent Child, only that child (and the Member if not currently enrolled) may be enrolled under this loss of coverage provision. Other Dependents may be enrolled if permitted under the employer's cafeteria plan and the rules of the Insurer.

To apply for coverage under the loss of coverage provision, you must submit all documentation requested by the Plan Administrator. This may include a letter from the former employer or former insurance company stating the date coverage terminated, the reason coverage terminated and the type of coverage lost (including the names of individuals covered under the prior plan).

Important

An employee seeking special enrollment rights under this provision must enroll within **30 days** following the loss of other coverage (**60 days** if the loss of coverage was Medicaid coverage or coverage under a state children's health insurance program). If elected, special enrollment coverage begins on the first day of the month following a completed request for enrollment or, if earlier, the date specified in the applicable Benefit Program Document.

- **Dependents Acquired Through Marriage**

Current employees who get married may enroll themselves, their new Spouse and any new Eligible Dependent Children acquired as a result of the marriage.

Important

An employee seeking special enrollment rights under this provision must request enrollment within **30 days** following the date of marriage. If elected, special enrollment coverage begins on the first day of the month following a completed request for enrollment or, if earlier, the date specified in the applicable Benefit Program Document.

- **Birth of a Child**

Current employees who acquire a new dependent child through birth may enroll themselves, their Spouse and the newborn child.

Important

An employee seeking special enrollment rights under this provision must request enrollment within **30 days** following the child's date of birth. If elected, coverage will begin on your new child's date of birth.

- **Adoption of a Child**

This Plan provides coverage for adopted children and children placed with an employee for adoption. A child is placed with a Member for adoption if the Member has taken on the legal obligation for the support of the child whom he or she plans to adopt. Current employees who adopt a child (or have a child placed with them for adoption) may enroll themselves, their Spouse and their new child.

Important

An employee seeking special enrollment rights under this provision must request enrollment within **30 days** following the date of adoption or placement for adoption. If elected, coverage will begin on the date the child is placed with the employee for adoption. An employee must submit proof of placement that is satisfactory to the Plan Administrator.

SECTION 5 – TERMINATION OF COVERAGE

OVERVIEW

Coverage under the Plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends. Coverage will end on the first to occur of any of the events described in this Section. ***Dependent coverage will always end on the date the Member's coverage ends.***

Important

The Benefit Program Documents may include information regarding the circumstances under which Plan benefits will end. If there is a conflict between any of the information in this Section and the information in the corresponding Benefit Program Document, the Benefit Program Document will govern. **Please review your Benefit Program Documents for details concerning the circumstances under which your coverage will terminate.** When your coverage ends for any of the reasons specified in this Section, you and your Dependents may have the right to continue your coverage under the Plan (i.e., COBRA) or convert your group coverage to an individual policy of insurance. Refer to Sections 5 and 7 and your Benefit Program Documents for information on these rights.

COBRA

If you or your Dependent lose group health plan coverage due to a "qualifying event" (such as termination of your employment, a reduction in hours, divorce, death, or a child ceasing to meet the Plan's definition of Dependent), you and/or your Dependent may have the right to continue coverage for a limited time under a federal law commonly referred to as COBRA. The COBRA notice furnished to Employees and their Spouses following enrollment explains COBRA. COBRA rights are also addressed in health plan Benefit Program Documents. Generally, dropping coverage during open enrollment is not considered a "qualifying event," and therefore does not trigger a right to continue coverage under COBRA.

TERMINATION OF BENEFITS

Coverage will end if the Plan (or any of its benefits) is terminated. Refer to Section 1 for more information about Plan changes and termination.

FRAUD OR MISREPRESENTATION

The Plan Administrator will immediately void coverage for any fraud or misrepresentation made by any person to gain eligibility or claim a Plan benefit for any person who is not eligible for the Plan or its benefits. **If your coverage ends for this reason, coverage will also end for your covered dependents.**

The Plan Administrator's right to terminate medical coverage *retroactively* is limited to circumstances that involve:

- Fraudulent conduct;
- Intentional misrepresentation of a material fact;
- A failure to pay timely premiums towards coverage; and

- Terminations in the normal course of business (e.g., a retroactive termination of coverage resulting from a failure to pay COBRA premiums or to notify the Plan of a divorce or of a Dependent who ceases to qualify as a Dependent).

If the Plan Administrator determines that an individual's coverage should be retroactively terminated as a result of fraud or intentional misrepresentation of material fact, the Plan Administrator will provide notice 30 days in advance of the date the Plan Administrator's determination is implemented. The prior notice requirement referenced in the preceding sentence should not be construed as a bar to retroactive termination of coverage.

