MEDICAL TRANSPORTATION MANAGEMENT, INC. BENEFITS WRAP PLAN

SUMMARY PLAN DESCRIPTION SUPPLEMENT

PLAN NO.: 512

Effective January 1, 2026

TABLE OF CONTENTS

SUMMARY PLAN DESCRIPTION SUPPLEMENT

This document, and the certificates and other documents issued with respect to the welfare programs described in ***Appendix A*** ("Program Documents"), and the Medical Transportation Management, Inc. Wellness Program as described in ***Appendix C*** together comprise the Summary Plan Description ("SPD") for the Medical Transportation Management, Inc. Benefits Wrap Plan (the "Plan"). In the case of any conflict between the terms of the Plan Document and the terms of this SPD, the terms of the Plan Document, including the Program Documents describing the welfare programs as identified in ***Appendix A*** ("Welfare Programs"), shall control.

The SPD summarizes your rights and obligations as a participant (or beneficiary) in the Plan. It is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded to you by the Plan or any applicable state law not pre-empted by ERISA, those legal rights supersede the rights set forth in the SPD.

GENERAL INFORMATION

NAME OF PLAN:

Medical Transportation Management, Inc. Benefits Wrap Plan.

Effective January 1, 2019, the following plans were merged into this Plan:

- Medical Transportation Management, Inc. Group Life Insurance Plan, Plan No. 501, originally effective September 1, 2000,
- Medical Transportation Management, Inc. Health Insurance Plan, Plan No. 502, originally effective September 1, 2000,
- Medical Transportation Management, Inc. Dental Insurance Plan, Plan No. 503, originally effective September 1, 2002,
- Medical Transportation Management, Inc. FSA Plan, Plan No. 504, originally effective July 1, 2015, and
- Medical Transportation Management, Inc. Legal Plan, Plan No. 505, originally effective September 1, 2016.

PLAN SPONSOR:

Medical Transportation Management, Inc.
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367

Phone: (888) 828-1316

Collectively, the Plan Sponsor and any affiliated employers of the Plan Sponsor who participate in the Plan are referred to as the "***Employer***"; provided however that for purposes of the administrative provisions of the Plan and as the context otherwise requires, Employer shall only mean the Plan Sponsor.

EMPLOYER IDENTIFICATION NUMBER:

43-1719762

PLAN NUMBER:

512

PLAN ADMINISTRATOR:

Medical Transportation Management, Inc.
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367

Phone: (888) 828-1316

TYPE OF PLAN:

Welfare benefit plan including medical, dental, vision, health flexible spending account, wellness program, group term life, voluntary life, accidental death and dismemberment, short-term disability, long-term disability, employee assistance program, telemedicine, pre-paid legal, severance, business travel insurance, ID theft protection, hospital indemnity, group accident, and critical illness benefits.

PLAN YEAR:

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

CLAIMS ADMINISTRATION:

If you have a claim for benefits, such claim should be directed to the provider and address set forth in ***Appendix A***, which may be amended from time to time by the Employer without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

AGENT FOR SERVICE OF LEGAL PROCESS:

Medical Transportation Management, Inc.
Kerri Mileski, CHRO, or successor in office
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367

You may also serve legal process on the Plan Administrator.

TYPE OF ADMINISTRATION:

Some benefits under the Plan are fully insured and are paid pursuant to the terms of insurance policies issued by insurance companies.

Other benefits are self-funded and are paid from the general assets of the Plan Sponsor. The Plan Sponsor has entered into contracts with third party vendors to assist the Plan Sponsor in administering self-funded benefits.

ELIGIBILITY:

You will be eligible to participate in the Plan as described below; provided, however, that (i) there is no hourly requirement for the employee assistance program Welfare Program and (ii) if you are a Hawaii Employee, you will be eligible to participate in the Plan and considered an eligible Employee for purposes of the medical premium benefit (or its successor), consistent with the eligibility requirements of the Hawaii Prepaid Health Care Act.

- You are eligible to participate in the (i) medical Welfare Program if you are regularly scheduled to work at least 30 hours per week, and (ii) for all other Welfare Programs if you are regularly scheduled to work at least 40 hours per week.

You will enter the Plan as follows:

Salaried Employee. If you are a salaried Employee, you will enter the Plan on your initial date of employment.

Hourly Employee. If you are an hourly Employee, you will enter the Plan on the first day of the month coinciding with or next following two months from your initial date of employment.

Union Employee. The foregoing notwithstanding, if you are an Employee whose employment is governed by the terms of a collective bargaining agreement between Employee representatives and the Employer (or any affiliated employer set forth in ***Appendix B***) under which benefits were the subject of good faith bargaining between the parties, you will be eligible to participate in certain Welfare Programs under the Plan and will enter the Plan as set forth in such agreement, and to the extent such agreement expressly provides for such coverage in the Plan; provided however, that the Employer, in its discretion, may permit such Employees to participate in additional Welfare Programs not expressly provided for in such agreement.

Hawaii Employee. Regardless of whether you are an hourly or salaried Employee, if you are a Hawaii Employee, you will enter the Plan with respect to the medical premium benefit (or its successor) consistent with the eligibility requirements of the Hawaii Prepaid Health Care Act.

Variable Hour Employee. If you are (i) classified as a "Variable Employee" (i.e., regularly scheduled to work less than 30 hours per week, or a variable hour or seasonal Employee (regardless of the number of hours worked)), and (ii) are determined by the Employer to have averaged at least 30 hours per week during a measurement period, you will be eligible to become a participant in the Plan for benefits under a medical Welfare Program subject to the Patient Protection and Affordable Care Act ("PPACA") (and for any additional Welfare Program) designated by the Employer for the immediately subsequent stability period. If, as a Variable Employee, you are determined by the Employer to be an eligible Employee for a given stability period, you will remain an eligible Employee for the entirety of such stability period, even if you are transferred during such stability period to a position in which you will work or are expected to work less than 30 hours per week, on average, on a regular basis, as long as you remain an Employee of the Employer without a period of thirteen or more weeks during which you do not provide any hours of service to the Employer. For a new Variable Employee, the initial measurement period means the twelve-month period measured from the Variable Employee's date of hire; the initial administrative period means the 31-day period beginning immediately following the initial measurement period; and the initial stability period means the twelve-month period beginning immediately following the Variable Employee's administrative period. The standard "measurement period" each year is a twelve-month period measured from November 1

through October 31, the standard "administrative period" each year is a 61-day period from November 1 through December 31, and the standard "stability period" each year is a twelve-month period measured from January 1 through December 31; provided however that your initial measurement, administrative and stability periods will be based on your date of hire. As a Variable Employee, you will enter the Plan, with respect to the Welfare Programs for which you are eligible, on the first day of the applicable stability period following the date the Employer determines you, as a Variable Employee, have satisfied the Plan's eligibility requirements. The Employer may, from time to time, adopt policies and procedures to implement and administer the provisions of the Plan relating to Variable Employees in a manner consistent with the PPACA ("Variable Employee Policy").

Pandemic Affected Employee. If you are classified as a Pandemic Affected Employee, as that term is defined in ***Appendix D***, you shall remain eligible or become eligible, as applicable, to participate (or become eligible to make a new election) in those Plan Welfare Programs consistent with the terms of ***Appendix D***.

The foregoing notwithstanding, the following individuals are not Eligible Employees:

- A commissioned Employee.
- A leased Employee.

If you are an employee of an affiliated employer of the Employer set forth in ***Appendix B,*** you may participate in the Plan if you satisfy all eligibility requirements under the Plan.

