DISCOVERY BENEFITS, INC.

MASTER AND PROTOTYPE
HEALTH REIMBURSEMENT ARRANGEMENT

Summary Plan Description

Rev'd January 2017

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ABOUT THIS SUMMARY PLAN DESCRIPTION

This Summary Plan Description ("SPD") is comprised of the following two parts –

- This document that describes information about your plan coverage and other statements that are required by law; and
- An Adoption Agreement for the Discovery Benefits, Inc. Master and Prototype Health Reimbursement Arrangement that is attached to this document and which contains addresses and phone numbers you can use to contact the Plan Administrator of your plan coverage.

If you do not have both parts of this SPD, contact your Employer.

The rules and operation of your group health plan are described in this SPD as clearly as possible with minimal use of the technical terms appearing in the official legal documents (including applicable insurance contracts). However, the official legal documents remain the final authority and, in the event of a conflict with this SPD, shall govern in all cases. You may request a copy of the official legal documents from the Plan Administrator.

This SPD covers a number of different types of Health Reimbursement Arrangements ("HRA"). The type of HRA your employer sponsors will determine eligibility, enrollment, benefits and other terms of your HRA. The HRA that your employer has elected to sponsor is set forth in the Adoption Agreement. If the HRA is established to comply with the San Francisco Health Care Security Ordinance ("SFHCSO"), the terms of your HRA are set forth in the Adoption Agreement and as provided by notices and other documents you may receive from your Employer.

This SPD may only be used when your Employer has contracted with Discovery Benefits to be the Claims Administrator of your Plan. Once Discovery Benefits is no longer the Claims Administrator, this document shall be void with respect to any term, condition or requirement of Discovery Benefits.

ELIGIBILITY AND PARTICIPATION

ELIGIBLE EMPLOYEES

You are eligible for the Plan if you are classified as a regular employee of your Employer and are scheduled to work the number of hours stated in the Adoption Agreement. You also must satisfy any additional eligibility requirements listed in the Adoption Agreement. Further, if this is an Integrated HRA as set forth in Section 9.a. of the Adoption Agreement, you must also be enrolled in other major medical employer group health plan coverage as noted in Section 10.a.

If this is a Retiree-Only HRA as listed in Section 9.c. of the Adoption Agreement, then only retirees or former employees may participate in the HRA. The retiree and former employee classifications eligible for a Retiree-Only HRA are listed in Section 10.d. of the Adoption Agreement.

INELIGIBLE PERSONS

The following employees or individuals are ***not*** eligible to participate in the Plan:

- Any employee who is paid from a non-U.S. payroll, either entirely or partly.
- Any individual who is classified by your Employer as an independent contractor (without regard to how the individual may be classified by a court or administrative agency).
- Any individual excluded by the terms of the Adoption Agreement.

It is expressly intended that individuals not treated as eligible employees or individuals by your Employer are to be excluded from participation in the Plan under all circumstances until your Employer changes their classification. Therefore, an independent contractor or any other ineligible individual who is reclassified by a court, administrative agency or other party, as an eligible employee or individual will not be considered an eligible employee or individual for periods before your Employer implements the reclassification decision, even if the decision applies retroactively.

RETURN FROM MILITARY SERVICE

If an employee returns to active employment in a position as an eligible employee following active military duty, any minimum age and service requirements and any waiting period applicable to new eligible employees will not apply. All benefits provided by the Plan will be restored to their status as of the eligible employee's last day worked provided the employee applies for reinstatement within the time period required by the Uniform Services Employment and Reemployment Rights Act (USERRA). Plan coverage will be effective on the date the employee returns to active employment in a position as an eligible employee.

SPOUSE AND DEPENDENT COVERAGE

As a Plan participant you can receive reimbursement for eligible claims for your eligible spouse and eligible children, subject to any specific requirements or limitations listed in the Adoption Agreement. In addition, if elected in your Adoption Agreement, you can also receive reimbursement for eligible claims for any other eligible individual who qualifies as your Federal income tax dependent. You can receive reimbursement for eligible claims for a child who is covered by a qualified medical child support order (QMCSO) under ERISA Section 609. If your Plan covers children as set forth in the Adoption Agreement, then a child of a participant (e.g., biological, adopted, step and eligible foster children) shall be a dependent hereunder up to his or her 26th birthday.

Your eligible spouse includes your legal spouse to whom you are legally married under any applicable state or foreign jurisdiction (including same and opposite sex spouses). Common law spouses are also eligible, where applicable based on state or foreign law.

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child

of a participant. The child becomes an "alternate recipient" and can receive benefits under the Plan, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

If you are enrolled in an Integrated HRA under Section 9.a. of the Adoption Agreement, then any eligible dependents of the Integrated HRA must be enrolled in major medical coverage under the participant's employer group health plan, the spouse's employer group health plan or the dependent child's employer group health plan, as applicable. However, if your HRA was in existence on December 16, 2015, then the requirement of the prior sentence does not apply until the first Plan Year beginning on or after January 1, 2017.

COMMENCEMENT OF PARTICIPATION

If you are eligible for participation in the Plan, the effective date of your coverage will be the date listed in the Adoption Agreement. Your enrollment rights are also subject to any waiting periods that your Employer may impose. Any applicable waiting period is listed in the Adoption Agreement. All waiting periods are calculated using the elapsed time method.