In the event of fraud or misrepresentation, the Plan is entitled to all remedies provided for in law and equity. This includes but is not limited to, recovery for the charges for benefits provided, attorneys' fees, costs of suit, and interest.

With respect to the Plan's fully-insured benefits, if any of the statements you make in a signed application are not complete and/or not true at the time they are made, the Insurer can reduce or deny any claim; or cancel your coverage from the original effective date.

TERMINATION OF EMPLOYMENT

Coverage for you and your Eligible Dependents will end if your employment terminates.

CHANGE IN EMPLOYMENT STATUS

Coverage for you and your Eligible Dependents will end if you cease to be in a class of employees who are eligible for that benefit.

NONPAYMENT OF REQUIRED PREMIUMS

Plan coverage will end for each covered individual on the last day of the period for which required contributions have been paid.

DEATH

In the event of your death, coverage for all individuals enrolled through you as Dependents (enrolled Spouses and Dependent Children) will terminate.

A DEPENDENT CHILD CEASES TO QUALIFY AS A DEPENDENT

Coverage for a Dependent Child will terminate if he or she ceases to meet the definition of a Dependent.

DIVORCE

If you get divorced or your marriage to your Spouse is annulled, your former Spouse's benefits will end. A former Spouse is not eligible for coverage under the Plan, even if ordered by a court, except as may be required by COBRA.

YOU CEASE ACTIVE EMPLOYMENT

As a general rule, Plan coverage terminates when you cease active employment for any reason. However, benefits may continue during an approved leave of absence in accordance with the leave policies established by your employer and as mandated by federal law. The Benefit Program Documents and your employer's leave

SECTION 6 - DISPUTED CLAIM PROCEDURES

DENIED CLAIMS PROCEDURES

If a person believes he or she is being denied any rights or benefits under the Plan, that person ***must*** file a claim with the Plan Administrator or the Claims Administrator (depending on the type of claim and benefit to which it relates).

Important

Before any claimant can commence a lawsuit, the claimant must exhaust his or her rights under this procedure. Furthermore, a claimant will permanently forfeit the right to challenge the Claims Administrator's decision in court unless he or she exhausts his or her rights under this procedure. **A claimant's lawsuit will not be considered timely, unless it is filed within 6 months from the date of the Claims Administrator's final decision on appeal.**

ELIGIBILITY DISPUTES

The following paragraphs describe the procedure for claims that pertain to an individual's eligibility for coverage under the Plan ("Eligibility Claims"). Eligibility claims also include requests to change an election to participate during the year.

How to File an Eligibility Claim

To initiate an eligibility claim, you must file a written request using the Plan's required form, which is available from your employer's human resources department.

A mere inquiry, verbally or in any other manner, is not a valid claim and, as such, does not initiate the ERISA claims and appeals procedures described below.

This form will ask you to describe the benefits for which you are applying and the reasons for the request. You will also be required to submit relevant documentation.

If you fail to provide sufficient information, the Plan Administrator will provide you with a notice explaining what additional information is needed and when it must be provided.

When Your Claim Will be Decided

The Plan Administrator will notify you of its decision within 90 days of the date it receives your written claim. In special circumstances, this period may be extended to 180 days. The Plan Administrator will notify you before the 90-day period expires if additional time is needed.

How Notice Will be Provided

You will be notified in writing of the decision on your claim. If your claim is partly or entirely denied, the written notice will contain the specific reason for the denial, the plan provisions on which the denial is based, any additional material or information you may need to submit to support your claim, and the Plan's appeal procedures.

policies describe the circumstances under which benefits may be continued during a leave of absence. You may obtain a copy of these policies upon written request of your employer's human resources/benefits department. ***See Section 7 for an explanation of your FMLA and military leave rights.***

CONTINUATION OR CONVERSION OF INSURANCE BENEFITS

An insured person who ceases to be insured under the Plan may have the right to continue his or her life, AD&D and disability insurance coverage. To exercise this right, the insured person must apply for conversion coverage and pay the first premium within a certain period of time (generally 30 days) following the end of group coverage. **Read the Benefit Program Documents that pertain to these benefits for a complete explanation of your right to continue your coverage.**

Your Right to an Appeal

You have the right to appeal an eligibility claim denial. Your appeal must be filed within 60 days from the date you receive written notice of your denied claim.

