WRAP DOCUMENT
AND
SUMMARY PLAN DESCRIPTION
FOR
AMY'S KITCHEN, INC.

RESTATED: 1/1/2021

Amy's Kitchen, Inc.
1650 Corporate Circle
Suite 100
Petaluma, California 94954

TABLE OF CONTENTS

ARTICLE I
INTRODUCTION

This document contains a summary of your rights and benefits under the Amy's Kitchen, Inc. Wrap Plan (the "Plan"). Complete details can be found in the underlying Component Benefit Program documents which govern the operation of the Plan and are available with this document or through the Plan Administrator. In the event of any difference or ambiguity between your rights or benefits described in this document and the underlying Component Benefit Program Plan Document(s), the underlying Component Benefit Program Plan Document(s) will control with regard to the specific benefits provided under the particular plan. For purposes of this document, Component Benefit Programs are those benefit programs, specified in the table below, and contained in the applicable component plan documents. Component Benefit Program documents include certificates of insurance, group insurance contacts, ERISA plan documents (if self-funded) and governing benefit plan documents for non-insurance benefit programs. All such Component Benefit Program Plan Document(s) are incorporate herein by reference. These documents describe the Plan as in effect on January 1, 2021. The Plan may be changed from time to time.

A copy of each certificate, summary or other governing document is included with this document, was previously provided, or can be obtained from the Plan Administrator. Information contained in the underlying Component Benefit Program Plan Document(s) define and govern specific benefits including your rights and obligations for each plan. If you have any questions about this document or the Component Benefit Program Plan Document, use the contact information contained in the table below to request a copy of your Component Benefit Program Plan Document or contact the Administrator of such Component Benefit Program.

Each benefit option is summarized in the Component Benefit Program Plan Document(s) issued by providers, Third Party Administrators, or the Employer. When the Plan refers to these documents, it also refers to any attachments to such contracts, as well as documents incorporated by reference into such contract (such as the application, certificate of insurance, ERISA plan documents and any amendments).

Because the benefits you receive through the Plan will be of importance to you and your family, you should retain this SPD as part of your permanent records. However, remember that it is only a summary. The SPD summarizes who is eligible for benefits and the nature of the benefits available. The SPD does not change the provisions of any benefit plan documents or any legal instrument related to the creation, operation, funding, or benefit payment obligations of the benefit plans.

ERISA STATUS

This Plan Document and Summary Plan Description together with the applicable certificates of insurance, insurance booklets, benefit summaries and/or group insurance contracts constitute the written plan document required by ERISA §402 and summary plan description for the Component Benefit Programs offered under the Amy's Kitchen, Inc. Wrap Plan.

For purposes of submission of Form 5500, this document is considered a "wrap" plan so the report is done on the wrap plan as a whole, not each individual plan.

PLAN ADMINISTRATION

The Administrator shall be responsible for the general administration of the Plan, including the Component Benefit Programs, and shall be the "plan administrator" and "named fiduciary "within the meaning of ERISA under the Plan and the Component Benefit Programs (except to the extent another person or entity is specifically designated in the Governing Documents); provided, however, for Fully Insured Benefit Programs, unless specifically provided otherwise in the Governing Documents, the Insurer shall be the "named fiduciary," and claims fiduciary responsible for administering and determining benefits under such Benefit Program, and shall have full authority and discretion to interpret the terms of the Benefit Program for those purposes. With respect to the Plan, including the Benefit Programs, the Administrator shall have, without limitation, the following discretionary authority, duties and powers:

1. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

2. Except to the extent reserved to the Insurer with respect to a Fully Insured Benefit Program, to interpret the provisions of the Plan, make findings of fact, and correct errors in, supply omissions from, and resolve inconsistencies or ambiguities in the language of the Plan, and to decide all claims and appeals arising under the Plan;

3. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

4. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

5. To allocate and delegate its fiduciary and administrative responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, often the Claims Administrator, any such allocation, delegation, or designation to be in writing. Without limitation, the Administrator may designate other organizations or persons (who also may be employed by an Employer) to carry out the following:

    a. pursuant to an administrative services or claims administration agreement, the responsibility for administering and managing a Benefit Program or Programs, including the processing and payment of claims under the Program and the recordkeeping related thereto;

    b. the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any government agency or to be prepared and disclosed to Employees, Participants or other persons entitled to disclosure under the Benefit Programs; and

    c. the responsibility to review claims or claim denials under the Benefit Programs, including discretionary authority to act as claims fiduciary to determine adverse claims determinations within the meaning of Department of Labor Regulation § 2560.503-1.

Subject to applicable law, any interpretation of the provisions of the Plan and the Component Benefit Programs and any decisions on any matter within the discretion of the Administrator made by the Administrator in good faith shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Administrator shall make such adjustment on account thereof as it considers equitable and practicable. The Administrator shall not be liable in any manner for any determination of fact made in good faith.

For additional information regarding the Plan, you should contact the Help Desk at (707) 787-1597 or refer to the Welfare Program documents and the full insurance contracts. Copies of the documents are available from the Employer on request. If the terms of this SPD conflict with the Plan documents, the Plan documents shall govern.

EXCLUSIVE BENEFIT

All Plan assets shall be used for the exclusive benefit of eligible Employees, their Spouses, their other designated Dependents and their designated beneficiaries, in accordance with the provisions of the Plan, and/or for paying reasonable expenses associated with administering the Plan.