LEAVES OF ABSENCE

When you apply for an authorized leave of absence (including a leave pursuant to the Family and Medical Leave Act of 1993) you will be advised of the specific requirements regarding the continuation of your participation in Plan coverage. You will also be advised of the requirements to resume your participation should your participation terminate while you are on leave. The following rules will apply to your leave of absence.

If your Employer is subject to the Family and Medical Leave Act of 1993 ("FMLA") as set forth in the Adoption Agreement, your Employer will provide up to 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. Please contact your Employer to see if you are covered by FMLA. In general, an Employer will be subject to FMLA rules, if your Employer employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

In general, if your Employer is subject to FMLA you will be eligible to take FMLA leave if:

- You have worked for your Employer at least 12 months before the leave;
- You have worked at least 1,250 hours during the 12 months immediately before the leave; and
- You have worked at a worksite where your Employer employs at least 50 employees in a 75-mile radius.

If you take a leave of absence pursuant to FMLA, your group health plan coverage will continue, if you continue to pay your portion of the premiums during your FMLA leave period. If you fail to pay the premiums as they become due, your Employer may choose to either pay them on your behalf, or to terminate your coverage after written notice. If your Employer pays your premiums, your Employer may recover them from any sum (such as from your unpaid wages)

due you after your return to work, or after you provide notice that you will not return after the end of the FMLA leave period. You may also revoke your group health plan coverage for the period of your FMLA leave. Upon returning from FMLA leave you will resume participation in group health plan coverage, whether you voluntarily revoked your participation or your participation was cancelled due to non-payment of the premiums.

TERMINATION OF PARTICIPATION

Your Plan coverage will terminate at the time when you no longer meet the criteria to be an eligible employee as listed above and in the Adoption Agreement. For example, your Plan coverage will terminate based on certain events, including:

- Termination of employment, including retirement, layoff and otherwise;
- When you are no longer considered an eligible employee.

In addition, your dependent children and spouse will cease to have Plan coverage when your participation as an employee terminates or earlier if your dependent children or spouse fail to satisfy the criteria as set forth above.

Please review the Adoption Agreement for any additional forfeiture, contribution and claims filing rules upon a termination of employment.

RESCISSION OF COVERAGE

If your Plan is an Integrated HRA as set forth in Section 9.a. of the Adoption Agreement or a Pre-2014 HRA as set forth in Section 9.b. of the Adoption Agreement, the Plan shall not rescind coverage for a participant or qualifying dependent, unless the participant or dependent performs an act, practice, or omission that constitutes fraud or unless the participant or dependent makes an intentional misrepresentation of a material fact with respect to the Plan. If coverage may be rescinded under the foregoing provisions, the participant or dependent shall be provided with at least 30 days advance written notice of such rescission. A rescission is subject to the claims procedures.

A rescission of Plan coverage is a cancellation or discontinuance of such coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission (and not subject to the rescission of coverage rules) if:

- The participant or dependent voluntarily requests such cancellation or discontinuance with a retroactive effective date;
- The cancellation or discontinuance of coverage has only prospective effect;
- The cancellation or discontinuance of coverage results from a participant's termination of employment from an Employer; or
- The cancellation or discontinuance of coverage of a dependent results from such dependent's failing to satisfy the applicable eligibility requirements to be a dependent.

This rescission of coverage section only applies if your Plan is an Integrated HRA as set forth in Section 9.a. of the Adoption Agreement or a Pre-2014 HRA as set forth in Section 9.b. of the Adoption Agreement.

BENEFITS

Note: If you are covered by an HRA that is intended to comply with the San Francisco Health Care Security Ordinance (SFHCSO), additional rules apply to you. Please see the heading "Special Rules for San Francisco Employees" at the end of the Benefits Section.

ANNUAL DEDUCTIBLE THRESHOLD

For certain types of HRAs, the Plan may apply an Annual Deductible Threshold as indicated in your Adoption Agreement. The dollar amount of any applicable Annual Deductible Threshold and how it is calculated is set forth in your Adoption Agreement. If an Annual Deductible Threshold applies, then you cannot be reimbursed for any Qualifying Medical Expenses until you satisfy the Annual Deductible Threshold for the year. Once you satisfy the Annual Deductible Threshold for the year, you may only be reimbursed for Qualifying Medical Expenses incurred thereafter and prior to the end of such year.

Remember, you must satisfy the Annual Deductible Threshold for each year. Expenses incurred in a year can only be used to satisfy the Annual Deductible Threshold for the same year. Expenses incurred in a prior year cannot be carried over to any subsequent year for purposes of satisfying any subsequent year's Annual Deductible Threshold.

REIMBURSEMENTS

The Plan allows you to be reimbursed for Qualifying Medical Expenses as set forth in the Adoption Agreement. However, certain types of HRAs further restrict the types of Qualifying Medical Expenses that can be reimbursed by that HRA.

The following types of HRAs and allowable reimbursements are set forth as follows –

<u>Integrated HRA</u>

If the major medical coverage with your Integrated HRA does provide minimum value (as set forth in Section 9.a. of the Adoption Agreement), then you can be reimbursed for any Code Section 213(d) expense.