If you are eligible to participate in a Welfare Program, you will become a Participant in such Welfare Program upon (1) meeting the eligibility requirements set forth in the applicable Policy or Welfare Program document, (2) enrolling in the Welfare Program at a time and in a manner set forth in the Welfare Program document and acceptable to the Plan Administrator, and (3) if applicable, satisfying any waiting period for initial enrollment as required by the Employer or the Welfare Program. If you are a Union Employee whose employment is governed by the terms of a collective bargaining agreement between Employee representatives and the Employer (or any affiliated employer set forth in ***Appendix B***) under which benefits were the subject of good faith bargaining between the parties, or a new Employee of the Employer (or its affiliated employers) who was acquired in an acquisition, merger or similar transaction by the Employer (or any affiliated employer) ("Acquisition"), your credited service for eligibility and entry into the Plan (and any underlying Welfare Program) may be altered, applicable pre-existing condition limitations, actively-at-work requirements or waiting periods may be waived, or you may receive credit for copayments, deductibles, coinsurance and similar expenses incurred under a medical, dental, vision or other health plan as determined by the Employer or as set forth in an applicable collective bargaining agreement or purchase agreement documenting an Acquisition. The Employer will timely communicate to you any change in credited service for eligibility and entry into the Plan (and any underlying Welfare Program), waiver of any applicable limitations or requirements under the Plan (or any underlying Welfare Program), or any grant of credit for copayments, deductibles, co-insurance or similar expenses incurred under a medical, dental vision or other health plan.

If you are a participant, terminate employment, and are rehired, you will reenter the Plan immediately on your date of rehire if rehired within 13 weeks of your date of termination, and except as described below, if you are not rehired within 13 weeks of your date of termination, you must again satisfy the Plan's eligibility requirements. The foregoing notwithstanding, for

accidental death and dismemberment, group term life, voluntary life, employee assistance program, long-term disability, and short-term disability, if you are a participant, terminate employment, and are rehired, you will reenter the Plan immediately on your date of rehire if rehired within 12 months of your date of termination and, solely with respect to these benefits, if you are not rehired within 12 months of your date of termination, you must again satisfy the Plan's eligibility requirements.

Any Employee who does not meet the above eligibility requirements is not eligible to participate in the Plan.

Other individuals, such as your dependents (including your spouse), are eligible to participate in the Plan under the terms and conditions described in the applicable Welfare Program document. However, the following individuals are not considered a "spouse" for purposes of eligibility:

- Domestic partners or civil union partners unless such individuals are required to be treated as a spouse by any applicable state insurance laws, including the laws of the state of California, Hawaii and Oregon, and solely with respect to insured benefits, or unless otherwise specifically identified in either the applicable Welfare Program document or herein.

- Common-law marriage spouses, even if such partnerships are recognized as legal marriages in the state in which the couple resides.

AMENDMENT AND TERMINATION:

The SPD contains a summary of the terms of the Plan and may be amended from time to time at its sole discretion by your Employer. The Plan and any Welfare Program may be terminated, modified or amended from time to time by the Employer, in its sole discretion and without notice. Any changes made shall be binding on each covered participant and any other covered persons referred to in the SPD.

The SPD will disclose Plan provisions governing your benefits, rights and obligations upon plan termination or the amendment or elimination of benefits under the Plan.

NO CONTRACT OF EMPLOYMENT:

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Employer or you and any of the companies listed in ***Appendix B*** to the effect that you will be employed for any specific period of time.

BENEFITS AND ADMINISTRATION:

The Plan provides medical, dental, vision, health flexible spending account, wellness program, group term life, voluntary life, accidental death and dismemberment, short-term disability, long-term disability, employee assistance program, telemedicine, pre-paid legal, severance, business travel insurance, ID theft protection, hospital indemnity, group accident, and critical illness benefits for eligible Employees and covered dependents as administered under policies of insurance as listed in ***Appendix A***. The insurers' administrative functions include paying claims and determining medical necessity. These benefits are insured or administered by the companies listed in ***Appendix A*** and are generally described in the Program Documents.

Replacements for lost or misplaced copies of the Program Documents may be obtained by writing to the Plan Administrator. Notification will be given of changes in benefits that may occur from time to time.

Please refer to the Program Documents for a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits.

SUMMARY OF PLAN BENEFITS

The Plan provides you and your eligible dependents with the coverages shown in the table set forth in ***Appendix A***. A summary of the benefits provided under the Plan is set forth in the Program Documents issued by the insurance companies or third party administrators who are shown in the table as set forth in ***Appendix A***.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

WOMEN'S HEALTH CANCER RIGHTS ACT:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

(a) All stages of reconstruction of the breast upon which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses; and

(d) Treatment of physical complications during all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits under this Plan.

LOSS OF BENEFITS:

The provisions regarding termination of coverage and limitations and exclusions of benefits that may result in reduction or loss of benefits are explained in the Program Documents.

CONTRIBUTIONS:

Contributions to the Plan are provided partially by the Plan Sponsor and partially by the covered Employees. Employee contributions are made via payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during open enrollment periods and upon request.

HOW TO RECEIVE YOUR BENEFITS:

This information is explained in the section entitled "CLAIMS PROCEDURES."

BENEFIT-SPECIFIC INFORMATION:

Please refer to the Program Documents for the following information:

- A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which you or a beneficiary will be responsible;
- Any annual or lifetime caps or other limits on benefits under the Plan;
- The extent to which preventive services are covered under the Plan;
- Whether and under what circumstances existing and new drugs are covered under the Plan;
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers;
- The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care; and
- Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

CLAIMS PROCEDURES

A claim for benefits under a Welfare Program must be submitted to the party designated under the claims procedure prescribed under the terms of the applicable Welfare Program as provided in the Program Documents. To the extent that a claims procedure is not provided under a Welfare Program or is inconsistent with applicable law, the claims procedure described in this section shall apply with respect to such Welfare Program as determine in the sole discretion of the Plan Administrator.

A “claim” is defined as any request for a Plan or Welfare Program benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. “Days” means calendar days, not business days.

A “Claims Supervisor” is the person responsible for benefits administration under a Welfare Program or the insurance company. For purposes of determination of the amount of, and entitlement to, benefits of your insured Welfare Program, the respective insurance company described in ***Appendix A*** is the Claims Supervisor, with the full power to interpret and apply the terms of the Plan as they relate to your benefits. For purposes of determining the amount of, and entitlement to, benefits under your self-funded Welfare Program, the Plan Administrator is the Claims Supervisor (unless such power is delegated to another party as described in the Program Documents, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to your benefits.

There are different types of claims (including disability, group health pre-service, group health concurrent and group health post-service), and each one has a specific timetable for either approval, payment, request for further information, or denial of the claim.

CLAIMS PROCEDURES FOR WELFARE PROGRAMS OTHER THAN GROUP HEALTH OR DISABILITY

(a) **Time for Decision on a Claim**. A claim shall be filed in writing with the Claims Supervisor and decided within 90 days by the Claims Supervisor unless the Claims Supervisor determines that special circumstances require an extension of time for processing the claim. If the Claims Supervisor determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or Welfare Program expects to render the benefit determination.

(b) **Notification of Adverse Determination**. Notice of the decision on such claim shall be furnished promptly to the claimant. Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan or Welfare Program provisions on which the determination is based; (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (iv) a description of the Plan's or Welfare Program’s review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

(c) **Right to Review**. A claimant may review all pertinent documents and may request a review by the Claims Supervisor of such decision denying the claim. Any such request must be filed in writing with the Claims Supervisor within 60 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 60 days will constitute a waiver of the claimant’s right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Claims Supervisor to consider.

(d) **Review Procedures**. During the review process, the Claims Supervisor will provide: (i) the claimant the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and (iii) for a review that takes 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 benefit determination.

(e) **Time for Decision on Review**. Written notice of the decision on review shall be furnished to the claimant within 60 days unless the Claims Supervisor determines that special circumstances require an extension of time for processing the claim. If the Claims Supervisor determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice will describe the special circumstances requiring an extension of time and the date by which the Plan or Welfare Program expects to render the determination on review.

(f) **Notification of Determination on Review.** Notice of the decision on such claim shall be furnished promptly to the claimant. Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan or Welfare Program provisions on which the benefit determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and (iv) a statement describing any voluntary appeal procedures, if any, offered by the Plan or Welfare Program and the claimant's right to obtain additional information about those voluntary review procedures, if any, and a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

(g) **Legal Remedies**. Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in the Program Documents for a particular Welfare Program, such later date with respect to a claim arising out of that Welfare Program.