Important

Before you can challenge a denial in court, you must exhaust the Plan's appeal process. If you fail to appeal an adverse determination within the 60-day period, you will forever lose the right to file suit.

How to File an Appeal

All appeals must be filed in writing with the Plan Administrator using the prescribed form (available from the human resources department).

When Your Appeal Will be Decided

The Plan Administrator will notify you of its decision within 60 days of the date it receives your written claim. In special circumstances, this period may be extended to 120 days. The Plan Administrator will notify you before the 60-day period expires if additional time is needed.

How Notice Will be Provided

You will be notified in writing of the decision on your claim. If your claim is partly or entirely denied, the written notice will contain the specific reason for the denial, the plan provisions on which the denial is based, any additional material or information you may need to submit to support your claim, and the Plan's appeal procedures.

Appeal Decisions are Final

Appeal decisions will not be reviewed and are considered final unless new circumstances arise or new facts are discovered that could not have been presented before the final determination was rendered. After an appealed decision has been rendered, you have the right to bring a civil action.

DISPUTES REGARDING FULLY INSURED BENEFITS

If the claim relates to an eligible enrolled person's entitlement to a benefit that is fully-insured, the claim should be submitted in the first instance to the insurance company providing the benefit to which your claim relates. Benefit claims that relate to fully-insured benefits are administered by the insurance company that underwrites the benefit. The insurance company will resolve all benefit disputes in accordance with its reasonable claims procedure, as required by ERISA. The Benefit Program Documents published by the insurance company explain the procedures that apply to disputes involving the Plan's fully-insured benefits. A copy of these procedures is available upon written request from the Plan Administrator.

DISPUTES REGARDING SELF-INSURED BENEFITS

If the claim relates to an eligible enrolled person's entitlement to a benefit that is self-insured, the claim should be submitted in the first instance to the Claims Administrator for the benefit to which your claim relates. Each Claims Administrator maintains a written procedure for resolving disputes concerning Plan benefits in accordance with the requirements of ERISA. These procedures are part of the Plan's SPD. Copies of these written claims procedures are available from the Plan Administrator upon written request.

REVIEW PROCEDURES FOR DENIED CLAIMS

Internal Appeals

When a Claims Administrator makes an adverse benefit determination on a claim for benefits, the Claims Administrator is required to tell you why it is denying your claim for benefits or coverage. It is also required to tell you that you have the right to appeal that decision. Once appealed, the law requires that the Plan provide a full and fair review of your denial. In urgent care situations, there is an expedited process for appealing the adverse determination.

Each Claims Administrator maintains an internal claim and appeal procedure that participants must use to make claims and appeal adverse benefit determinations. The claims and appeal process for the medical plan is managed and administered by the insurance company that sponsors the plan in accordance with its published procedures.

If you would like a copy of the internal claims and appeals procedures maintained by the Plan's Claims Administrators, contact the Plan Administrator.

External Appeals

If your internal appeal is not successful, you may be able to request an *external appeal* to an independent decision-maker, referred to as an Independent Review Organization ("IRO") or External Review Organization ("ERO").

As a general rule, you may not seek an external appeal until you have exhausted the internal appeal process; however, you are permitted expedited access to external review in emergency situations and in cases where the internal claims and appeal process was not followed.

Not all adverse benefit determinations are eligible for external review. Typically, you may only seek independent review of decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. Under the Affordable Care Act, you may have the right to request external appeal for other decisions as well.

If you would like to request external review, you must make a request to the Claims Administrator within 4 months of the date you receive notice of the Plan's adverse determination. If you request an external review, the Claims Administrator will tell you whether your claim qualifies for external review and how to request an external review.

The Claims Administrator has 5 days following the date of receipt of your request for external review to complete a preliminary review to determine that you were eligible for and enrolled in the Plan; that the denial qualifies for external review; and that either you have exhausted the internal review process or you are not required to do so because your Claims Administrator did not follow the rules; and that you provided all information and forms required to perfect an external review.

Once this preliminary review is completed, the Claims Administrator must tell you within 1 business day after the review is complete whether any additional information is needed, and if no additional information is needed, whether your request is eligible for external review. If you are informed that your request is not complete, your Claims Administrator will tell you what is needed. If your claim is not eligible for external review, your Claims Administrator will tell you why.

If the Claims Administrator determines that your claim is eligible for external review, your claim will be assigned to an Independent Review Organization. If the Independent Review Organization agrees with your position, the Plan is generally bound by the decision.

SECTION 7 – YOUR RIGHTS UNDER FEDERAL LAW

ERISA RIGHTS STATEMENT

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled 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, 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 summary plan description.