If the major medical coverage with your Integrated HRA is not providing minimum value (as set forth in Section 9.a. of the Adoption Agreement), then Qualifying Medical Expenses will be limited to co-payments, co-insurance and deductibles under the major medical coverage, plus any other Code Section 213(d) expenses that are not considered essential health benefits.

However, in all cases, you cannot be reimbursed for individual insurance premiums and employer group health plan premiums paid on a pre-tax basis from an Integrated HRA.

If Section 16.a.3. in the Adoption Agreement is checked, then the HRA will reimburse a spouse's employer group health plan premiums, as long as those premiums are paid by the spouse on an after-tax basis.

Limited Integrated HRA

If your HRA is a limited Integrated HRA under Section 16.b. of the Adoption Agreement, then your HRA will only reimburse the following Code Section 213(d) expenses (to the extent that they are selected in Section 16.b. –

- Medical deductibles paid under an applicable employer group health plan,
- Medical co-insurance paid under an applicable employer group health plan,
- Medical co-payments paid under an applicable employer group health plan, and/or
- Pharmacy deductibles, co-insurance and/or co-payments paid under an applicable employer group health plan.

Pre-2014 HRA

If your Plan is a Pre-2014 HRA as noted in Section 9.b. of the Adoption Agreement, then you can be reimbursed for any Code Section 213(d) expense based on applicable guidance in effect on December 31, 2013.

Retiree-Only HRA

If your Plan is a Retiree-Only HRA as noted in Section 9.c. of the Adoption Agreement, then you can be reimbursed for any Code Section 213(d) expense, including individual insurance premiums. However, you cannot be reimbursed for employer group health plan premiums.

Excepted Benefit Premium Reimbursement HRA

If your Plan is an Excepted Benefit Premium Reimbursement HRA as noted in Section 9.d. of the Adoption Agreement, then your HRA will only reimburse individual insurance premiums that are considered HIPAA excepted benefits as follows –

- Stand-alone individual dental insurance,
- Stand-alone individual vision insurance,
- Non-coordinated, individual insurance coverage for a specific disease or illness (e.g., specific coverage for cancer, hospitalization, etc.), and
- Non-coordinated, individual insurance coverage that is hospital indemnity or fixed indemnity (e.g., coverage that pays you a certain dollar amount per day of hospitalization).

Excepted Benefit HRA

If your Plan is an Excepted Benefit HRA as noted in Section 9.e. of the Adoption Agreement, then you can be reimbursed for any Code Section 213(d) expense up to the dollar amount set forth in Section 9.e. of the Adoption Agreement. However, individual insurance premiums and employer group health plan premiums cannot be reimbursed.

Excepted Benefit Dental and Vision Only HRA

If your Plan is an Excepted Benefit Dental and Vision Only HRA as noted in Section 9.f. of the Adoption Agreement, then your HRA will only reimburse Code Section 213(d) expenses that are classified as dental or vision expenses as determined by the Claims Administrator. Major medical expenses and prescription drug expenses will not be reimbursed under this type of HRA.

HRA Integrated with Dental Only and/or Vision Only Coverage

If your Plan is an HRA Integrated with Dental Only and/or Vision Only Coverage as noted in Section 9.g. of the Adoption Agreement, then your HRA will only reimburse Code Section 213(d) expenses that are classified as dental or vision expenses as determined by the Claims Administrator and as elected in Section 9.g. of the Adoption Agreement. Major medical expenses and prescription drug expenses will not be reimbursed under this type of HRA.

After-Tax Reimbursement Account

If your Plan is an After-Tax Reimbursement Account as noted in Section 9.h. of the Adoption Agreement, your Plan will only reimburse the following Code Section 213(d) expenses to the extent they are selected in Section 16.i. of the Adoption Agreement –

- Stand-alone individual dental insurance,
- Stand-alone individual vision insurance,
- Non-coordinated, individual insurance coverage for a specific disease or illness (e.g., specific coverage for cancer, hospitalization, etc.),
- Non-coordinated, individual insurance coverage that is hospital indemnity or fixed indemnity (e.g., coverage that pays you a certain dollar amount per day of hospitalization), and/or
- Any Code Section 213(d) expense (excluding individual major medical insurance premiums and excluding employer group health plan premiums).

Coverage under an After-Tax Reimbursement Account is treated as taxable compensation to you by your employer. Your employer determines the amount, timing and other rules with respect to treating the account reimbursements as taxable compensation. If you have any questions concerning the taxation of this account, you should contact your employer.

Qualifying Small Employer Health Reimbursement Arrangement (QSEHRA)

If your Plan is a QSEHRA as noted in Section 9.j. of the Adoption Agreement, then you can be reimbursed for the following types of expenses –

- Major medical insurance premiums for yourself and your eligible spouse and children, including for policies purchased on a Federal or state exchange,
- Dental and vision insurance premiums for yourself and your eligible spouse and children, and
- Other Code Section 213(d) expenses for yourself and your eligible spouse and children.

NOTE: To be reimbursed for any of the above expenses, you must provide proof that you have major medical coverage, as determined by the Claims Administrator. A QSEHRA will not reimburse employer-sponsored health coverage premiums that are paid on a pre-tax basis. Also review the special rules for QSEHRAs in the QSEHRA section later in this SPD.