ARTICLE II
GENERAL PLAN INFORMATION

Type of Plan:	Welfare, including the following Welfare Programs: Amy's Kitchen, Inc. Medical Plan, Prescription Drug Plan, Regence Expressions Dental Plan (Oregon), Reliance Standard Dental Plan, VSP Vision Plan, Prudential Group Life Insurance Plan, Prudential Group Accidental Death and Dismemberment Insurance Plan,

	Prudential Group Long-Term Disability Plan, Prudential Short-Term Disability Plan, Health Care Flexible Spending Account, Premium Conversion Plan as enumerated in Appendix A
Plan Name:	Amy's Kitchen, Inc. Employee Benefit Plan (the "Plan")
Plan Number:	502
Plan Year:	The Plan Year is the twelve month period ending December 31.
Plan Sponsor:	Amy's Kitchen, Inc. (the "Employer") 1650 Corporate Circle Suite 100 Petaluma, California 94954 (707) 781-7625 For a list of Participating Employers, please refer to Appendix B.
Plan Sponsor's Employer Identification Number:	68-0154899
Plan Administrator:	Amy's Kitchen, Inc. 1650 Corporate Circle Suite 100 Petaluma, California 94954 (707) 781-7625
Agent for Service of Legal Process:	Amy's Kitchen, Inc. ATTN: Plan Administrator 1650 Corporate Circle Suite 100 Petaluma, California 94954 (707) 781-7625 And Amy's Kitchen, Inc. ATTN: Office of General Counsel 1650 Corporate Circle Suite 100 Petaluma, California 94954 (707) 781-7660 Service of legal process may also be made upon the Plan Administrator.
Plan Administration:	Welfare Programs available under the Plan are administered by providers/insurers from which services or benefits are purchased. Unless otherwise indicated, all benefit plans are administered by the respective insurers or providers who provide and guarantee the benefits. Self-insured or unfunded benefits, if any, are paid from the Employer's general assets.
Claims Administrators:	See chart below and/or the separate summary that may apply to a particular type of coverage.

For Claims On	Claims Administrator Name	Contact
Amy's Kitchen, Inc. Medical Plan	Hawaii Mainland Administrators (HMA)	(833) 396-2697
Prescription Drug Plan	Caremark	(800) 237-2767
Regence Expressions Dental Plan (Oregon)	Regence BCBS of Oregon	(888) 675-6570
Reliance Standard Dental Plan	Reliance Standard	(800) 228-0978
VSP Vision Plan	VSP (Vision Service Plan)	(800) 877-7195
Prudential Group Life Insurance Plan	Prudential Financial	(800) 524-0542
Prudential Group Accidental Death and Dismemberment Insurance Plan	Prudential Financial	(800) 524-0542
Prudential Group Long-Term Disability Plan	Prudential Financial	(800) 524-0542
Prudential Short-Term Disability Plan	Prudential Financial	(800) 524-0542
Health Care Flexible Spending Account	Infinisource Benefit Services	(866) 370-3040

ARTICLE III
ELIGIBILITY, BENEFITS AND CONTRIBUTIONS

An Employee (and his or her Spouse and Dependents, if applicable) is eligible to participate in the Plan only if and to the extent the Participant is eligible with respect to a particular type of coverage under the Plan and the Participant makes the required employee contribution for the coverage selected. The Plan Administrator will inform you of the amount of required employee contributions, if any, for each type of coverage.

In general, the eligibility requirements for each type of coverage include the following:

Amy's Kitchen, Inc. Medical Plan	
Provider or Program Administrator Information	Hawaii Mainland Administrators (HMA) 1600 W. Broadway Rd. Suite 300 Tempe, Arizona 85282 (833) 396-2697 http://www.members.hmatpa.com
Funding Medium	**Self-Insured** – The benefit is self-insured
Eligibility	Generally, employees who work an average of 24 hour(s) per week. Spouse Dependent/Child Domestic Partner
Employees Excluded from Coverage	Not Applicable

Waiting Period	An Employee who has completed 45 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Prescription Drug Plan	
Provider or Program Administrator Information	Caremark P.O. Box 94467 Palatine, Illinois 60094 (800) 237-2767 http://www.caremark.com
Funding Medium	**Self-Insured** – The benefit is self-insured
Eligibility	Generally, employees who work an average of 24 hour(s) per week. Spouse Dependent/Child Domestic Partner
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee who has completed 45 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Regence Expressions Dental Plan (Oregon)	
Provider or Program Administrator Information	Regence BCBS of Oregon P.O. Box 1071 Portland, Oregon 97207 (888) 675-6570 https://www.regence.com
Funding Medium	**Self-Insured** – The benefit is self-insured
Eligibility	Generally, employees who work an average of 24 hour(s) per week. Spouse Dependent/Child Domestic Partner
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee who has completed 45 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Reliance Standard Dental Plan

Provider or Program Administrator Information	Reliance Standard P.O. Box 82510 Lincoln, Nebraska 68501 (800) 228-0978 http://www.reliancestandard.com
Funding Medium	**Self-Insured** – The benefit is self-insured
Eligibility	Generally, employees who work an average of 24 hour(s) per week. Spouse Dependent/Child Domestic Partner
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee who has completed 45 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

VSP Vision Plan	
Provider or Program Administrator Information	VSP (Vision Service Plan) 3333 Quality Drive Rancho Cordova, California 95670 (800) 877-7195 https://vsp.com
Funding Medium	**Self-Insured** – The benefit is self-insured
Eligibility	Generally, employees who work an average of 24 hour(s) per week. Spouse Dependent/Child Domestic Partner
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee who has completed 45 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Prudential Group Life Insurance Plan	
Provider or Program Administrator Information	Prudential Financial 70368 (Contract Number) 751 Broad St Newark, New Jersey 07102 (800) 524-0542 https://www.prudential.com
Funding Medium	**Fully Insured** – The benefit is fully insured by the above named Provider

Eligibility	Generally, employees who work an average of 24 hour(s) per week. Spouse Dependent/Child Domestic Partner
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee who has completed 45 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Prudential Group Accidental Death and Dismemberment Insurance Plan	
Provider or Program Administrator Information	Prudential Financial 70368 (Contract Number) 751 Broad St Newark, New Jersey 07102 (800) 524-0542 https://www.prudential.com
Funding Medium	**Fully Insured** – The benefit is fully insured by the above named Provider
Eligibility	Generally, employees who work an average of 24 hour(s) per week. Spouse Dependent/Child Domestic Partner
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee who has completed 45 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Prudential Group Long-Term Disability Plan	
Provider or Program Administrator Information	Prudential Financial 70368 (Contract Number) 751 Broad St Newark, New Jersey 07102 (800) 524-0542 https://www.prudential.com
Funding Medium	**Fully Insured** – The benefit is fully insured by the above named Provider
Eligibility	Generally, employees who work an average of 24 hour(s) per week.
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee is eligible to participate six months.

Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate the day the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Prudential Short-Term Disability Plan	
Provider or Program Administrator Information	Prudential Financial 70368 (Contract Number) 751 Broad St Newark, New Jersey 07102 (800) 524-0542 https://www.prudential.com
Funding Medium	**Fully Insured** – The benefit is fully insured by the above named Provider
Eligibility	Generally, employees who work an average of 24 hour(s) per week.
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee is eligible to participate six months.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate the day the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Health Care Flexible Spending Account	
Provider or Program Administrator Information	Infinisource Benefit Services 15 E. Washington St., PO Box 889 Coldwater, Michigan 49036 (866) 370-3040 https://www.infinisource.com
Funding Medium	**Self-Insured** – The benefit is self-insured
Eligibility	Generally, employees who work an average of 24 hour(s) per week. Spouse Dependent/Child The above Participants must be eligible to enroll in the Employer's primary group health plan.
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee who has completed 45 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month following or coinciding with the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate on the dayin which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

For all Employees, the Employer uses a special measurement method (called the "look-back" method) to determine whether each Employee has sufficient hours of service to obtain full-time status for purposes of group health plan coverage, based on rules adopted by the Internal Revenue Service to comply with the Patient Protection and Affordable Care Act ("ACA"). Under the look-back method, the Employer calculates the hours of service of each Employee in a

prior period (called the "measurement period") to determine the status of the Employee during a future period (called the "stability period"). The Employer may also utilize an additional time period (called the "administrative period"), between the measurement period and the stability period, to complete administrative functions such as determining which Employees are eligible for coverage and enrolling Employees in coverage. Details regarding each of these periods and the rules for counting hours of service are available upon request to the Plan Administrator. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the applicable Employer Shared Responsibility provisions of the ACA and its accompanying regulations.

Under ERISA, the Plan Administrator of the group health plan may have fiduciary responsibilities regarding distribution of dividends, demutualization and use of the Medical Loss Ratio rebates from group health insurers. Some or all of any rebate may be an asset of the plan, which must be used for the benefit of the participants covered by the policy. Participants should contact the Plan Administrator directly for information on how the rebate will be used.

ENROLLING IN THE PLAN

The Plan Administrator will establish procedures in accordance with each type of coverage for the enrollment of eligible Employees, their Spouses or Dependents, if any, and will communicate these procedures to eligible Employees. The Plan Administrator will prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself, your Spouse or Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Spouse and Dependents in this plan if you or your Spouse or Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Spouse's or Dependents' other coverage). However, you must request enrollment within 30 days after your or your Spouse's or Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Spouse and Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your Spouse or Dependents are eligible, but not enrolled, in the Group Medical Plan listed in Appendix A you may enroll when:

- Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and you request coverage under the Group Medical Plan listed in Appendix A within 60 days after the termination, or
- You or your Spouse or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP and you request coverage under the Group Medical Plan listed in Appendix A within 60 days after eligibility is determined.

The special enrollment rules do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (*e.g.*, spending accounts that limit benefits to employee salary reduction amounts).

To request special enrollment or obtain more information, contact the Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A qualified medical child support order ("QMCSO") is a medical child support order issued under state law that creates or recognizes the existence of an "alternative recipient's" right to receive benefits for which a Member or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a Member (including a child adopted by or placed for adoption with a member in a group health plan) who is recognized under a medical child

support order as having a right to enrollment under a group health plan with respect to such member is an alternate recipient.

With respect to any Component Benefit Program that is a group health plan, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA Section 609(a)). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

In the event the Plan Administrator receives a qualified medical child support order, the Plan Administrator will notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a QMCSO. Within a reasonable period, the Plan Administrator will determine whether the order is a qualified medical child support order and will notify the Participant and alternate recipient of such determination.

BENEFITS

The benefits provided under the Plan for each group or classification of Participants are those set forth in the Plan Documents for the applicable Component Benefit Program.

CONTRIBUTIONS

1. Employer Contributions. For each Plan Year, the Employer shall make such contributions under the Component Benefit Programs in such amounts and at such times as the Employer shall determine are appropriate to fund the Component Benefit Programs.

2. Employee Contributions. As a condition of eligibility under a Component Benefit Program, a Participant may be required to make contributions, in amounts and at times specified by the Employer and the applicable Component Benefit Program, applicable to the coverage option selected and the group or classification of Participants of which such Participant is a member. Such contribution requirements may be adjusted from time to time. Contributions shall be made in such manner as the Administrator shall specify.

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Plan contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You should review the benefits booklets and other relevant materials for further information. You may lose coverage under the Plan if the Employer terminates the Plan or amends it to reduce or eliminate your coverage. You may forfeit the right to benefits if, among other things:

- You revoke your election to participate;
- You terminate employment with the Employer;
- You fail to make required contributions;
- You fail to file benefits claims on a timely basis;
- You make fraudulent benefit claims;
- You cease to be an eligible Employee; or
- The Plan terminates.

ARTICLE IV
PLAN AMENDMENT OR TERMINATION

The Employer expects to maintain the Plan indefinitely but reserves the right to amend, modify or terminate the Plan in any respect, including but not limited to, implementing a change in the amount or percentage of premiums or cost that must be paid by the Member. No Member shall have any vested right to any benefits under the Plan, subject to

any duty to bargain that may exist. The Employer shall have the right to amend the Plan at any time and to any extent deemed necessary or advisable; provided, however, that no amendments shall:

1. Have the effect of discriminatorily depriving, on a retroactive basis, any eligible Employee, dependent or beneficiary of any beneficial interest that has become payable prior to the date such amendment is effective; or
2. Have the result of diverting the assets of the Plan to any purpose other than those set forth in this Plan.

The Plan Administrator may sign insurance contracts for this Plan on behalf of the Employer, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

If you have elected to participate in the Plan, you will be notified in writing if there is any significant amendment or if the Plan is terminated. If the Plan is terminated, the Employer will cease deducting contributions from your salary to pay for Welfare Programs. However, all previous salary deductions will be used to pay for Welfare Programs that you have elected.

ARTICLE V
CLAIMS PROCEDURES

CLAIMS

The following claims procedures shall apply specifically to claims made under any group health plan under this Plan. To the extent that these procedures are inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for the group health plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials shall supersede these procedures as long as such other claims procedures comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, as applicable to the Plan.

SELF-FUNDED CLAIMS PROCEDURES

The specific guidelines for filing a Claim or a request for a review of a denied claim shall be set out in the Plan Document for each Component Benefit Program. Such procedures shall comply with the general provisions of this Article and shall be designed to ensure the independence and impartiality of the persons involved in making decisions on such Claims. A Claimant must follow all internal claims and appeal procedures and, where applicable, all external review procedures, before he or she can file a lawsuit to contest the decision.