DISABILITY CLAIMS PROCEDURES

(a) **Time for Decision on a Claim**. A claim shall be filed in writing with the Claims Supervisor and decided within 45 days after receipt of the claim by the Claims Supervisor. If the Claims Supervisor determines that an extension is necessary due to matters beyond the control of the Plan or Welfare Program, a maximum of two 30-day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

(b) **Notification of Adverse Determination**. Notice of the decision on such claim shall be furnished to the claimant within the applicable time periods set forth in subsection (a) above and shall contain the following information:

(i) For claims for disability benefits filed under this Plan or a Welfare Program on or before April 1, 2018 (or such other effective date as required by law), every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(ii) For claims for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by law), every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan or Welfare Program of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan or Welfare Program in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan or Welfare Program made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program do not

exist; and (8) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

In the case of a claim for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by law), the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(c) **Right to Review**. A claimant may review all pertinent documents and may request a review by the Claims Supervisor of such decision denying the claim. Any such request must be filed in writing with the Claims Supervisor within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant's right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Claims Supervisor to consider.

(d) **Review Procedures**. During the review process, the Claims Supervisor will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (iii) for a review that takes 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 benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan or Welfare Program who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vi) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan or Welfare Program in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; (vii) that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and (viii) effective after April 1, 2018 (or such other effective date as required by law), before an adverse benefit determination can be issued, the claimant shall be provided, free of charge and as soon as possible and sufficiently in advance of the date on which notice of the adverse benefit determination on review must be provided to the claimant to give the claimant reasonable opportunity to respond prior to the deadline, (A) any new or additional evidence considered relied upon, or generated by the Plan, Welfare Program, insurer, or other person making the benefit determination (or at the direction of the Plan, Welfare Program, insurer of such other person) in connection with the claim; and (B) any new or additional rationale that the disability benefit claim is based on.

(e) **Time for Decision on Review**. Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Claims Supervisor expects to render a decision. The extension may be for up to 45 additional days from the end of the initial period.

(f) **Notification of Determination on Review.** Notice of the decision on such claim shall be furnished to the claimant within the applicable time periods set forth in subsection (e) above and shall contain the following information:

(i) For claims for disability benefits filed under this Plan or a Welfare Program on or before April 1, 2018 (or such other effective date as required by law), every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan or Welfare Program and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(ii) For claims for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by law), every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan or Welfare Program and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA, which statement shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan or Welfare Program of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan or Welfare Program in connection with a claimant's

adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan or Welfare Program made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide oral language services that include answering questions in the non-English language and provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan or Welfare Program.

(g) **Legal Remedies**.

(i) Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in the Program Documents for a particular Welfare Program, such later date with respect to a claim arising out of that Welfare Program.

(ii) If the Plan (or Welfare Program) fails to strictly adhere to these claims review procedure requirements with respect to a claim for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by law), the claimant is deemed to have exhausted the administrative remedies available under the Plan or Welfare Program, except as provided in the paragraph below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan (or Welfare Program) failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(iii) Except as provided in the paragraph above, the administrative remedies available under the Plan (or Welfare Program) with respect to a claim for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by law), will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan (or Welfare Program) demonstrates that the violation was for good cause or due to matters beyond the control of the Plan (or Welfare Program) and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan (or Welfare Program) and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan (or Welfare Program). The claimant may request a written explanation of the violation from the Plan (or Welfare Program), and the Plan (or Welfare Program) must provide such explanation within 10 days, including a specific description of its bases, if any, for

asserting that the violation should not cause the administrative remedies available under the Plan (or Welfare Program) to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan (or Welfare Program) met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's (or Welfare Program's) receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan (or Welfare Program) shall provide the claimant with notice of the resubmission.

GROUP HEALTH CLAIMS PROCEDURES

(a) **Pre-Service Claim Determinations**. When a covered person requests a medical necessity determination prior to receiving care, the Claims Supervisor will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Supervisor's control, the Claims Supervisor will notify the individual within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice.

If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain which cannot be managed without the requested services, the Claims Supervisor will make the pre-service determination on an expedited basis. The Claims Supervisor will notify the covered person of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Supervisor will notify the individual within 24 hours after receiving the request to specify what information is needed. The covered person must provide the specified information to the Claims Supervisor within a reasonable amount of time (at least 48 hours), taking into account the circumstances. The Claims Supervisor will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If the covered person fails to follow the Claims Supervisor's procedures for requesting a pre-service medical necessity determination, the Claims Supervisor will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

(b) **Concurrent Claim Determinations**. When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Supervisor shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Supervisor will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

(c) **Post-Service Claim Determinations**. When a covered person requests a claim determination after services have been rendered, the Claims Supervisor will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Supervisor's control, the Claims Supervisor will notify the individual within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice.

(d) **Notice of Adverse Determination**.

(i) To the extent that the Welfare Program is not subject to the PPACA, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

(ii) To the extent that the Welfare Program is subject to the PPACA, every notice of an adverse benefit determination will be provided in writing or electronically in a culturally and linguistically appropriate manner calculated to be understood by the claimant, and will include all of the following that pertain to the determination: (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 Plan 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 Plan'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) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; (7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; (8) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim; and (9) the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan or Welfare Program.

(e) **Appeal of Denied Claim**.

(i) First Level of Appeal. If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Supervisor. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Supervisor immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Supervisor will issue a decision on review.

The Claims Supervisor's review will be processed in accordance with the following time frames: (a) 72 hours in the case of an urgent care claim; (b) 15 days in the case of a pre-service claim; (c) before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment; (d) 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or (e) 30 days in the case of a post-service claim.

(ii) Second Level of Appeal. If, after exhausting the first level appeal with the Claims Supervisor, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer (or another fiduciary named by the Plan Administrator in writing, which writing is incorporated herein by reference). Appeals will not be considered by the Employer unless and until the claimant has first exhausted the claims procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days

of the Claims Supervisor's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

In the normal case, the Employer will make a determination on the basis of the supporting file documents and written statement as submitted. However, the Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth in subsection (e)(i) above.

To the extent that the Welfare Program is subject to the PPACA, after exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available.

(f) **Notice of Benefit Determination on Appeal**.

(i) To the extent that the Welfare Program is not subject to the PPACA, every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information (as defined below); (4) a statement describing any voluntary appeal procedures offered by the Plan or Welfare Program and any claimant's right to bring an action under ERISA Section 502(a); (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(ii) To the extent that the Welfare Program is subject to the PPACA, every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (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 to the extent that the Welfare Program is subject to the PPACA; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (5) a statement describing any voluntary appeal procedures offered by the Plan or Welfare Program; (6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline,

protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (8) a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency.

(iii) Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(g) **Review Procedures on Appeal**. In the conduct of any review, the following will apply:

(i) No deference will be afforded to the initial adverse determination;

(ii) The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

(v) Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

(vii) To the extent that the Welfare Program is subject to the PPACA, the claimant will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

(h) **Deemed Exhaustion of Internal Claims and Appeals Processes**. To the extent that the Welfare Program is subject to the PPACA, if the Plan fails to strictly adhere to the internal claims and appeals requirements of 29 CFR 2590.715-2719(b)(2), the claimant may initiate an external review or may bring an action under Section 502(a) of ERISA. A deemed exhaustion, however, does not occur if violations of the claims review process are de minimis violations that do not cause, and are not likely to cause prejudice or harm to the claimant so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between the claimant and the Plan Administrator, Claims Supervisor, claims administrator or Named Fiduciary. The claimant may request a written explanation of the violation from the Plan Administrator, which must be provided within 10 days, including the basis for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. In case there is a deemed exhaustion, the claimant may also be entitled to remedies under Section 502 of ERISA by filing a case in court. Unless otherwise specified herein, the claimant is required to exhaust the internal claim and appeal process before filing a request for external review or filing a lawsuit.

(i) **External Claims Procedure**. To the extent that the Welfare Program is subject to the PPACA, after receiving notice of an adverse benefit determination or a final internal adverse benefit determination (or been deemed to have exhausted the internal appeal process), a claimant may file with the Plan a request for an external review, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the Plan is not eligible for the external review process. A claimant may request from the Claims Supervisor additional information describing the Plan's external review procedure.