- Obtain copies of all documents governing the operation of the Plan, the summary plan description, any insurance contract through which benefits are paid and administered, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor. The Plan Administrator may impose 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.

- Receive information about your ability to continue healthcare coverage for yourself, your 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 to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials in writing from the Plan Administrator 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

The court decides who should pay court costs and legal fees. If you are successful, the court may order the opposing party 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.

Important

Please take particular note of the following:

- All disputes concerning the Plan must be adjudicated under the Plan's disputed claim and appeal procedures. See Section 7. A person claiming entitlement to coverage or benefits may not file legal action unless the claim or dispute is adjudicated using the Plan's required claims and appeal procedure. Failure to exhaust the Plan's claims and appeal procedures may result in a permanent loss of benefits.

- Legal actions involving the Plan (e.g., legal actions seeking entitlement to Plan benefits) **must** be commenced within 6 months following the date when the Claims Administrator renders (or is deemed to have rendered) a final decision regarding a claim. If a Benefit Program Document specifies a longer period, the longer period will apply.

- If you fail to meet the deadline for filing a legal action (referred to as a "statute of limitations"), you will permanently forfeit the right to file a lawsuit challenging the decision of the Plan Administrator (or Claims Administrator) as the case may be.

If you have any questions about this statement or 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 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.

YOUR COBRA NOTICE

If you or your Dependent loses group health plan coverage due to a "qualifying event" (such as termination of your employment, a reduction in your hours, divorce, death, or a child ceasing to meet the Plan's definition of Dependent), you and your Dependent may have the right to continue coverage for a limited time under a federal law commonly referred to as COBRA.

The Plan Administrator will provide each covered Employee and Spouse with an initial COBRA notice at the time the Employee and Spouse commence coverage under a group health plan. The initial COBRA notice provides a general description of COBRA, the individuals who are eligible for COBRA (referred to as "qualified beneficiaries"), and the kinds of events (referred to as "qualifying events") that give rise to COBRA rights.

Important

Importantly, the initial COBRA notice contains an explanation of the notices qualified beneficiaries must provide to preserve COBRA rights. For example, qualified beneficiaries must notify the Plan Administrator in the event of a divorce or legal separation, or in the event a child ceases to be a Dependent Child. Qualified beneficiaries are also required to notify the Plan Administrator of a determination by the Social Security Administration that a qualified beneficiary is disabled. This notice will explain the procedures for providing notice including when and how the notice must be provided and to whom it must be provided (among other things).

The initial COBRA notice is part of this SPD and should be kept with this SPD for reference. Failure to meet the Plan's COBRA notice requirements could result in the loss of COBRA benefits.

delivery, or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother's or newborn's physician, 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 generally may not, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable. Also, the Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portions of the stay.

No Annual or Lifetime Dollar Limits on Essential Health Benefits

Your medical plan may not impose annual or lifetime dollar limits on any essential health benefit. Your health plan Insurer will determine whether a service is "essential" (as defined by the Affordable Care Act) by reference to applicable law. Please refer to your health plan Benefit Program Documents for additional information.

First Dollar Coverage of Preventive Care Services

Your medical plan is required to cover recommended preventive health services without copayments, co-insurance requirements or deductibles when delivered by an in-network provider. Please refer to your health plan Benefit Program Documents for additional information.

Out-of-Network Coverage of Emergency Services

Your medical plan is required to cover emergency services without regard to whether a particular health care provider is an in-network provider and without imposing copayment or coinsurance that is greater than what would be imposed if services were provided in-network. Please refer to your health plan Benefit Program Documents for additional information.

Clinical Trials

If your medical plan provides coverage to a "qualified individual", then the Insurer is prohibited, under federal law, from doing any of the following:

- Denying the individual participation in an approved clinical trial.
- Denying or limiting, or imposing additional conditions on, the coverage of routine patient costs for items or services furnished in connection with participation in the approved clinical trial.
- Discriminating against the individual on the basis of the individual's participation in the approved clinical trial.

A "qualified individual" is an individual who is enrolled or participating in a health plan and who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. To be a qualified individual, the individual's participation in the approved clinical trial is must be appropriate to treat the disease or condition.

Please refer to your health plan Benefit Program Documents for additional information regarding this new benefit mandate.