DEFINITIONS

For purposes of this Article, the following capitalized terms shall have the meanings set forth below:

"Non-Grandfathered Plan" means a Component Benefit Program that is (1) subject to Title I of the Patient Protection and Affordable Care Act of 2010, as amended, and (2) does not meet the requirements for "grandfathered status" within the meaning of that Act.

"Claimant" means the person who files a Claim or a person who has been authorized by the Claimant to act on his behalf in accordance with the procedures of the Component Benefit Program.

"Claim" means any request for a benefit under a Component Benefit Program, made by a Claimant or his representative, which complies with the reasonable procedures for making benefit Claims under such program.

"Concurrent Care Claim" means a Claim for an ongoing course of treatment to be provided over a period of time or number of treatments. Any reduction or termination by the Component Benefit Program of the course

of treatment (other than by plan amendment or termination) before the end of the period of time or number of treatments originally approved is considered an Adverse Benefit Determination.

"Pre-Service Claim" means any Claim for a benefit under a Component Benefit Program which conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

"Urgent Care Claim" means a Pre-Service Claim for medical care or treatment with respect to which the time frame for a non-urgent care determination could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of the Component Benefit Program applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

"Post-Service Claim" means any Claim that is not a Pre-Service Claim.

"Adverse Benefit Determination" means a total or partial denial of a Claim. For a Non-Grandfathered Plan, a retroactive rescission of coverage due to fraud or misrepresentation shall be treated as an Adverse Benefit Determination.

"Appeal" means a Claimant's written request for review of an Adverse Benefit Determination.

"Final Adverse Benefit Determination" means an Adverse Benefit Determination issued in connection with the last stage of Appeal.

NOTICE TO CLAIMANT OF ADVERSE BENEFIT DETERMINATIONS.

a. Initial Claims. Except with respect to Urgent Care Claims (the notification for which may be oral followed by written or electronic notification within three days of the oral notification), upon its initial determination of a Claim, the Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the Claimant:

1. The specific reason or reasons for the adverse determination, including, for Non-Grandfathered Plans, the denial code and its corresponding meaning, and a description of the Non-Grandfathered Plan's standard, if any, that was used in denying the Claim.

2. Reference to the specific Component Benefit Program provisions on which the determination 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 Component Benefit Program's Appeal procedures including any voluntary appeal procedures offered by the Component Benefit Program and, for Non-Grandfathered Plans, any external review procedures, and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under ERISA §502.

5. If the Adverse Benefit Determination 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, or a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy 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 or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Component Benefit Program to the Claimant's medical circumstances, will be provided, or a statement will be included that such explanation will be provided free of charge, upon request.

7. For Non-Grandfathered Plans, information sufficient to allow the Claimant to identify the Claim involved (including date of service, the healthcare provider and the Claim amount, if applicable, and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the Claimant as soon as feasible upon request).

8. For Non-Grandfathered Plans, information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals procedures and external review process

    a. Appeals. The Administrator shall also provide written or electronic notice of an Adverse Benefit Determination on Appeal. This notice shall contain the information listed in subsections (a)(i) through (viii), as well as:

9. 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.

10. In the case of a Final Adverse Benefit Determination for a Non-Grandfathered Plan, a discussion of the decision.

CLAIMS PROCEDURE FOR BENEFITS BASED ON DETERMINATION OF DISABILITY

The following claims procedure shall apply specifically to claims made under the Plan for benefits based on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for such plans, the claims procedure in the other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulations.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification regarding the claim denial. This claim denial will include the reasons for the denial, reference to the Plan provision supporting the denial, and a description of the Plan's appeals procedures. The discussion of the claim denial will also include:

- if applicable, an explanation for disagreeing with or not following the views of health care professionals or vocational experts, or with a disability benefit determination made by the Social Security Administration;
- the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim (or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist); and
- 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, if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances (or a statement that such explanation will be provided free of charge upon request).

You will receive a benefit denial notice within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it

cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

You have 180 days to appeal an adverse benefit determination. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits. You will be notified of the Claims Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request.

The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

BENEFIT DETERMINATIONS

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the group health plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

How to Appeal a Claim Decision

When a Claimant receives an Adverse Benefit Determination, the Claimant has 180 days following receipt of the notification in which to request a review of the decision unless a shorter time is permitted by law. You can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider's name.
- The reason(s) you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal,

you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

PROVIDER RECONSIDERATION REQUEST

When a Provider receives a copy of an Adverse Benefit Determination related to a Claim, the Provider may request a reconsideration of the decision. The request must be in writing and must be sent to the Claims Administrator within 180 days after the date of the Adverse Benefit Determination. The request must include the claim number, the reason for the request (i.e., an explanation of why the provider thinks the claim was processed incorrectly), and supporting documentation that was not included with the initial claim submission. Provider reconsideration requests sent later than 180 days after the date of the determination will not be considered. A Provider does not have the same rights as a Member and Providers are not Authorized Representatives of Members unless specifically appointed in writing. However, Providers will be allowed to exhaust the internal claims procedures under the terms of this Plan on behalf of a Member without the appointment as the Member's Authorized Representative. The Provider shall not, under any circumstances have the right to sue the Plan.

APPEALS DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

External Review

If you exhaust all internal appeals procedures, a Claimant may request that the Claim be reviewed under the Non-Grandfathered Plan's external review process. The Non-Grandfathered Plan shall comply with the applicable State external review process, if any, and if none, the federal external review process. If the federal external review process applies, the following guidelines shall apply.

The Claimant must file his request for external review within 4 months after receipt of the Final Adverse Benefit Determination.

The Administrator will determine whether the Claim is eligible for review under the external review process. This determination is based on whether:

1. The Claimant is or was covered under the Non-Grandfathered Plan at the time the Claim was made or incurred;
2. The denial relates to the Claimant's failure to meet the Non-Grandfathered Plan's eligibility requirements;
3. The Claimant has exhausted the Non-Grandfathered Plan's internal claims and appeal procedures; and
4. The Claimant has provided all the information required to process an external review.

Within one business day after completion of this preliminary review, the Administrator will provide written notification to the Claimant of whether the claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Administrator will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll-free number.