(j) **Legal Remedies**. Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in the Program Documents for a particular Welfare Program, such later date with respect to a claim arising out of that Welfare Program.

WHEN COVERAGE TERMINATES

Your participation in the Plan will end when you cease to participate in all Welfare Programs. Generally, coverage under a Welfare Program will terminate at the end of the day in which you or your spouse or dependent become ineligible for such coverage, in accordance with the terms of the applicable Program Documents. Notwithstanding the foregoing: (i) coverage under an applicable Welfare Program for a dependent who ceases to meet the eligibility requirements of the applicable Welfare Documents will terminate on the last day of the month in which the dependent ceases to be eligible for such coverage, and (ii) if your employment terminates, your coverage under an applicable Welfare Program (including the medical Welfare Program for Hawaii Employees effective January 1, 2024) will end on the last day of the month in which your employment terminates. When your coverage under the Plan or an applicable Welfare Program terminates, the coverage for your spouse and dependents will also terminate on the same day.

WHEN COVERAGE MAY BE CONTINUED

You and your covered dependents may continue your group health coverage under this Plan under certain circumstances, according to the terms of your employer's Leave of Absence Policy, the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment And Reemployment Rights Act (USERRA), and the Consolidated Omnibus Budget

Reconciliation Act (COBRA). Group health coverage for yourself and your covered dependents may be continued if you cease active work because of an approved medical, family, personal, or military leave of absence or if your employment with the Employer ends.

CONTINUATION OF COVERAGE UNDER COBRA:

To the extent a description of COBRA rights is not provided in the Program Documents, the following applies:

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan 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 Plan (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.

Are there other coverage options?

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (“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. 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. Please note that certain excepted benefits such as health flexible spending accounts or standalone vision or dental plans will not be offered under the Marketplace. For more information about health insurance options available through the Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a Covered Employee (as defined below), 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 Plan 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.

(b) 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 Plan 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 Plan 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 Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with the Plan's 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. Although a domestic partner of a participant is not a Qualified Beneficiary under COBRA, the Plan may provide continuation coverage to a participant's domestic partner on the same terms and conditions as COBRA, but only as required by any applicable state insurance laws (including the laws of the state of California and Oregon) with respect to insured benefits.

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.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan 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:

(a) The death of a Covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a Covered Employee's employment.

(c) 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 Plan 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.

(d) A Covered Employee's entitlement to any part of Medicare.

(e) A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

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 Plan under the same terms and conditions as in effect immediately before the Qualifying Event, 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 Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under 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 Plan 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 Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

Premiums: This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

Provider Networks: If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

Drug Formularies: For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

Severance payments: If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

Service Areas: If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

Other Cost-Sharing: In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

What is the procedure for obtaining COBRA continuation coverage?

The Plan 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.

What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 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. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a Covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as amended ("Trade Act"), and the Employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information. More information about the Trade Act is also available at www.doleta.gov/tradeact.

The Trade Act also created a tax credit for certain TAA-eligible individuals and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of a significant portion of the premiums for qualified health insurance, including continuation coverage. Effective January 1, 2016, individual coverage purchased through the Marketplace is excluded from the list of qualified health insurance. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

Is a Covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan 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 (if the Employer is not the Plan Administrator) 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:

(a) the end of employment or reduction of hours of employment,

(b) death of the Employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the Employee to 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:

Inspira Financial Services on behalf of ADP Direct Bill
Benefit Billing Department
P.O. Box 953374
St. Louis, MO 63195-3374

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**, you may be required to provide **a copy of the divorce decree, the legal separation agreement** or other relevant documentation as required by the Plan Administrator.

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 that plan coverage would otherwise have been lost. 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.

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.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan 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.

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:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment (as defined below) is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan.

(e) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(f) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) 29 months after the date of the Qualifying Event or 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

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates 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 Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

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.

(a) 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.

(b) In the case of a Covered Employee's entitlement to Medicare 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:

(1) 36 months after the date the Covered Employee becomes entitled to Medicare; or

(2) 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.

(c) 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.

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

Under what circumstances can the maximum coverage period be expanded?

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-

month maximum coverage period, the original period is expanded 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 expanded 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 in accordance with the procedures above.

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 Plan 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 in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, 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 expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

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

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 Plan by a later date is also considered Timely Payment if either under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan 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 Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to

satisfy the Plan's requirement for the amount to be paid, unless the Plan 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.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan 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 Plan 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 Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Is State COBRA coverage available?

With respect to benefits under an insured group health Welfare Program under this Plan which are subject to state continuation coverage laws, you (or your covered dependent) may be able to continue coverage beyond the eighteen (18) months of continuation coverage allowable under federal COBRA laws but only if you (or your covered dependent) meet certain eligibility, notice or residency requirements, if applicable, or any other requirements set forth by such state continuation coverage law. Specifically, and without excluding any other applicable state laws:

- California. If you receive eighteen (18) months of continuation coverage under federal COBRA laws and are a resident of the State of California, you may be able to continue coverage for up to an additional eighteen (18) months through California COBRA, known as “Cal-COBRA”; provided, however, that this right shall only apply to insured medical benefits and only to the extent required by Cal-COBRA.

For more information

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 (ERISA), including COBRA, PPACA, 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.

CONTINUATION OF COVERAGE UNDER FMLA:

If you take leave under the Family and Medical Leave Act, you may continue, revoke or change your existing group health plan Welfare Program elections in a manner consistent with the Employer’s leave policy. For more information about your rights and obligations when on an FMLA leave, please contact Human Resources.

CONTINUATION OF COVERAGE UNDER USERRA:

USERRA provides for continuation of health care coverage for Employees called for active duty military service.

Except to the extent greater benefits are provided under the terms of the Program Documents, the maximum length of extended coverage under USERRA is the lesser of:

- 24 months beginning on the date that the military leave begins; or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee.

If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

COBRA continuation coverage and USERRA continuation coverage are concurrent.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan. A QMCSO may apply to coverage under the medical Welfare Program under this Plan. Once the Plan Administrator determines that the order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Plan Administrator receives a QMCSO, you and the affected child will be notified by the Plan Administrator before benefits are assigned pursuant to the order.

SUBROGATION & RIGHT OF REIMBURSEMENT

The provisions of this section pertaining to subrogation shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to subrogation, or (ii) a court, arbitrator, mediator or other judicial body determines that the subrogation provisions of a Welfare Program are not enforceable. The provisions of this section pertaining to a right of reimbursement shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to a right of reimbursement, or (ii) a court, arbitrator, mediator or other judicial body determines that the right of reimbursement provisions of a Welfare Program are not enforceable.

If a covered person becomes sick or injured and has the right to receive benefits under this Plan, but also has the right to receive compensation for the sickness or injury from a third party (such as an insurance company, for example), the Plan, or the Plan's designee, has a right of recovery.

The Plan's right of recovery includes the right to be reimbursed from any payment by the third party for the covered person's sickness or injury, for Plan benefits paid with respect to the sickness or injury. The Plan's right of recovery also includes the right of subrogation which means that the Plan can choose to assert the covered person's right of recovery against the third party. The Plan's right of recovery extends to any right of recovery the covered person's estate, spouse, dependents, guardian or other representative may have against the third party.

The Plan will have a first priority lien on any full or partial recovery by or on behalf of the covered person from the third party. The covered person (and the covered person's personal representative, beneficiary, or estate) shall agree to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the sickness or injury. The covered person (or the covered person's personal representative, beneficiary, or estate) shall serve as a constructive trustee over the funds due and owed to the Plan and hold such funds in trust.

The Plan's right of recovery will apply regardless of whether the covered person is made whole from the recovery against the third party, and will not be reduced or prorated by or on account of the covered person's attorneys' fees and costs. Any full or partial recovery by the covered person against a third party shall be deemed to be recovery for Plan benefits incurred with respect to the injury or sickness for which the third party is liable, regardless of whether or not the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically limited to certain kinds of damages or payments.