CODE SECTION 213(D) EXPENSES

If your HRA includes reimbursements for any Code Section 213(d) expense, the IRS requires that the expense is:

- For the diagnosis, cure, mitigation, treatment or prevention of disease and for treatments affecting any part or function of the body, and
- Primarily to alleviate or prevent a physical or mental defect or illness.

Expenses NOT generally eligible for reimbursement are those:

- Solely for cosmetic reasons, or
- Merely beneficial to one's general health (for example, health spas, vacations)

Even though your Plan includes reimbursements for Code Section 213(d) expenses, the Plan may be limited to specific types of expenses, such as only dental or vision expenses, or the Plan may exclude certain types of expenses, such as insurance premiums. You should review the section entitled "Reimbursements" very carefully to determine whether there are any restrictions or limitations on your Plan.

Further, if your Plan includes reimbursements for medical expenses, you still cannot receive any reimbursements for over the counter medicines or drugs, unless you have a written prescription for such medicine or drug from your physician.

If you have any questions as to whether an expense satisfies the Code Section 213(d) requirements, please review the rules set forth on the Claims Administrator's website at www.discoverybenefits.com, or contact Participant Services at 1-866-451-3399 or via email at customerservice@discoverybenefits.com.

Notwithstanding the foregoing, the only Plan that will reimburse major medical individual insurance premiums is a Retiree-Only HRA as set forth in Section 9.c. of the Adoption Agreement or a QSEHRA as set forth in Section 9.j. of the Adoption Agreement. However, a Retiree-Only HRA will only reimburse such premiums, if the reimbursement is otherwise allowed as set forth in Section 16 of the Adoption Agreement.

SPECIAL REIMBURSEMENT RULES

The following includes other special rules regarding Plan reimbursements and benefits –

- Any expense submitted for reimbursement under the Plan cannot also be reimbursed or paid by any other health plan.

- You must file any claims for eligible expenses by the end of the period outlined in the Adoption Agreement following the year in which the eligible expense was incurred. Claims filed after the end of the period as outlined in the Adoption Agreement following the year in which the expense was incurred will not be paid. Expenses incurred prior to the effective date of the Plan or before you began Plan participation are not eligible for reimbursement.

- Eligible expenses incurred for yourself may be reimbursed from the HRA Account. Expenses incurred for your spouse, your child or other dependent will only be reimbursed if your spouse, child or other dependent satisfies the provisions to be eligible for the Plan as set forth in the Adoption Agreement. Expenses for your domestic partner and your partner's dependent children are not eligible for reimbursement from your HRA Account, unless they are considered your tax dependents for federal income tax purposes and such individuals are otherwise eligible as set forth in the Adoption Agreement.

- Any money you don't use in a particular Plan Year will carry over to the following Plan Year, subject to any limitations set forth in the Adoption Agreement.

- If you leave the Employer or otherwise terminate Plan participation, you have until the end of the period outlined in the Adoption Agreement for terminated employees / participants to file claims for eligible expenses incurred prior to your termination. You may be able to file claims for eligible expenses incurred after your termination, if a carryforwards applies or COBRA applies, subject to any waiver requirements. See below for additional information.

- If your HRA is a QSEHRA as set forth in the Adoption Agreement, you must provide proof of major medical coverage before you can be reimbursed for <u>any</u> expense.

- If you die while employed by the Employer, your eligible spouse and eligible dependents can continue to use the HRA Account for their eligible expenses incurred both before and after your death until the HRA Account is exhausted, subject to any waiver requirements. See below for additional information.

Participants may be provided with a debit card by the Claims Administrator to pay for Qualifying Medical Expenses. Any debit card shall be subject to the debit card's terms of use and any other requirements established by the Claims Administrator for this purpose. If a debit card is used to pay for an expense that is not a Qualifying Medical Expense, the Claims Administrator shall apply correction procedures as set forth in guidance promulgated pursuant to Section 125 of the Internal Revenue Code.

MAXIMUM REIMBURSEMENTS

The amount that your Employer will credit to your HRA Account is set forth in the Adoption Agreement. Unused amounts from the prior calendar year may be carried forward to subsequent calendar years as set forth in the Adoption Agreement, and subject to any limitations in the Adoption Agreement. You may not be reimbursed for an amount of eligible expenses that is

greater than your HRA Account balance at the time the reimbursement is to be made. Any excess amount will be carried over to the next reimbursement cycle.

After your Plan eligibility terminates, no additional amounts will be credited to your HRA Account. However, you may be able to spend down the remaining balance in your HRA Account for eligible claims incurred after termination if a spend down feature applies to your Plan as set forth in the Adoption Agreement. If a spend down feature does not apply to your Plan, then you will not be able to use your HRA Account for claims incurred after your eligibility terminates.

If your Plan is an Excepted Benefit HRA under Section 9.e. of the Adoption Agreement, unused amounts at the end of the year will forfeit, unless your employer has elected the special carryover rule set forth in Section 9.e. of the Agreement. Claims incurred after a forfeiture has occurred cannot be reimbursed and are not subject to COBRA continuation coverage.

SPECIAL WAIVER RULES

If your Plan is an Integrated HRA, you may be eligible for special waiver rules, as follows –

- If your Integrated HRA does not forfeit upon a termination of employment, you will be allowed to voluntarily forfeit any future coverage from the HRA upon your termination. Completing a waiver in this situation means that you forfeit the existing balance of the HRA and you cannot be reimbursed for any claim incurred after the effective date of the waiver.