FAMILY MEDICAL LEAVE ACT

Group health benefits may be continued during the pendency of an approved FMLA leave of absence provided you pay the required premium in accordance with the terms of your leave. During the leave, your coverage will be maintained on the same terms and conditions as coverage would have been provided if you had been continuously employed during the entire leave period. For example, the amount you will be required to pay for coverage will be the same as for similarly situated active employees. If you do not wish to continue coverage, you may cancel (or change) your elections provided you do so within 30 days of your leave start date. If coverage terminates during the FMLA leave, and you return to work in accordance with the terms of your leave, your coverage will be reinstated if you are then an eligible employee. Coverage will also be reinstated for any dependent who had coverage when the leave started and who is then an eligible dependent. Coverage will be reinstated to the same extent that it was in force when coverage terminated. If your coverage ends under circumstances in which you and/or your dependents are entitled to elect COBRA, your COBRA start date is the date your leave ended (or the date you informed your employer that you would not be returning from your leave).

UNIFORMED SERVICES EMPLOYEE RIGHTS AND REEMPLOYMENT ACT

If your leave is a military leave covered under the requirements of the Uniformed Services Employee Rights and Reemployment Act (USERRA), your group health plan coverage will terminate at the start of your leave subject, however, to your right to continue coverage for yourself and your Dependents for up to 24 months. Any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

FEDERAL BENEFIT MANDATES

The benefits to which you are entitled under the Plan are detailed in your Benefit Program Documents. However, there are certain rights to which you are entitled by federal law. These rights are briefly described below.

No Preexisting Condition Exclusions

Your medical plan is prohibited from denying coverage for pre-existing conditions to children who are *under* 19 years of age. This prohibition will apply for people of all ages effective January 1, 2014. Please refer to your health plan Benefit Program Document and Coverage Summaries for additional information.

Special Rights for Women with Breast Cancer

Your health plan must provide coverage for medical and surgical benefits with respect to a mastectomy and also must provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Your health plan may impose deductible or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductible and coinsurance are consistent with those established for other benefits under the Plan. If you have any questions about coverage of mastectomies and reconstructive surgery, contact the Claims Administrator.

The Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for a mother or newborn child to less than 48 hours following a vaginal

Designation of Primary Care Provider

If your medical plan requires or allows for the designation of a primary care provider, you have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from anyone (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a primary care provider, or for a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator. Please refer to your health plan Benefit Program Documents for additional information.

Age 26 Dependent Medical Coverage

The Affordable Care Act requires medical plans that offer dependent coverage to make coverage available to a Member's child until the child reaches the age of 26.

Your medical plan cannot condition Dependent Child eligibility on the child's marital status, employment status, place of residence or any other factor or condition. If an individual is your "child" (as defined below or as defined in the Benefit Program Documents), and he or she is under the age of 26, you have the right to enroll your child for medical benefits.

Under the Affordable Care Act, an individual is your "child" if he or she is one of the following:

- your natural child;
- your legally adopted child under age 18 at the time of the adoption; or
- a child placed with you for adoption who is under age 18 at the time of placement.

For children and young adults who do not meet the definition of "child" under the Affordable Care Act (e.g., grandchildren, nephews and nieces, children of domestic partners, children for whom you have been designated legal guardian), Dependent coverage will be available only as described in the Benefit Program Document that pertains to the Plan's medical benefits.

Prohibition on Excessive Waiting Period

Your medical plan may not apply a waiting period that exceeds 90 days. "Waiting period" is defined as the period of time that must pass before coverage for an individual who is *otherwise eligible* to enroll under the terms of a group health plan can become effective. In this context, being *otherwise eligible* to enroll in a plan means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period).

YOUR PRIVACY RIGHTS

For purposes of the Plan's group health programs (i.e., medical, dental, health FSA and EAP benefits), the Plan uses and discloses health information about you and any covered dependents only as needed to administer these programs.

The Plan's group health programs will comply with the applicable health information privacy requirements of federal rules issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's "Notice of Privacy Practices." If you are an employee and you are covered under any of the Plan's group health programs, you should have received a copy of the Plan's Notice of Privacy Practices (if you did not previously receive one). In addition, a copy of this notice is always available upon request.

Please contact the Plan Administrator if you would like to request a copy of the Notice of Privacy Practices or if you have questions about the Plan's privacy policies.

For any insured coverage, the Insurer is responsible for providing its own Notice of Privacy Practices, so you should contact the insurer if you need a copy of the insurer's Notice.