The Plan's right of recovery may be from the third party, any liability or other insurance covering the third party, malpractice insurance; the covered person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal injury protection (PIP); or, any other first or third party insurance coverages which are paid or payable.

If the Plan takes legal action to enforce its recovery rights, the Plan shall be entitled to recover its attorneys' fees and costs from the covered person.

The covered person shall not do anything to hinder the Plan's right of recovery. The covered person shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the third party or any insurance coverages to which the covered person may be entitled. The Plan is not obligated to pay Plan benefits incurred with respect to a covered person's injury or sickness until the covered person, or someone legally qualified and authorized to act for the covered person, enters into a written agreement with the Plan regarding its right of recovery. Also, the Plan may suspend payment of Plan benefits if the covered person does not execute such an agreement or does not comply with the terms of such an agreement. Payment of Plan benefits by the Plan before such a written agreement is obtained, or while the covered person is not in compliance with the terms of such a written agreement, shall not constitute a waiver by the Plan of its right of recovery.

The Plan Administrator, in its sole discretion, may waive the Plan's right of recovery. Waivers may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. The Plan's waiver of its right of recovery with respect to one claim shall not constitute a waiver of its right of recovery with respect to another claim; and the Plan's waiver of its right of recovery with respect to one covered person shall not constitute a waiver of its right of recovery with respect to another covered person.

INSURANCE REFUNDS OR REBATES:

You and any beneficiaries are not entitled to any refunds, rebates, discounts or other arrangements based on the actual cost of providing benefits under the Plan or Welfare Program. The Employer has complete discretion to apply any payments received from an insurer, including premium rebates based on experience, dividends, and proceeds from demutualization, to reduce its contributions to any Welfare Program offered under the Plan.

PPACA COMPLIANCE

Pre-Existing Conditions. Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any limitation or exclusion on coverage of pre-existing conditions for individuals. Any pre-existing condition exclusions will only apply during Plan years that begin before January 1, 2014.

Lifetime/Annual Limits. Notwithstanding anything contained in the Plan to the contrary, the Plan does not place any lifetime or annual limits on the dollar value of essential benefits for any individual under the group health plan. “Essential benefits” are those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

Cost Sharing Requirements for Preventive Care Expenses. With regard to non-grandfathered benefits under the Plan, there will be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.

Dependent Definition. The term “dependent" includes any child of a participant who is covered under an insurance contract, as defined in the contract, or under a self-funded plan, as defined in the plan, as allowed by reason of PPACA and the regulations and guidance issued thereunder.

No Rescission of Coverage. The Plan and each Welfare Program that is “group health plan” subject to ERISA Section 715 and 29 CFR 2590.715-2712 shall not rescind coverage under this Plan or such Welfare Program to a participant unless that participant or covered dependent performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of this Plan or such Welfare Program. The Plan will provide at least 30 days' advance written notice to each participant who would be affected before coverage may be rescinded under 29 CFR § 2590.715-2712(a)(1). For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

Selection of Providers. If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. The plan or issuer must also permit the participant to designate an in-network pediatrician who is available to accept the participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the participant, beneficiary, or enrollee.

Emergency Services. With respect to non-grandfathered benefits under the Plan, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services.

Cost Sharing Limits. With respect to non-grandfathered benefits under the Plan, effective January 1, 2014, this Plan does not impose cost sharing amounts (i.e., copayments, coinsurance, and deductibles, but not premiums) that are more than the maximum allowed for high deductible health plans. In 2026, these limits are $8,500 for an individual and $17,000 for family coverage. After 2026, these amounts will be adjusted for health insurance premium inflation. The foregoing notwithstanding, for the first plan year beginning on or after January 1, 2014, if the Plan utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums, the Plan will comply with the annual limitation on out-of-pocket maximums if (i) the Plan's major medical coverage (including mental health and substance use disorder benefits) complies with the out-of-pocket maximums, and (ii) the out-of-pocket maximums that apply to each other type of plan coverage (e.g., prescription drug coverage) separately satisfy the out-of-pocket maximums.

Clinical Trials. With respect to non-grandfathered benefits under the Plan, effective January 1, 2014, this Plan will not deny any "qualified individual," as set forth in Public Health Service Act §2709, participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. This Plan also will not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. Finally, this Plan will not discriminate against the individual on the basis of the individual's participation in such trial.

Provider Discrimination. With respect to non-grandfathered benefits under the Plan, effective January 1, 2014, this Plan shall not discriminate with respect to participation under the Plan against any health care provider that is acting within the scope of that provider's license or certification under the laws of the state issuing such license or certification, as required by Public Health Service Act §2706(a).

Applicability. This section will apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.

ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SPD APPENDIX A
WELFARE PROGRAMS AND CLAIMS ADDRESSES

Welfare Program*	Funding:	Paid by:	Payroll deduction	Claims Administrator and Address:	Policy Number:
Medical	Self-funded	Employer/ Employee	Pre-tax	UMR Claims Appeal Unit PO Box 30546 Salt Lake City, UT 84130 Prescription Drug: Express Scripts Inc. PO Box 66588 St. Louis, MO 63166	76-411009 8060
Medical (Effective on and after June 1, 2020)	Fully-insured	Employer/ Employee	Pre-tax	United Healthcare P.O. Box 30555 Salt Lake City, UT 84130-0555	921451
Medical (Effective on and after January 1, 2023)	Fully-insured	Employer/ Employee	Pre-tax	Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St., Suite 100 Portland, OR 97232	25272
Dental	Self-funded	Employee/ Employer	Pre-tax	Delta Dental of Missouri PO Box 8690 St. Louis, MO 63126	2088-1000
Vision†	Fully-insured	Employer/ Employee	Pre-tax	VSP 3333 Quality Drive Rancho Cordova, CA 95670	30068737
Health Flexible Spending Account	Self-funded	Employee	Pre-tax	Inspira Financial Services PO Box 8369 Omaha, NE 68108-0396	N/A
Wellness Program	Self-funded	Employer	Pre-tax	WellRight 175 West Jackson Blvd Suite 1425 Chicago, IL 60604	N/A
Group Term Life	Fully-insured	Employer	N/A	Aflac 1932 Wynnton Road Columbus, GA 31999	GLD0000008
Voluntary Life	Fully-insured	Employee	Post-tax	Aflac 1932 Wynnton Road Columbus, GA 31999	GLD0000008
Accidental Death and Dismemberment	Fully-insured	Employer	N/A	Aflac 1932 Wynnton Road Columbus, GA 31999	GLD0000008
Short-term Disability	Fully-insured	Employer	Pre-tax	Aflac 1932 Wynnton Road Columbus, GA 31999	GLD0000008
Long-term Disability	Fully-insured	Employee	Post-tax	Aflac 1932 Wynnton Road Columbus, GA 31999	GLD0000008
Employee Assistance Program	Fully-insured	Employer	N/A	Aflac 1932 Wynnton Road Columbus, GA 31999	GLD0000008

Welfare Program*	Funding:	Paid by:	Payroll deduction	Claims Administrator and Address:	Policy Number:
Telemedicine	Self-funded	Employer	N/A	First Stop Health (FSH) 222 North Columbus Drive, Suite D Chicago, IL 60601	N/A
Pre-paid Legal	Fully-insured	Employee	Post-tax	MetLife Legal 1111 Superior Ave, Suite 800 Cleveland, OH 44114	926/0106
ID Theft Protection	Fully-insured	Employee	Post-tax	Allstate Identity Protection 7350 North Dobson Road, Suite 101 Scottsdale, AZ 85256-2712	N/A
Hospital Indemnity**	Fully-insured	Employee	Post-tax	American Heritage Life Insurance Company 1776 American Heritage Life Drive Jacksonville, FL 32224	N/A
Group Accident**	Fully-Insured	Employee	Post-tax	American Heritage Life Insurance Company 1776 American Heritage Life Drive Jacksonville, FL 32224	G1924
Critical Illness**	Fully-insured	Employee	Post-tax	American Heritage Life Insurance Company 1776 American Heritage Life Drive Jacksonville, FL 32224	G1924
Medical Transportation Management, Inc. Employee Severance Pay Plan	Self-funded	Employer	N/A	Medical Transportation Management, Inc. 16 Hawk Ridge Dr. Lake St. Louis, MO 63367	N/A
Business Travel Insurance	Self-funded	Employer	N/A	LINA (Cigna) P.O. Box 188061 Chattanooga, TN 37422-8061	N/A

*If you are a Union Employee you are eligible to participate in certain Welfare Programs under the Plan as set forth below. For a list of the specific medical plan options available to Union Employees, please see Appendix F.