- If your Integrated HRA includes a carryforward of existing balances to the next plan year, you will be allowed to voluntarily forfeit any future coverage from the HRA for the following plan year. Completing a waiver in this situation means that you forfeit the existing balance of the HRA for the following plan year and you cannot be reimbursed for any claim incurred during the plan year to which the waiver applies.

All waivers are subject to the terms and conditions as set forth on the waiver form. All waivers are irrevocable once made. Contact your employer or the Claims Administrator for any waiver questions.

If a waiver is available, you may wish to make such a waiver if you intend to enroll in an individual policy through the Insurance Marketplace and use premium tax credits to pay for all or a portion of such policy's premiums. You should contact your personal tax advisor for any questions related to claiming premium tax credits.

REIMBURSEMENT REQUESTS

During the course of the calendar year, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than the end of the period outlined in the Adoption Agreement following the year in which the expense is incurred. The Claims Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Claims Administrator proof of

the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter.

SPECIAL RULES FOR QSEHRAS

If your HRA is a QSEHRA, then a number of special rules apply to the operation of your HRA as set forth in your Adoption Agreement and discussed as follows –

- The Claims Administrator will only reimburse an eligible expense after you have provided proof that you are enrolled in major medical coverage for the period in which the expense was incurred.

- If you are enrolled in minimum essential coverage (MEC), then the value of your QSEHRA will be tax-free. However, if you are not enrolled in MEC for one or more months, then the value of your QSEHRA may become taxable for the months in which you were not enrolled in MEC. In general, if you are enrolled in employer-sponsored major medical coverage or enrolled in an individual major medical policy purchased on a federal or state exchange, then you should have MEC for the months you are enrolled. Your Employer is responsible for calculating any taxable income that may result from not being enrolled in MEC.

- Coverage under a QSEHRA may affect your ability to obtain a premium tax subsidy for coverage that is purchased through a federal or state exchange. Under this special rule, you or your spouse or dependent will not be eligible for a premium tax subsidy if the QSEHRA provided to you is considered to be "affordable". Your QSEHRA coverage will be considered affordable if –

    - One-twelfth of your Employer's annual contribution to the QSEHRA is not less than the monthly premium for a self-only, second-lowest cost silver plan; and

    - Your monthly cost of coverage for the individual major medical policy purchased through the federal or state exchange does not exceed one-twelfth of 9.5% of your household income.

    If you have any questions whether your QSEHRA will affect your premium tax subsidy, please contact your Employer or your personal tax advisor.

CLAIM AND APPEALS

When you have a claim to submit for reimbursement, you must:

(1) Obtain a claim form from the Claim Administrator;

(2) Complete the Employee portion of the form; and

(3) Attach copies of all bills or receipts from the healthcare provider for which you are requesting reimbursement.

All claims must be filed within 12 months of when the claim was incurred, unless a shorter time period applies as set forth in the Adoption Agreement. If you are a San Francisco Employee, this claim filing limitation does not apply to you. See the special rules in the San Francisco Employee section for additional information.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances but no later than the time periods set forth below. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of insufficient information	15 days
Required Response by Participant	45 days

The Claim or Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was 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 review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following a denial on review.

(5) 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 claim; and

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided

free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

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

Once an appeal is filed, the Claim Administrator or Plan Administrator will notify you within 60 days thereafter of whether the appeal is approved or denied.

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

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) Constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

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

EXTERNAL REVIEW

If your Plan is an Integrated HRA or a Pre-2014 HRA, external review of denied appeals may be available once you complete the regular claims and appeal process noted above. However, external review is limited to only the following types of claims and appeals –

- Medical Judgment Claims and Appeals: External review procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a benefit or experimental or investigational determinations).
- Rescissions of Coverage: External review procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission.

(Subject to certain exceptions, generally a rescission is a retroactive termination of coverage.)

External review procedures do not apply to any other adverse determination (other than medical judgment and rescissions as set forth above), including eligibility appeals. Further, external review is not available for any other HRA types other than the two HRAs noted in the first sentence of this section. Contact the Claims Administrator to determine if external review applies to your Plan.

SPECIAL RULES FOR SAN FRANCISCO EMPLOYEES

If your HRA is set up to comply with the San Francisco Health Care Security Ordinance (SFHCSO), then special rules apply to your HRA contributions and reimbursements. The special SFHCSO rules are set forth in your Adoption Agreement. However, unless different rules apply as discussed in this special section, then all of the regular rules of the Plan discussed in this SPD also apply to you. Your Employer will also provide you with special notices and documents regarding the HRA contributions made to your HRA Account. You can also contact the Claims Administrator at any time to determine the amount of contributions made to your HRA Account, as well as prior reimbursements paid or submitted for processing.

Compliance with the SFHCSO, including the amount of contributions, is the responsibility of your Employer and not the Claims Administrator.