If the request is not complete, the notice will describe the information needed to complete it. The Claimant will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the external review process, the Administrator will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for external review has been accepted. The notice should include a statement that the Claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. the IRO will share this information with the Non-Grandfathered Plan. The Non-Grandfathered Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the external review process will end.

If the Non-Grandfathered Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

1. The Claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;
4. The terms of the Non-Grandfathered Plan;
5. Appropriate practice guidelines;
6. Any applicable clinical review criteria developed and used by the plan; and
7. The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Non-Grandfathered Plan and the Claimant of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain

1. A general description of the reason for the external review, including information sufficient to identify the claim;
2. The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
3. References to the evidence or documentation the IRO considered in reaching its decision;
4. A discussion of the principal reason(s) for the IRO's decision;

5. A statement that the determination is binding, and that judicial review may be available to the Claimant; and
6. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under federal guidelines.

Generally, a Claimant must exhaust the Non-Grandfathered Plan's claims and appeal procedures in order to be eligible for the external review process. However, an expedited external review is available if

1. The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Non-Grandfathered Plan's internal claims and appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

2. The Claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Non-Grandfathered Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external re0view listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Claimant and the Non-Grandfathered Plan.

FULLY INSURED CLAIMS PROCEDURE

The specific guidelines for filing a claim or a request for a review of a denied claim shall be set out in the Plan Document for each Component Benefit Program. To the extent a claim involves a claim for disability benefits, such procedures shall comply with the general provisions of this Section. A Claimant must follow all internal claims and appeal procedures before he can file a lawsuit to contest the decision.

ESTOPPEL

No person is entitled to any benefit under the Plan except and to the extent expressly provided under the terms and conditions of the applicable Component Benefit Program. The fact that payments have been made from the Plan in connection with any claim for benefits does not (a) establish the validity of the claim; (b) provide any right to have such benefits continue for any period of time; or (c) prevent the Plan from recovering the benefits paid to the extent that the Administrator determines that there was no right to payment of the benefits under the Plan. Thus, if a benefit is paid and it is thereafter determined that such benefit should not have been paid (whether or not attributable to an error by the Participant or any other person), then the Administrator may take such action as it deems necessary or appropriate to remedy such situation, including without limitation, by deducting the amount of any overpayment theretofore made to or on behalf of such Participant from any succeeding payments to or on behalf of such Participant under the Plan or from any amounts due or owing to such Participant by the Employer or under any other plan, program or arrangement benefiting the Employees or former Employees of the Employer, or otherwise recovering such overpayment from whomever has benefited from it.

If the Administrator determines that an underpayment of benefits has been made, then the Administrator shall take such action as it deems necessary or appropriate to remedy such situation.

ARTICLE VI
MISCELLANEOUS PROVISIONS

INFORMATION TO BE FURNISHED BY MEMBERS

Member's under the Plan must furnish the Plan Administrator with such evidence, data or information as the Administrator considers necessary or desirable to administer the Plan and the Component Benefit Programs. A fraudulent or knowing misstatement or omission of fact made by a Member or dependent in an enrollment form, a claim for benefits or similar manner may result in cancellation of coverage and/or denial of claims for benefits.

RECORDS

As a condition of receiving benefits payable under a Component Benefit Program, a Participant may be required to provide the Administrator with any evidence and records of expenses incurred by such Participant and each of such Participant's Dependents in such form as the Administrator shall from time to time specify.

UNIFORM RULES

The Plan Administrator shall administer all Component Benefit Programs on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons in similar situations.

WAIVER OF NOTICE

Any notice required under the Plan or a Component Benefit Program may be waived by the person entitled to such notice.

GENDER AND NUMBER

Where the context permits, words in the masculine gender shall include the feminine and neuter genders, the singular shall include the plural, and the plural shall include the singular.

CONTROLLING LAW

Except to the extent superseded by ERISA and other applicable laws of the United States or inconsistent with the terms of the underlying Component Benefit Program Plan Document, the laws of the state of Texas shall be controlling in all matters relating to the Plan

INTERESTS NOT TRANSFERABLE

Except as otherwise expressly permitted by a Component Benefit Program or as may be required by the tax withholding provisions of the Internal Revenue Code or any state's income tax act, benefits under the Plan and the Component Benefit Programs are not in any way subject to the debts or other obligations of the persons entitled thereto and may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered. Any attempt to accomplish the same is void. If the Plan Administrator finds that such an attempt has been made, it may, in its sole discretion, elect to pay the benefits due the Participant to the Participant's Spouse, parent, adult child, legal guardian of a minor child, sibling or other relative. Any such payment constitutes a complete discharge of the liability of the Plan, the Administrator and Employer with respect to such benefits.

FACILITY OF PAYMENT

When any person entitled to benefits under the Plan or a Component Benefit Program is under legal disability or in the Plan Administrator's opinion is in any way incapacitated so as to be unable to manage his or her affairs, the Plan Administrator, in its sole discretion, may cause such person's benefits to be paid to such person's legal representative

for his or her benefit, or to be applied for the benefit of such person in any other manner that the Administrator may determine. Such payment shall constitute a full discharge of liability of the Plan, the Component Benefit Programs, the Administrator and Employer for such benefits.

NO VESTED INTEREST

No person shall have any right, title or interest in or to any contributions made under the Plan and the Component Benefit Programs, such contributions being made for the sole purpose of providing benefits under the Programs in accordance with their terms. Neither the Employer nor the Plan Administrator shall in any way guarantee the payment of any benefit that may be or become due to any person under the Plan or the Component Benefit Programs.

NO GUARANTEE OF EMPLOYMENT

The Plan is not an employment contract. Nothing contained in this document nor the benefits booklet gives you the right to be retained in the service of the Employer or interferes with the right of the Employer to discharge you or to terminate your service at any time.

COST OF PLAN AND PROGRAM ADMINISTRATION

The costs and expenses incurred in the administration of the Plan and the Component Benefit Programs shall be paid, in the discretion of the Plan Administrator, (i) from assets accumulated under the Plan and the Component Benefit Programs, if any; (ii) from Employee contributions; and/or (iii) by the Employer in such proportion as the Administrator shall determine.