**Domestic partners are eligible for hospital indemnity, group accident, and critical illness Welfare Program benefits under this Plan if you are also eligible for such benefits, subject to the terms and conditions set forth in the applicable Welfare Program document.

† If you are a non-union Employee or an Employee whose employment is governed by the terms of a collective bargaining agreement between: (i) ATU Local Union #1091 in Austin, Texas; (ii) ATU Local Union #757 in Bend, Oregon; or (iii) Teamsters Local Union #439 in Manteca, California, and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties, you must pay the full premium for vision Welfare Program benefits.

ATU Local Union #1091 Austin, Texas

If you are an Employee classified on the Employer's books and records as a full-time Employee and your employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #1091 in Austin, Texas and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, dental, vision, health flexible spending account, group term life, accidental death and dismemberment, voluntary life, long-term disability, short-term disability, employee assistance program, and business travel insurance Welfare Program benefits under this Plan.

If you are an Employee classified on the Employer's books and records as a part-time Employee and your employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #1091 in Austin, Texas and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, and employee assistance program Welfare Program benefits under this Plan.

Employees who are classified on the Employer's books and records as ACA eligible part-time Employees whose employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #1091 in Austin, Texas and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties are only eligible for medical, telemedicine, and employee assistance program Welfare Program benefits under this Plan.

If you are an Employee that is designated to serve as a full-time officer or employee of ATU Local Union #1091 in Austin, Texas you will be eligible to participate in the same Welfare Program benefits that you would be able to participate in as an active Employee of the Employer, on the same terms and conditions that would apply to you as an active Employee of the Employer. In addition, if you take a leave of absence to transact the business of ATU Local Union #1091, any time missed while on such leave of absence will be considered time worked for the Employer for all purposes of the Plan.

Teamsters Local Union #439 Tracy, California

If you are an Employee classified on the Employer's books and records as a full-time Employee and your employment is governed by the terms of a collective bargaining agreement between the Teamsters Local Union #439 in Tracy, California and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, dental, vision, health flexible spending account, group term life, accidental death and dismemberment, voluntary life, long-term disability, short-term disability, employee assistance program, pre-paid legal, business travel insurance, and wellness program (only with respect to the tobacco surcharge component) Welfare Program benefits under this Plan.

If you are an Employee classified on the Employer's books and records as an ACA eligible part-time Employee whose employment is governed by the terms of a collective bargaining agreement between the Teamsters Local Union #439 in Tracy, California and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, employee assistance program, and wellness program (only with respect to the tobacco surcharge component) Welfare Program benefits under this Plan.

ATU Local Union #757 Bend, Oregon

If you are an Employee classified on the Employer's books and records as a full-time Employee or you are an Employee regularly scheduled to work a minimum of 30 hours per week and your employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #757 in Bend, Oregon and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, dental, vision, group term life, accidental death and dismemberment, voluntary life, long-term disability, short-term disability, employee assistance program, pre-paid legal, and business travel insurance Welfare Program benefits under this Plan.

If you are an Employee classified on the Employer's books and records as a part-time Employee, you are regularly scheduled to work less than 30 hours per week and your employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #757 in Bend, Oregon and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for employee assistance program Welfare Program benefits under this Plan.

If you are an Employee classified on the Employer's books and records as an ACA eligible part-time Employee, you are regularly scheduled to work less than 30 hours per week and your employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #757 in Bend, Oregon and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, dental, vision, and employee assistance program Welfare Program benefits under this Plan.

ATU Local Union #757 Salem, Oregon

Effective January 1, 2023:

If you are an Employee classified on the Employer's books and records as a full-time Employee and your employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #757 in Salem, Oregon and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, dental, vision, group term life, accidental death and dismemberment, voluntary life, long-term disability, short-term disability, employee assistance program, pre-paid legal, business travel insurance, and wellness program (only with respect to the tobacco surcharge component) Welfare Program benefits under this Plan.

If you are an Employee classified on the Employer's books and records as an Extra Board Employee, you are regularly scheduled to work a minimum of 30 hours per week and your employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #757 in Salem, Oregon and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, dental, vision, employee assistance program, and wellness program (only with respect to the tobacco surcharge component) Welfare Program benefits under this Plan.

If you are an Employee classified on the Employer's books and records as a part-time Employee, you are regularly scheduled to work less than 30 hours per week and your employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #757 in Salem, Oregon and MTM Transit, LLC under which benefits were the subject of good faith bargaining

between the parties you are only eligible for employee assistance program Welfare Program benefits under this Plan.

If you are an Employee classified on the Employer's books and records as an ACA eligible part-time Employee, you are regularly scheduled to work less than 30 hours per week and your employment is governed by the terms of a collective bargaining agreement between the ATU Local Union #757 in Salem, Oregon and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, employee assistance program, and wellness program (only with respect to the tobacco surcharge component) Welfare Program benefits under this Plan.

Teamsters Local Union #533 Donner and the Tahoe Basin, Reno and Northern Nevada

If you are an Employee classified on the Employer's books and records as a full-time Employee and your employment is governed by the terms of a collective bargaining agreement between the Teamsters Local Union #533 in Donner and the Tahoe Basin, Reno and Northern Nevada and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for employee assistance program, and business travel insurance Welfare Program benefits under this Plan.

If you are an Employee classified on the Employer's books and records as a part-time Employee, you are regularly scheduled to work less than 30 hours per week and your employment is governed by the terms of a collective bargaining agreement between the Teamsters Local Union #533 in Donner and the Tahoe Basin, Reno and Northern Nevada and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for employee assistance program Welfare Program benefits under this Plan.

Teamsters Local Union #439 Manteca, California

Effective as of July 1, 2023:

Employees who are classified on the Employer's books and records as full-time Employees whose employment is governed by the terms of a collective bargaining agreement between the Teamsters Local Union #439 in Manteca, California and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties are only eligible for medical, telemedicine, dental, vision, voluntary life, long-term disability, short-term disability, employee assistance program, pre-paid legal, business travel insurance, and wellness program (only with respect to the tobacco surcharge component) Welfare Program benefits under this Plan.

Employees who are classified on the Employer's books and records as part-time Employees whose employment is governed by the terms of a collective bargaining agreement between the Teamsters Local Union #439 in Manteca, California and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties are only eligible for employee assistance program Welfare Program benefits under this Plan.

Employees who are classified on the Employer's books and records as ACA eligible part-time Employees whose employment is governed by the terms of a collective bargaining agreement between the Teamsters Local Union #439 in Manteca, California and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties are only eligible for telemedicine Welfare Program benefits under this Plan.

United Service Workers Union #455 Denver, Colorado

Effective as of July 1, 2023:

Employees who are classified on the Employer's books and records as full-time Employees whose employment is governed by the terms of a collective bargaining agreement between the United Service Workers Union #455 in Denver, Colorado and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties are only eligible for employee assistance program, and business travel insurance Welfare Program benefits under this Plan.

United Service Workers Union #455 Gilber and Peoria, Arizona

Effective as of January 1, 2025:

If you are an Employee classified on the Employer's books and records as a full-time Employee and your employment is governed by the terms of a collective bargaining agreement between the United Service Workers Union #455 in Gilbert and Peoria, Arizona and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, dental, vision, health flexible spending account, group term life, accidental death and dismemberment, voluntary life, long-term disability, short-term disability, employee assistance program, pre-paid legal, business travel insurance, and wellness program (only with respect to the tobacco surcharge component) Welfare Program benefits under this Plan.