Contributions

Your Employer will calculate and make quarterly contributions to your HRA Account based on the requirements of the SFHCSO. Contributions may only be made for Irrevocable Health Care Expenditures (as set forth in Section 13 of the Adoption Agreement). Prior to January 1, 2017, your Employer was allowed to make a limited amount of Revocable Health Care Expenditures

Contributions are made within 30 days following the end of a calendar quarter. Upon a termination or separation of employment, your Employer will make a final contribution to your HRA Account for hours worked prior to your termination or separation from employment. This final contribution may be made within 3 days of termination or separation of employment (a "Separation Contribution"), or it may be made during the regular quarterly cycle (a "Post-Separation Contribution"). Please see the Adoption Agreement for which contribution your Employer will make.

Qualifying Expenses

The types of eligible expenses that can be reimbursed from your HRA Account depend upon when your HRA Account was established and when the HRA contribution was made.

Pre-2014 HRA Accounts. If your HRA Account was established prior to January 1, 2014, then for those Employer contributions that are credited for periods on or after January 1, 2014, the following expenses qualifying under Code Section 213(d), can be reimbursed from such post-2013 contributions –

- If your HRA is an Excepted Benefits HRA as set forth in Section 14.a.2. of the Adoption Agreement –
    - Any expense classified by the Claims Administrator as a dental-only or vision-only expense.
    - Any individual insurance premium that is considered a HIPAA excepted benefit as follows –
        - Stand-alone individual dental insurance,
        - Stand-alone individual vision insurance,
        - Non-coordinated, individual insurance coverage for a specific disease or illness (e.g., specific coverage for cancer, hospitalization, etc.), and
        - Non-coordinated, individual insurance coverage that is hospital indemnity or fixed indemnity (e.g., coverage that pays you a certain dollar amount per day of hospitalization).
- If your HRA is an Integrated HRA as set forth in Section 14.a.3. of the Adoption Agreement –
    - Any Code Section 213(d) expense (other than individual insurance premiums and employer group health plan premiums paid on a pre-tax basis), if the integrated group health plan provides minimum value;
    - Only co-payments, co-insurance and deductibles under the applicable employer group health plan, if the plan is not providing minimum value, plus any Code Section 213(d) expenses (other than individual insurance premiums and employer group health plan premiums paid on a pre-tax basis) that are not considered essential health benefits; and/or.
    - If Section 15.a.3. in the Adoption Agreement is checked, then the HRA will reimburse a spouse's employer group health plan premiums, as long as those premiums are paid by the spouse on an after-tax basis.

- If your HRA is a Limited Integrated HRA as set forth in Section 15.b. of the Adoption Agreement, then your HRA will only reimburse the following Code Section 213(d) expenses (to the extent that they are selected in Section 15.b.) –
    - Medical deductibles paid under an applicable employer group health plan,
    - Medical co-insurance paid under an applicable employer group health plan,
    - Medical co-payments paid under an applicable employer group health plan, and/or
    - Pharmacy deductibles, co-insurance and/or co-payments paid under an applicable employer group health plan.

If your HRA Account includes any Employer contributions that were credited for periods prior to January 1, 2014, see the Adoption Agreement for expenses that can be reimbursed from such pre-2014 contributions.

Post-2013 HRA Accounts. If your HRA Account is established on or after January 1, 2014, then the following eligible expenses can be reimbursed from your HRA Account as follows –

- If your HRA is an Excepted Benefits HRA as set forth in Section 14.b.1. of the Adoption Agreement –

- Any expense classified by the Claims Administrator as a dental-only or vision-only expense.
- Any individual insurance premium that is considered a HIPAA excepted benefit as follows –
  - Stand-alone individual dental insurance,
  - Stand-alone individual vision insurance,
  - Non-coordinated, individual insurance coverage for a specific disease or illness (e.g., specific coverage for cancer, hospitalization, etc.), and
  - Non-coordinated, individual insurance coverage that is hospital indemnity or fixed indemnity (e.g., coverage that pays you a certain dollar amount per day of hospitalization).

- If your HRA is an Integrated HRA as set forth in Section 14.b.2. of the Adoption Agreement –
  - Any Code Section 213(d) expense (other than individual insurance premiums and employer group health plan premiums paid on a pre-tax basis), if the integrated group health plan provides minimum value;
  - Only co-payments, co-insurance and deductibles under the applicable employer group health plan, if the plan is not providing minimum value, plus any Code Section 213(d) expenses (other than individual insurance premiums and employer group health plan premiums paid on a pre-tax basis) that are not considered essential health benefits; and/or.
  - If Section 15.a.3. in the Adoption Agreement is checked, then the HRA will reimburse a spouse's employer group health plan premiums, as long as those premiums are paid by the spouse on an after-tax basis.

- If your HRA is a Limited Integrated HRA as set forth in Section 15.b. of the Adoption Agreement, then your HRA will only reimburse the following Code Section 213(d) expenses (to the extent that they are selected in Section 15.b.) –
  - Medical deductibles paid under an applicable employer group health plan,
  - Medical co-insurance paid under an applicable employer group health plan,
  - Medical co-payments paid under an applicable employer group health plan, and/or
  - Pharmacy deductibles, co-insurance and/or co-payments paid under an applicable employer group health plan.

- If your HRA is a QSEHRA as set forth in Section 15.e. of the Adoption Agreement, then your HRA will only reimburse the following –
  - Major medical insurance premiums for you and your eligible spouse and dependents;
  - Other health insurance premiums (such as dental and vision premiums) for you and your eligible spouse and dependents; and
  - Any other Code Section 213(d) expense for you and your eligible spouse and dependents.