EVIDENCE

Evidence required of anyone under the Plan and the Component Benefit Programs may be by certificate, affidavit, document or other information which the Administrator considers pertinent and reliable, and signed, made or presented by the proper party or parties.

PHYSICAL EXAMINATION AND AUTOPSY

In addition to any rights and privileges granted under a Component Benefit Program, the Administrator, at its own expense, shall have the right and opportunity to have a physician, designated by the Administrator, examine any individual whose injury or sickness is the basis of a claim under the Plan and the Component Benefit Programs, when and as often as it may reasonably require during the pendency of a claim or any period of benefits under the Plan and the Component Benefit Programs and to make an autopsy in case of death, provided it is not otherwise prohibited by law. Notwithstanding the foregoing, neither the Plan nor the Component Benefit Programs shall request or require an individual to undergo a genetic test.

RECOVERY OF BENEFITS

If, because of fraud, mistake or any other reason, a person receives a benefit payment under the Plan and the Component Benefit Programs that exceeds the benefit payment that should have been made, the Administrator shall have the right to recover the amount of such excess from such person. The Plan Administrator may, however, at its option, deduct the amount of such excess from any subsequent benefits payable to, or for, the Participant or such Participant's Dependents to whom or on whose behalf the excess payment was made.

LAWSUITS CONCERNING BENEFITS

No lawsuit may be brought by any person or entity to recover benefits under the Plan more than one year from the date Plan benefits are finally denied.

WORKERS' COMPENSATION NOT AFFECTED

The Plan is not in lieu of, and does not affect any requirement for, coverage under Workers' Compensation.

SEVERABILITY

In case any provisions of the Plan or any Component Benefit Program shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan or any Component Benefit Program, and the Plan and all Component Benefit Programs shall be construed and enforced as if such illegal and invalid provisions had never been set forth in the Plan or Component Benefit Program.

FAILURE TO ENFORCE

Failure to enforce any provision of the Plan shall not affect the Employer's or Plan Administrator's right thereafter to enforce such provision, nor shall such a failure affect the Employer's or Administrator's right to enforce any other provision of the Plan.

INDEMNIFICATION

In addition to whatever rights of indemnification the members of the board of directors of the Employer or any Employee or Employees of the Employer to whom any power, authority, or responsibility is delegated pursuant to this Plan or any Component Benefit Program, may be entitled under the articles of incorporation, by-laws or regulations of the Employer, under any provision of law, or under any other agreement, the Employer shall satisfy any liability actually and reasonably incurred by any such person or persons, including expenses, attorneys' fees, judgments, fines, and amounts paid in settlement (other than amounts paid in settlement not approved by the Employer in connection with any threats and pending or completed action, suit, or proceeding that is related to the exercising or failure to exercise by such person or persons of any of the powers, authority, responsibilities, or discretion as provided under the Plan or a Component Benefit Program, or reasonably believed by such person or persons to be provided hereunder, and any action taken by such person or persons in connection therewith) unless the same is judicially determined to be the result of such person or persons' gross negligence or willful misconduct.

NO GUARANTEE OF TAX CONSEQUENCES

Notwithstanding any provision in the Plan (including the Component Benefit Programs) to the contrary, neither the Plan nor the Employer make any commitment or guarantee that any amounts paid to or on behalf of an Employee or dependent under the Plan will be excludable from the Employee's gross income for federal or state income tax purposes.

RESPONSIBILITY FOR GOODS OR SERVICES

The Employer does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program because these goods and services are provided by personnel and agencies outside of the control of the Employer.

DATA

Participants who may receive benefits under the Plan must furnish the Employer or its designated representatives such documents, evidence, information, releases or authorizations, as it considers necessary or desirable for the purpose of administering the Plan, or to protect the Employer. It shall be a condition of the Plan that each such person must furnish such information promptly and sign such documents as the Employer may require before any benefits become payable under the Plan.

ELECTRONIC COMMUNICATIONS

Whenever an Employee, Member, spouse, other dependent or beneficiary is required to provide information or perform a written process, the Plan Administrator may, in its discretion, permit or require that electronic means be

used. In addition, meetings with the Plan Administrator may be held in person or through electronic or telephonic means or a combination thereof and written actions of the Plan Administrator may be taken using electronic or conventional means. In the use of electronic communication, the Plan Administrator shall follow all guidelines published by the Department of Labor and the Internal Revenue Service.

NON-ASSIGNABILITY AND SPENDTHRIFT CLAUSE

To the extent permitted by law, the benefits or payments under the Plan will not be subject to alienation, sale, assignment, pledge, attachment, garnishment, execution, encumbrance or other transfer, nor will they be subject to any claim by any creditor of any Member under the Plan other than a physician or treatment facility so authorized by the Participant or to legal process by any creditor of any Member (except in the case of death or obligations owed to the Employer). Any attempt to circumvent these provisions shall be considered null and void.

EFFECT OF MISTAKES

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Member, or the amount of distributions made or to be made to a Member or other person, the Plan Administrator will, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Member or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due the Plan or the Employer from compensation paid by the Employer.

COMPLIANCE WITH STATE AND FEDERAL MANDATES

The Plan, including the Component Benefit Programs, will comply to the extent applicable with the requirements of all applicable state and federal laws, including but not limited to USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, GINA and PPACA.

ARTICLE VII
HIPAA PRIVACY AND SECURITY

If a Component Benefit Program is not exempted from the requirements of the Privacy Standards and the Security Standards, then this Section shall apply.

DISCRIMINATION BASED ON HEALTH-RELATED FACTORS PROHIBITED

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits health plans from discriminating against any participant or dependent in terms of eligibility to participate in the Plan based on a health-related factor. Accordingly, benefits provided under your Plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The Plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

HIPAA PRIVACY AND SECURITY STANDARDS

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

1. The Plan shall not disclose Protected Health Information to any member of an Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information

about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment. "Protected Health Information" shall include "genetic information," as defined in the Privacy Standards. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan treatment, payment functions and health care operations. The terms "treatment," "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" shall include activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information shall not be used or disclosed for "underwriting" purposes, as defined in the Privacy Standards.