If you are an Employee classified on the Employer's books and records as an ACA eligible part-time Employee whose employment is governed by the terms of a collective bargaining agreement between the United Service Workers Union #455 in Gilbert and Peoria, Arizona and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties you are only eligible for medical, telemedicine, employee assistance program, and wellness program (only with respect to the tobacco surcharge component) Welfare Program benefits under this Plan.

Teamsters Local Union #137 Redding, California

Effective as of June 1, 2025:

Employees who are classified on the Employer's books and records as full-time Employees whose employment is governed by the terms of a collective bargaining agreement between the Teamsters Local Union #137 in Redding, California and MTM Transit, LLC under which benefits were the subject of good faith bargaining between the parties are only eligible for employee assistance program and business travel insurance Welfare Program benefits under this Plan.

Special Eligibility Related to Collective Bargaining and Corporate Transactions

For the 2023 Plan Year, if you are an Employee whose employment is governed by the terms of a collective bargaining agreement between ATU Local Union #1091 in Austin, Texas and MTM Transit, LLC, you will receive credit for any copayments, deductibles, co-insurance and similar expenses you incur under an Employer sponsored medical plan between January 1, 2023 and March 31, 2023 if you enroll in any of the following medical plan options on or after April 1, 2023:

- Core PPO Plan (PN# 008),
- Buyup PPO Plan (PN# 009)
- HDHP Plan (PN# 010)

To the extent permitted by applicable law, if you satisfy the applicable deductible or out of pocket limit under an Employer sponsored medical plan between January 1, 2023 and March 31, 2023, such limit will be deemed satisfied for the remainder of the 2023 Plan Year under the Core PPO Plan, Buyup PPO Plan or HDHP Plan, as applicable.

This ***Appendix A*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

This ***Appendix A*** is effective on and after: **January 1, 2026**, except as otherwise indicated herein.

SPD APPENDIX B
AFFILIATED EMPLOYERS

Employees of the following affiliated employers are considered "Employees" for purposes of eligibility to participate in the Plan.

MTM Transit, LLC
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
26-3937729

AAA Cab Service, Inc. (Effective 7/27/23)
4525 E. University
Phoenix, AZ 85034
86-0593914

This ***Appendix B*** is effective as of: **January 1, 2026**.

SPD APPENDIX C
WELLNESS PROGRAM

The Employer sponsors the Medical Transportation Management, Inc. Wellness Program (the "Wellness Program"). Along with the eligibility, benefits and other information described in the Summary Plan Description Supplement, to learn more about the Wellness Program please refer to the Employer's benefits guide (and any successor pamphlets or other documents provided by the Employer and the third party administrator of the Wellness Program) describing benefits under the Medical Transportation Management, Inc. Wellness Program ("Pamphlets").

Your participation in the Wellness Program is voluntary, but to receive benefits under the Wellness Program, you must satisfy the requirements of the Wellness Program. These requirements will be outlined in the Pamphlets and/or annual wellness informational packet provided to all eligible participants. As discussed in the Pamphlets and/or annual wellness informational packet, the requirements to qualify for a reward under the Wellness Program can be satisfied in many different ways, regardless of your health status. The wellness information outlined will include: program requirements, ways to meet requirements, program dates and deadlines, and any supplemental information regarding the Wellness Program.

Notwithstanding anything to the contrary in this Appendix C, you will not be entitled to a reward under the Wellness Program unless: (1) you are not excluded from eligibility for this Wellness Program pursuant to a collective bargaining agreement between Employee representatives (within the meaning of Code Section 7701(a)(46)), and the Employer (or any affiliated employer set forth in Appendix B) ("CBA"), subject to the Employer's discretion to permit certain Union Employees to participate in the Wellness Program notwithstanding the terms of a CBA, as set forth in the section entitled "GENERAL INFORMATION" above; (2) you satisfy the requirements to qualify for the reward while actively employed by the Employer and while enrolled in the Basic EPO Plan (PN# 003), Select EPO Plan (PN# 004) or HDHP w HSA Plan (PN# 004 or 005) under the self-funded medical Welfare Program administered by UMR (each an "Eligible Medical Plan"); and (3) you remain enrolled in an Eligible Medical Plan at the time the reward is delivered, either as an active Employee or pursuant to a COBRA election.

The Wellness Program is or may in the future be comprised of participatory and activity-only components and portions of the Wellness Program are paid through the Plan. Individuals are not required to participate in any particular component of the Wellness Program.

Benefits. Participants may qualify for an incentive or reward under the Wellness Program up to one time per year. Incentives and rewards must be used by the end of the calendar year for which they are earned and do not carry over to the next calendar year. Any incentives or rewards remaining on the last the last day of a calendar year will be forfeited and Participants will not be entitled to such amounts.

The Wellness Program is reasonably designed to promote health and prevent disease, and includes the following elements:

1. An activity-based program under which Employees can earn incentives when they complete specified wellness activities.

2. Such additional programs and benefits as now or in the future are described in the Wellness Program Pamphlets and communicated to Employees.

Eligibility. All Employees and their covered dependents who are at least 18 years old may participate in the Wellness Program's activities; however, only eligible Employees participating in an Eligible Medical Plan are eligible to earn rewards under this Wellness Program (Employees not enrolled in an Eligible Medical Plan are not eligible to earn rewards under the Wellness Program; Spouses and other dependents of eligible Employees are not eligible to earn rewards under the Wellness Program even if they participate in an Eligible Medical Plan. Participation in the Wellness Program does impact "eligibility" for (or other terms of) the Plan.

The Pamphlets may, in the future, be revised to include additional covered individuals; provided, however that Eligible Employees will be notified in the preceding Plan Year in which any changes in eligibility or benefits under the Wellness Program occur.

One or more elements of the Wellness Program are classified as participatory. Participatory wellness programs must be made available to all similarly situated individuals, regardless of health status. Under a participatory wellness program, you are required to engage in an activity that is not related to a health factor (with no specific outcome required) to receive an incentive or a reward under the wellness program. The reward, as discussed in the Pamphlets, is your ability to receive a reward upon satisfying the Wellness Program's standard(s).

One or more elements of the Wellness Program are classified as activity-only. An activity-only wellness program requires you to complete or to perform an activity related to a health factor in order to obtain the offered reward or incentive, but it does not require you to attain any specific health outcome to receive the reward. Activity-only wellness programs must meet certain requirements in order to comply with HIPAA; the requirements can be found on the Department of Labor (DOL) website.

If you are unable to participate in an activity-only wellness program due to a health factor, your employer will provide safeguards to ensure you are given a reasonable opportunity to qualify for the incentive or reward (i.e., a reasonable alternative standard) or the condition for obtaining the award will be waived. Under an activity-only wellness program, it is permissible for a plan or issuer to seek verification, such as a statement from your personal physician, that a health factor makes it unreasonably difficult for you to satisfy, or medically inadvisable for you to attempt to satisfy, the otherwise applicable standard in an activity-only wellness program, if reasonable under the circumstances. If your personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for you, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of your personal physician with regard to medical appropriateness or waive the condition for obtaining the reward. The employer may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

In order to ensure compliance with PPACA and HIPAA, the maximum permissible reward (or penalty) under the Wellness Program components is capped. Specifically, the maximum permissible reward (or penalty) under the Wellness Program is capped. Specifically, the maximum rewards (or penalties) for the components of the Wellness Program that may be classified as (i) activity-only wellness programs that are offered in connection with the Employer group health plan, and/or (ii) outcome-based wellness programs that are offered in connection with the Employer group health plan may not total up to more than 30% of the total cost of coverage (including both Employer and Employee contributions). In addition, the maximum permissible reward (or penalty) is 50% of the total cost of coverage for wellness program incentives designed to prevent or reduce tobacco use.

The Plan Administrator shall in good faith administer the Wellness Program to ensure that the maximum reward or incentive offered under the Wellness Program for portions of the Wellness Program that contain disability-related inquiries and/or medical examination(s) are set at a level wherein the participation in the Wellness Program shall be voluntary. To the extent the EEOC or other applicable governmental entity establishes a specific dollar or percentage threshold to determine whether a particular Wellness Program is voluntary, the Wellness Program shall comply with such threshold at such time it becomes effective and applicable.