  NOTE: You must provide proof of major medical coverage to be reimbursed for <u>any</u> expense listed above. A QSEHRA cannot reimburse employer sponsored group health plan coverage premiums or premium equivalents to the extent the premiums or premium

equivalents were paid on a pre-tax basis. The requirements set forth under the Special Rules for QSEHRA section also apply.

Special Reimbursement Rules

Eligible expenses can be incurred any time after your effective date of Plan participation. You do not have to incur or file claims for eligible expenses within the same or following calendar year. Unused amounts in your HRA Account will not forfeit while you are employed by your employer. Unused amounts in your HRA Account carry forward to subsequent calendar years, but you may not be reimbursed for an amount of eligible expenses that is greater than your HRA Account balance at the time the reimbursement is to be made. Any excess amount of reimbursement will be carried over to the next reimbursement cycle.

For Revocable Health Care Expenditures, if you terminate or separate employment from your Employer, a final run-out period exists during which you can incur and submit your eligible claims. All claims must be incurred and submitted for reimbursement no later than 210 days following your termination or separation from employment. Claims incurred or submitted after the above timeframe will be void and will not be reimbursed. Unused amounts in your HRA Account after the above timeframe will be forfeited. These rules apply without electing COBRA coverage.

For Irrevocable Health Care Expenditures, such contributions will never forfeit and you can continue to be reimbursed from such contributions after termination or separation from employment. COBRA does not apply to Irrevocable Health Care Expenditures, because such contributions never forfeit.

Special Trust Rules

If your Employer is contributing Irrevocable Health Care Expenditures, your Employer is required to retain such contributions in a trust. Your Employer will provide you with documentation that sets forth the trustee's name, address, phone number and any other related information. The Claims Administrator is not responsible for the trust, and provides claim administration only services.

COBRA COVERAGE

If you are employed by an Employer that has 20 or more employees, the following COBRA rules in this section will apply to you. If your Employer has less than 20 employees or your Employer sponsors a QSEHRA, you are not entitled to COBRA coverage and this section of the SPD does not apply to you. Please contact your Employer to determine if the Plan is covered by COBRA. If you are a San Francisco employee, COBRA does not apply to Irrevocable Health Care Expenditures.

GENERAL EXPLANATION OF COBRA RIGHTS

You and your dependents have the option to extend your Plan coverage at group rates in certain instances when coverage would otherwise end (or the cost of coverage would increase). This is

called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. This section gives you a general description of your rights under COBRA.

At the same time, you may have other health coverage options as well. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage, and provide more coverage. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. You can learn more about many of these options at www.healthcare.gov or by calling 1-800-318-2596.

COBRA PARTICIPATION

If one of the circumstances listed in the COBRA continuation chart below causes you or a dependent to lose health coverage, you may continue group health plan coverage for yourself and your dependents if you pay the entire cost of coverage, with an additional 2 percent to cover administrative expenses.

Continued coverage is available for a maximum of 18, 29, or 36 months, depending on the circumstances outlined in the chart. The maximum continuation period if multiple circumstances should occur during the 18-month COBRA period is a total of 36 months. For example, if you terminate your employment and then die, your dependents' coverage may continue for 36 months, as long as COBRA was elected at termination and in effect at your death.

It is the responsibility of you, your spouse, or your dependent children to contact your Employer within 60 days of the event to request an application to continue participation due to your divorce or legal separation or a child no longer qualifying as a dependent. Also, to extend coverage beyond 18 months because of disability, you or your covered dependent must become disabled for Social Security purposes within 60 days of the qualifying event, and notice of the Social Security Administration's determination must be provided both within the initial 18-month period and within 60 days of when the determination is made.

If the disability ceases, notice should be provided within 30 days of the final determination that the disability has ended. You or your dependents must pay the full group rate for continued coverage, with an additional 2 percent for administrative expenses. In addition, if you (or a dependent) are disabled and coverage continues for 29 months, during the 19th through 29th month of COBRA participation, the cost for coverage will be greater than that usually charged for COBRA coverage.

If COBRA is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, coverage and cost will be modified as the Employer makes regular changes to the programs, and you will be given the opportunity to make a new election during annual enrollment or when you have a change in family status (if applicable). Any newly eligible dependents you may have may be covered under the same rules that apply to active employees.

You or your eligible dependents have 60 days after you receive a COBRA notice to elect continued participation under COBRA. An election by you or your spouse to continue coverage will apply to all the qualified beneficiaries losing coverage in the same qualifying event, unless the election specifies otherwise. Once you make your election, you will have up to 45 days to pay any make-up premiums you missed and the monthly premium for the current month. COBRA coverage will be effective the day after the qualifying event.

TERMINATION OF COBRA

COBRA coverage will terminate before the end of the indicated time period if:

- You or your dependent becomes covered under another group healthcare plan after electing COBRA.
- You or certain of your dependents become entitled to Medicare after electing COBRA continuation coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
- If coverage is extended beyond 18 months because of disability, the date a final determination is made that the individual is no longer disabled.
- All health plans for active employees are terminated by your Employer.