3. The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

    a. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
    b. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

        i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
        ii. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
        iii. mitigation of any harm caused by the breach, to the extent practicable; and
        iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

4. The Employer agrees to:

    a. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

    b. Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan;

    c. Ensure that any agent or subcontractor, (i) to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information, and/or (ii) to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information;

    d. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

e. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

f. Make available Protected Health Information to individual Plan members as required by Section 164.524 of the Privacy Standards;

g. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information as required by Section 164.526 of the Privacy Standards;

h. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members as required by Section 164.528 of the Privacy Standards;

i. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

j. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

k. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above, and to use reasonable and appropriate security measures to comply with this provision.

ARTICLE VIII
OTHER PROVISIONS

MEDICAID

If a Component Benefit Program is subject to ERISA § 609(b), then this Section shall apply.

Payment for benefits with respect to a Participant under a Component Benefit Program will be made in accordance with any assignment of rights made by or on behalf of such Participant or a beneficiary of the Participant as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

The fact that a Participant is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account in enrolling such Participant or in determining or making benefit payments for such Participant.

To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act in any case in which a Component Benefit Program has a legal liability to make payment for items or services constituting such assistance, payment for benefits under such program will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

FAMILY AND MEDICAL LEAVE ACT

If an Employer is subject to the Family and Medical Leave Act of 1993, as amended (FMLA), then this Section shall apply. A Participant who is on an approved leave of absence under the FMLA shall be entitled to continue his or her

participation in the Component Benefit Programs during such leave to the extent required by and in accordance with the FMLA, applicable regulations, and the Component Benefit Program as well as this Plan.

COBRA CONTINUATION COVERAGE

If the Component Benefit Program is not exempted from the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), and the regulations thereunder, the Component Benefit Program shall be operated in accordance with such requirements, as set out in the Plan Documents of such Component Benefit Program.

UNIFORMED SERVICES REEMPLOYMENT RIGHTS (USERRA)

If a Component Benefit Program is not exempted from the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA) and the regulations thereunder, the Component Benefit Program shall be operated in accordance with such requirements. This Plan shall be interpreted to comply with USERRA and any pertinent regulations. USERRA provisions may vary slightly among the various Component Benefit Programs. To the extent consistent with applicable law, the specific USERRA provisions in any Component Benefit Program shall govern over the terms of this Section.
Unless otherwise specifically provided in the applicable Governing Documents:

1. a Participant must notify the Employer of his intention to elect USERRA continuation of coverage prior to the expiration of the COBRA election period provided under the Component Benefit Program; and
2. any period of USERRA continuation of coverage shall run concurrently with COBRA continuation coverage.

COVERAGE OF DEPENDENT CHILDREN IN CASE OF ADOPTION

If a Component Benefit Program is subject to ERISA § 609(c), then this Section shall apply.

1. With respect to any such Component Benefit Program that provides coverage for the dependent children of Employees, such Component Benefit Program shall provide benefits to dependent children placed with an Employee for adoption (as defined by ERISA § 609(c)) under the same terms and conditions as apply to the natural children of the Employee, irrespective of whether the adoption has become final.

2. Such Component Benefit Program shall not restrict coverage of a child adopted or placed for adoption by an Employee, solely on the basis of a preexisting condition of such child at the time such child would otherwise become eligible for coverage under the Component Benefit Program, if the adoption or placement for adoption occurs while the Employee is eligible for coverage under the Component Benefit Program.

HIPAA PORTABILITY AND NONDISCRIMINATION REQUIREMENTS

If a Component Benefit Program is not exempted under ERISA § 732 from the HIPAA portability and nondiscrimination requirements as set out in ERISA §§ 701 through 703 and the regulations thereunder, the Component Benefit Program shall be operated in accordance with such requirements.

A Component Benefit Program shall be operated in accordance with the provisions of ERISA § 702 which restrict the use and collection of genetic information and the requirement or request for genetic testing.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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 attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a

provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)

If a Component Benefit Program is subject to ERISA § 712, then the terms of this Section shall apply.

A Component Benefit Program that provides both medical and surgical benefits and mental health and/or substance abuse benefits shall not impose any limits on mental health or substance abuse benefits that violate the requirements of ERISA § 712.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If a Component Benefit Program is subject to ERISA § 713 and provides medical and surgical benefits with respect to a mastectomy or lumpectomy, then this Section shall apply.

Such Component Benefit Program shall, with respect to a Participant who is receiving benefits in connection with a mastectomy or lumpectomy, and who elects breast reconstruction in connection with such mastectomy or lumpectomy, provide coverage for the following (subject to applicable deductibles, co-payments and other Component Benefit Program limitations):

1. Reconstruction of the breast on which the mastectomy or lumpectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications for all stages of mastectomy or lumpectomy, including lymphedemas;

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

ARTICLE IX
STATEMENT OF ERISA RIGHTS

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants 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 Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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.

ARTICLE X
SUBROGATION AND THIRD PARTY RECOVERY

SUBROGATION AND RECOVERY

If a Participant incurs covered expenses or receives benefits under a Component Benefit Program with respect to an injury or illness for which a third party (or its insurer) may be liable, the Plan retains all rights of subrogation, recovery and reimbursement as set out more specifically in the Plan Document(s) for each Component Benefit Program.

COORDINATION OF BENEFITS

When a Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received. The terms shall apply, except to the extent specifically provided otherwise in the Plan Document(s) of a Component Benefit Program.

The plan that pays first according to the rules will pay as if there were no other plan involved. If this Plan is secondary or subsequent, it will pay the amount it would have otherwise paid, minus whatever the primary plan paid, so that benefits are not duplicated. The total reimbursement will never be more than the amount that would have been paid if this Plan had been the primary plan.

BENEFIT PLAN

This provision will coordinate the health benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.

2. Blue Cross and Blue Shield group plans.

3. Group practice and other group prepayment plans.

4. Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms and applicable law, does not allow coordination.

6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

ALLOWABLE CHARGE

For a charge to be an Allowable Charge it must be a usual and reasonable charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in- network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Participant does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Participant used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

BENEFIT PLAN PAYMENT ORDER

When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:

    a. The benefits of the plan which covers the person directly (that is, as an employee, Spouse, or Dependent) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

    b. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

    c. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those benefits of a benefit plan which covers that person as a laid-off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

    d. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

    e. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

        i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

        ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

    f. When a child's parents are divorced or legally separated, these rules will apply:

        i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

        ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered next. The benefit plan of the stepparent without custody will be considered last.

        iii. This rule will be in place of clauses (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

        iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

g. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

5. The Plan will pay primary to any governmental plan to the extent required by federal law.

CLAIMS DETERMINATION PERIOD

Benefits will be coordinated on a yearly basis. This is called the Claims Determination Period.

RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION

This Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Participant must give this Plan the information it asks for about other plans and their payment of Allowable Charges.

FACILITY OF PAYMENT

This Plan may repay other plans for benefits paid that the Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

RIGHT OF RECOVERY

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

APPENDIX A
AMY'S KITCHEN EMPLOYEE BENEFIT PLAN

WELFARE PROGRAMS

The following Welfare Programs shall be treated as comprising the Plan:
Amy's Kitchen, Inc. Medical Plan
Prescription Drug Plan
Regence Blue Cross Blue Shield Expressions Dental Plan (Oregon)
Reliance Standard Dental Plan
Vision Service Plan (VSP) Vision Plan
Prudential Group Life Insurance Plan
Prudential Group Accidental Death and Dismemberment Insurance Plan
Prudential Group Long-Term Disability Plan
Prudential Short-Term Disability Plan
Health Care Flexible Spending Account

APPENDIX B
ADDITIONAL REQUIRED PLAN NOTICES ENCLOSURES

Employer's Children's Health Insurance Program (CHIP)
Notice Health Insurance Exchange Notice
Medicare Part D Creditable Coverage Notice
Notice of Privacy Practices
Wellness Program

Employer's Children's Health Insurance Program (CHIP) Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility —

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

	Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Health Insurance Exchange Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact:

Amy's Benefits Help Desk
1650 Corporate Circle, Suite 100
Petaluma, California 94954
(707) 787-1597
benefitshelp@amys.com

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Amy's Kitchen, Inc.	4. Employer Identification Number (EIN) 68-0154899	
5. Employer address 1650 Corporate Circle, Suite 200	6. Employer phone number (707) 787-1597	
7. City Petaluma	8. State California	9. ZIP code 94954
10. Who can we contact about employee health coverage at this job? Carme Lewis		
11. Phone number (707) 787-1597	12. Email address carme.lewis@amys.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  ☑ Some employees. Eligible employees are:
  All active employees of Amy's Kitchen, working an average of 24 or more hours per week

- With respect to dependents:
  ☑ We do offer coverage. Eligible dependents are: Spouse Domestic Partner Children to age 26 Children over the age of 26, who was covered under the plan prior to turning 26, that are incapable of self-support due to a physical or mental disability

  If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Medicare Part D Creditable Coverage Notice

Important Notice from Amy's Kitchen, Inc. About Your Prescription Drug Coverage and Medicare
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Amy's Kitchen, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Amy's Kitchen, Inc. has determined that the prescription drug coverage offered by the Amy's Kitchen, Inc. Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Amy's Kitchen, Inc. coverage will be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Amy's Kitchen, Inc. coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Amy's Kitchen, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information call Carme Lewis at (707) 781-7625. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Amy's Kitchen, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 1/1/2021

Name of Entity/Sender: Amy's Kitchen, Inc.

Contact--Position/Office: Plan Administrator

Address: 1650 Corporate Circle, Suite 100, Petaluma, California 94954

Phone Number: (707) 787-1597

Notice of Privacy Practices

Amy's Kitchen, Inc.
1650 Corporate Circle, Suite 100
Petaluma, California 94954
(707) 787-1597
benefits.filice.com/amys

Privacy Official:

Carme Lewis
1650 Corporate Circle, Suite 100
Petaluma, California 94954
(707) 781-7625
carme.lewis@amys.com

Effective Date: 01/01/2021

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- Get a copy of your health and claims records;
- Correct your health and claims records;
- Request confidential communication;
- Ask us to limit the information we share;
- Get a list of those with whom we've shared your information;
- Get a copy of this privacy notice;
- Choose someone to act for you; and
- File a complaint if you believe your privacy rights have been violated.

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends;
- Provide disaster relief; and
- Market our services and sell your information.

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive;
- Run our organization;
- Pay for your health services;
- Administer your health plan;
- Help with public health and safety issues;
- Do research;
- Comply with the law;
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director;
- Address workers' compensation, law enforcement, and other government requests; and
- Respond to lawsuits and legal actions.

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Carme Lewis
  1650 Corporate Circle, Suite 100
  Petaluma, California 94954
  (707) 781-7625
  carme.lewis@amys.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

- For workers' compensation claims

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

WELLNESS PLAN

Your Employer is committed to helping you achieve your best health. Therefore, we have instituted a wellness plan to improve and promote your health and fitness. The completion of some of the programs in the wellness plan may result in rewards, such as a reduction in health plan contribution costs for you and, if participating in the wellness program, for your spouse.

If you think you might be unable to meet a standard for a reward under a particular wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Plan Administrator at (707) 781-7625 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you.

For further information regarding the wellness plan, please contact the Plan Administrator or refer to your benefit plan component documents. Below is a description of the wellness plan (also referred to as "wellness program") offered through Amy's Kitchen.

Annual Preventive Exam Wellness Program – Amy's Kitchen offers a significant financial incentive for participation in the companywide Healthy Living Wellness Program ("wellness program"). Employees, spouses, and domestic partners covered by the Amy's Open Access Plan are eligible to participate. Between December 1and November 30, an annual physical exam with basic metabolic blood panel and submit a completed affidavit by November 30 to HMA will receive full deductible credit towards their medical plan deductible for the following plan year.

- Employees enrolled in employee-only coverage who complete the wellness program are eligible to receive $1,500 in deductible credit.
- Employees enrolled in Employee + Child(ren) coverage in who complete the wellness program are eligible to receive $3,000 in deductible credit.
- Employees enrolled in Employee + Spouse/Domestic Partner or Employee + Family coverage who complete the wellness program are eligible to receive $1,500 deductible credit, and

spouses or domestic partners enrolled in the Employee + Spouse/Domestic Partner or Employee + Family coverage who complete the wellness program are eligible to receive $1,500 in deductible credit for a total of $3,000 in deductible credit.

Employees initially eligible for benefits on or after September 1 will automatically receive full deductible credit for the plan year immediately following but will need to participate in the wellness program that begins immediately following their date of eligibility for benefits to receive deductible credit for the associated plan year.

Preventive Care Exam is an affidavit form only. No personal health information is collected for determination of wellness program participation or incentives.