To ensure compliance with the Genetic Information Nondiscrimination Act of 2008, as amended ("GINA"), if the Wellness Program now or in the future includes an online personal health assessment, and you complete the Employer's online personal health assessment, you will still receive credit for completing the assessment even if you do not answer the questions on family medical history and other genetic information. You must provide consent to participate in the Wellness Program. Any information disclosed to the Employer is only provided on an aggregate basis. In addition, the Wellness Program shall comply with the Equal Employment Opportunity Commission (EEOC) regulations pertaining to wellness programs in which your spouse may participate and which include a disability inquiry or medical exam (such as nicotine testing).

To obtain further information regarding the Wellness Program, please contact: MTM, Inc., 16 Hawk Ridge Dr. Lake St. Louis, MO 63367, Phone: (888) 828-1316.

SPD APPENDIX D -
SPECIAL ELIGIBILITY – COVID-19

The following special COVID-19 eligibility provisions shall apply effective March 17, 2020, with respect to Medical Transportation Management, Inc. Employees and March 13, 2020, with respect to MTM Transit, LLC employees (each date being the "**Effective Date**" for the respective groups of Employees):

Pandemic Affected Employee: You are considered to be a Pandemic Affected Employee if you were an eligible Employee, were subsequently placed on furlough by the Employer in response to the COVID-19 (Coronavirus) pandemic and you: (i) were actively participating in any Welfare Programs under the Plan as of Effective Date, (ii) were hired or transferred into a benefits eligible position but had not yet completed your waiting period as of Effective Date; or (iii) experience a qualifying status change or special enrollment event ("***Mid-Year Enrollment Event***") such that you would, but for you being placed on furlough, be eligible to elect coverage under the Plan mid-year. Notwithstanding the foregoing, if you are a Pandemic Affected Employee who had not reached your entry date into the life and disability Welfare Programs as of Effective Date, you shall not be eligible to enroll in the life and disability Welfare Programs.

Special Eligibility Rules Pandemic Affected Employees: If you are determined to be a Pandemic Affected Employee as of the Effective Date, you and your eligible dependents (i) will remain eligible for coverage under each Welfare Programs under the Plan in which you were enrolled on Effective Date, (ii) will become eligible to make a new election under a Welfare Program in which you could have enrolled had you reached your entry date into the Plan as of Effective Date (except for the life and disability Welfare Programs), or (iii) will be permitted to make a new election based on a Mid-Year Enrollment Event consistent with the terms of the applicable Welfare Program. Importantly, however, if you are an MTM Transit, LLC Employee, you will only remain eligible for medical Welfare Program benefits during your furlough period.

Coverage will continue while you are on furlough for the period set forth in the Welfare Program document or described in the Employer's leave policy (as determined by the Plan Administrator, in its sole discretion); provided, however that (a) life Welfare Program benefits cease the later of 90 days following the start of your furlough or December 31, 2020, and (b) disability Welfare Program benefits cease the later of 90 days following the start of your furlough or August 31, 2020 ("*Extended Coverage Period*").

Note, if you are a Pandemic Affected Employee who was not actively participating in a particular Welfare Program as of Effective Date and you become eligible to elect coverage mid-year due the fact that you have completed the Welfare Program's applicable waiting period while a Pandemic Affected Employee or because you have experienced a Mid-Year Enrollment Event, you are required to timely make an active election to enroll in each Welfare Program for which you wish to participate at a time and in the manner set forth in the Welfare Program document and that is acceptable to the Plan Administrator.

As a Pandemic Affected Employee, although you will be required to pay the Employee-portion of each Welfare Program premium upon you return to work, during the time you are on furlough and remain enrolled in the Plan, the Employer will pay both the Employer-portion and the Employee-portion of all applicable premiums for the Welfare Programs in which you are enrolled. Upon your return from furlough however, you will be required to repay such premiums at the time and in the manner set forth in the Employer's leave policy.

SPD APPENDIX E -
MEDICAL PLAN ELIGIBILITY – NON-UNION EMPLOYEES

Company	Location	Eligible Group(s)	Medical Plan Option(s)
Medical Transportation Management, Inc.	Hawaii	**Salaried**: Full-Time; Part-Time ACA Eligible **Hourly**: Full-Time; Part-Time ACA Eligible	UMR/Express Scripts, Inc.: Hawaii Options PPO
Medical Transportation Management, Inc.	All other MTM Locations	**Salaried**: Full-Time; Part-Time ACA Eligible **Hourly**: Full-Time; Part-Time ACA Eligible	UMR/Express Scripts, Inc.: Basic EPO (PN# 003) Select EPO (PN# 007) HDHP w HSA (PN# 004 and 005)
MTM Transit, LLC	All MTM Transit Locations	**Salaried**: Full-Time; Part-Time ACA Eligible **Hourly**: Full-Time; Part-Time ACA Eligible	UMR/Express Scripts, Inc.: Basic EPO (PN# 003) Select EPO (PN# 007) HDHP w HSA (PN# 004 and 005)

This ***Appendix E*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

This ***Appendix E*** is effective on and after: **January 1, 2026**.

SPD APPENDIX F -
MEDICAL PLAN ELIGIBILITY – UNION EMPLOYEES

Company	Union/ Location	Eligible Group(s)	Medical Plan Option(s)
MTM Transit, LLC	ATU Local Union #1091; Austin Texas	**Salaried**: N/A **Hourly**: Full-Time; Part-Time; Part-Time ACA Eligible	UMR/Express Scripts, Inc.: Core PPO (PN# 008) Buy-Up PPO (PN# 009) HDHP (PN# 010)
MTM Transit, LLC	Teamsters Local Union #439; Tracy, California	**Salaried:** N/A **Hourly**: Full-Time; Part-Time ACA Eligible	UMR/Express Scripts, Inc.: Basic EPO (PN# 003) Select EPO (PN# 007) HDHP w HSA (PN# 004 and 005)
MTM Transit, LLC	ATU Local Union #757 Bend, Oregon	**Salaried**: N/A **Hourly**: Full-Time; Regularly Scheduled 30+ Hours Per Week; Part-Time ACA Eligible	UMR/Express Scripts, Inc.: Basic EPO (PN# 003) Select EPO (PN# 007) HDHP w HSA (PN# 004 and 005)
MTM Transit, LLC	ATU Local Union #757 Salem, Oregon	**Salaried**: N/A **Hourly**: Full-Time; Extra Board Regularly Scheduled 30+ Hours Per Week; Part-Time ACA Eligible	UMR/Express Scripts, Inc.: Basic EPO (PN# 003) Select EPO (PN# 007) HDHP w HSA (PN# 004 and 005) Kaiser Permanente: Kaiser HMO
MTM Transit, LLC	Teamsters Local Union #533 Donner and the Tahoe Basin, Reno and Northern Nevada	N/A	N/A
MTM Transit, LLC	Teamsters Local Union #439 Manteca, California	**Salaried:** N/A **Hourly**: Full-Time; Part-Time ACA Eligible	UMR/Express Scripts, Inc.: Basic EPO (PN# 003) Select EPO (PN# 007) HDHP w HSA (PN# 004 and 005)
MTM Transit, LLC	United Service Workers Union #455 Denver, Colorado	N/A	N/A
MTM Transit, LLC (effective January 1, 2025)	Teamsters Local Union #455; Gilbert and Peoria, Arizona	**Salaried:** N/A **Hourly**: Full-Time; Part-Time ACA Eligible	UMR/Express Scripts, Inc.: Basic EPO (PN# 003) Select EPO (PN# 007) HDHP w HSA (PN# 004 and 005)
MTM Transit, LLC (effective June 1, 2025)	Teamsters Local Union #137 Redding, California	N/A	N/A

This ***Appendix F*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

This ***Appendix F*** is effective on and after: **January 1, 2026**, except as otherwise indicated herein.