COBRA CONTINUATION CHART

CIRCUMSTANCES	MAXIMUM CONTINUATION PERIOD		
	EMPLOYEE	SPOUSE	CHILD
Employee loses coverage because of reduced work hours	18 months	18 months	18 months
Employee terminates for any reason (except gross misconduct)	18 months	18 months	18 months
Employee or covered dependent is disabled (as defined by Title II or XVI of the Social Security Act) during the first 60 days of COBRA coverage	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse legally separate or divorce	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Child no longer qualifies as dependent	N/A	N/A	36 months

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that Employers must meet for certain employees who are involved in the uniformed services. If your coverage under the Plan terminates due to your service in the uniformed services, you may elect special continuation coverage under USERRA for yourself and your covered dependents. Please contact your Employer for additional information if you think these special rules apply to you.

AMENDMENT AND TERMINATION

Your Employer reserves the right to discontinue or terminate the Plan, or to reduce, amend or modify coverage in whole or in part and in any respect. The Claims Administrator also has the right to amend and revise certain provisions of the Plan. This may be done at any time and without advance notice. Benefits for claims occurring after the effective date of a modification or termination are payable in accordance with the revised provisions of the Plan.

All statements in this SPD and all representations by your Employer, the Claims Administrator and their personnel are subject to this right of amendment and termination. This right applies without limitation even after an individual's circumstances have changed by retirement, termination or otherwise. Except for Irrevocable Health Care Expenditures for San Francisco employees, benefits do not become vested at any time.

MISCELLANEOUS

OFFICIAL PLAN INFORMATION

Your Plan coverage is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The official name of the Plan and other related information is located in the Adoption Agreement.

The financial and other records for the Plan are kept on a plan year basis. The Plan Year ends on each December 31, or such other date as set forth in the Adoption Agreement.

PLAN SPONSOR AND PLAN ADMINISTRATOR

The plan sponsor is your Employer. Identifying and contact information for your Employer is located in the Adoption Agreement. The plan administrator is your Employer or other entity as identified in the Adoption Agreement. Contact information for the plan administrator is located in the Adoption Agreement.

AGENT FOR SERVICE OF LEGAL PROCESS

Legal process may be served on your Employer. Identifying and contact information is located in the Adoption Agreement.

THIRD-PARTY ADMINISTRATOR / CLAIMS ADMINISTRATOR

Discovery Benefits, Inc. provides certain third-party administration services related to the Plan. Contact information is as follows –

Discovery Benefits, Inc.
4321 20th Avenue S
Fargo, ND 58103
Phone: (866) 451-3399
Fax: (866) 451-3245
www.discoverybenefits.com

PLAN FUNDING

Contributions for Plan coverage are made by your Employer. Benefits are self-insured and paid out of general assets of your Employer. The Claims Administrator is not responsible for funding or insuring Plan benefits.

If you are a San Francisco employee and your Employer makes Irrevocable Health Care Expenditures, such contributions to the HRA will be held in trust. In that case, your Employer will provide additional documentation with respect to the trust. The Claims Administrator provides claim administration services only, and is not responsible for maintaince of the trust.

NO GUARANTEE OF EMPLOYMENT

Nothing in the Plan or this SPD may or can be interpreted as a guarantee of future employment or continued employment for any duration.

ANTI-ASSIGNMENT RULES

Your rights and benefits under the Plan cannot be assigned, sold or transferred to any person, including your healthcare provider. For this purpose, your Plan rights and benefits, include, without limitation, the right to file an administrative appeal (internal and external), the right to sue following a denied administrative appeal, and any other Plan rights and benefits, whether actual or potential. Any purported assignment of rights and/or benefits under the Plan shall be void and shall not apply to the Plan. Further, a payment or reimbursement of eligible expenses by the Claims Administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

In addition, during a visit to your healthcare provider, your provider may ask you to authorize him / her to receive payments directly for your covered healthcare services. Such authorizations to receive direct payments are not assignments of benefits or rights under the Plan. Further, such authorizations are void and will not apply to the Plan.

Any payments made directly to you of claims for benefits will fulfill the Plan's obligation to make a payment. The Plan is not responsible for paying healthcare provider invoices that are balance-billed to you.

AUTHORIZED REPRESENTATIVE RULES

You may appoint an authorized representative to act on your behalf for purposes of the Plan.

If you need to appoint an authorized representative for any purpose, your appointment of an authorized representative must:

- Be in writing and dated;
- Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative;
- Be signed by you and notarized by a notary public;
- Satisfy any other legal requirement applicable to appointments under state or federal law; and
- Be approved by the Claims Administrator or Plan Administrator (or its delegate) in writing.

The Plan will also recognize a court order appointing a person as your authorized representative. The Claims Administrator or Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys.

Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the Plan and any such appointment (whether pursuant to the rules of a Claims Administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

YOUR RIGHTS UNDER ERISA

This plan is considered a government plan and, therefore, is exempt from ERISA.

The following statement is required by federal law. As a participant in the group health 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 the following rights:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You may examine, without charge, at the Employer's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts 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.

You may obtain, upon written request to the Employer, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Employer may make a reasonable charge for the copies.

You will receive a summary of the plan's annual financial reports. The Employer is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You may continue 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 and the documents governing the plan on the rules governing your COBRA continuation coverage rights and reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 plans. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a plan 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 the plan documents and/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 Employer 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 Employer. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a 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 if, for example, it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about a plan, you should contact your Employer. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your Employer, 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.