SECTION 8 - PLAN IDENTIFICATION AND ADMINISTRATION

PLAN INFORMATION

This summary relates to the following welfare benefit plan:

Plan Name	Plan #
Homemakers Upstate Group, Inc. Health and Welfare Benefits Plan	501

TYPE OF PLAN

The Plan is an employee welfare benefit plan within the meaning of ERISA § 3(1). Benefits are not insured by the Pension Benefit Guaranty Corporation or any other Federal or state agency.

PLAN YEAR

The Plan Year of the Plan is the 12-consecutive month period ending on the last day of December of each year.

PLAN SPONSOR

Homemakers Upstate Group, Inc.
2465 Sheridan Drive
Tonawanda, NY 14150

PLAN ADMINISTRATOR

Homemakers Upstate Group, Inc.

The Plan Administrator is responsible for the overall management and administration of the Plan. The Plan Administrator may delegate its duties to others. In carrying out its functions, the Plan has the authority and discretion to construe the terms of the Plan and to determine all questions arising in connection with the administration, interpretation and application of the Plan. Any delegation of duties carries with it any authority (including discretionary authority) conferred upon the Plan Administrator by the terms of the Plan. The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, interpretations, and disputed issues of fact) will be final and binding on all parties.

HOW BENEFITS ARE ADMINISTERED AND PAID

Fully-Insured Benefits

Some benefits are fully-insured, a term that means that an insurance company assumes full responsibility for administering and paying benefits in accordance with the terms of an insurance policy issued in the name of your employer.

The insurance company is responsible for determining an enrolled person's entitlement to benefits, and for paying those benefits. As such, the insurance company is solely responsible for processing claims payments and resolving disputed benefit claims in accordance with the complaint and appeals procedures set forth in the Benefit Program Documents issued to Members as part of the SPD. Your employer has no responsibility to administer or pay any Plan benefit that is designed to be fully-insured.

This Plan does not include any insured benefit unless it is funded and administered pursuant to a group insurance arrangement; benefits delivered through individual policies or contracts of insurance are not offered as employer-sponsored benefits under the terms of this Plan.

A list of the insurance companies that currently underwrite the Plan's benefits is attached to this summary as **Appendix A**. Please note that insurance companies specified in **Appendix A** may be replaced from time to time for any reason.

Self-Insured Benefits

Some Plan benefits are self-insured, which means that benefits are paid from your employer's general assets and from any contributions by participants and beneficiaries. The Plan's self-insured benefits are listed in **Appendix A** of this summary. Unless expressly provided under the terms of the Benefit Program Documents, there is no trust fund or other segregated investment account owned by the Plan from which self-insured benefits will be paid.

EMPLOYEE/MEMBER CONTRIBUTIONS

Elective Benefits have a cost, typically expressed as a monthly premium or premium-equivalent contribution. The amount you are required to contribute toward the cost of your coverage, if any, is determined by your employer and communicated as part of the Plan's enrollment information. After-tax contributions will be used in their entirety prior to using employer contributions to pay for premiums under the Plan. Any dividend, retroactive rate adjustment or other refund of any type that may become payable under any insurance contract that funds Plan benefits is the property of your employer, except to the extent, if any, that the Plan Administrator determines that a portion of the amount payable (e.g., after-tax employee contributions) belongs to the Plan. Any portion of such a payment that belongs to the Plan may be used to provide or pay for benefits or reasonable Plan expenses, or may be used or paid in any manner that is consistent with applicable law regarding the use of Plan assets.

LEGAL ACTIONS

The Plan Sponsor is the agent for service of legal process upon the Plan. This Plan will be interpreted according to the laws of the State of New York, without reference to its choice of law provisions, to the extent not preempted by federal law. In any dispute involving the Plan, exclusive jurisdiction and venue will be in the state or federal courts located in Erie County, New York.

Important

Please take particular note of the following:

- All disputes concerning the Plan must be adjudicated under the Plan's disputed claim and appeal procedures. See Section 7. A person claiming entitlement to coverage or benefits may not file legal action unless the claim or dispute is adjudicated using the Plan's required claims and appeal procedure. Failure to exhaust the Plan's claims and appeal procedures may result in a permanent loss of benefits.

- Legal actions involving the Plan (e.g., legal actions seeking entitlement to Plan benefits) **must** be commenced within 6 months following the date when the Claims Administrator renders (or is deemed to have rendered) a final decision regarding a claim. If a Benefit Program Document specifies a longer period, the longer period will apply.

- If you fail to meet the deadline for filing a legal action (referred to as a "statute of limitations"), you will permanently forfeit the right to file a lawsuit challenging the decision of the Plan Administrator (or Claims Administrator) as the case may be.

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