CATHOLIC HEALTH SERVICES OF LONG ISLAND
HEALTH & WELFARE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

Effective October 1, 2024

ABOUT THIS SUMMARY

The following is a summary of some of the principal features of the Catholic Health Services of Long Island Health & Welfare Benefits Plan (the "Plan"). We urge you to read this summary carefully.

This summary is the "Summary Plan Description" for the Plan and is meant to summarize the Plan in easy-to-understand language. However, in the event of any ambiguity or any inconsistency between this Summary Plan Description and any formal Plan documents, the Plan documents will control.

Copies of the formal Plan documents for the Plan are on file at Catholic Health Services of Long Island, Inc. d/b/a Catholic Health ("Catholic Health") and are available to you for inspection at a time and place mutually agreeable to you and to Catholic Health.

If anything in this Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator.

When this Summary Plan Description uses the term "Plan Sponsor", it is referring to Catholic Health, which sponsors the Plan. When this Summary Plan Description uses the term "Employer", it is referring to all of the Plan's participating Employers, which, effective January 1, 2024, includes the Plan Sponsor and Good Samaritan Hospital, Mercy Hospital, St. Catherine of Siena Hospital, St. Charles Hospital, St. Francis Hospital & Heart Center ®, St. Joseph Hospital, Catholic Health Services, Inc., Good Samaritan Nursing Home, St. Catherine of Siena Nursing Home, Our Lady of Consolation Nursing and Rehabilitative Care Center, Good Shepherd Hospice and Catholic Home Care. To determine whether your employer is a participating Employer in the Plan on any given date, contact the Plan Administrator at the address provided later in this Summary Plan Description.

Finally, please note this Plan is intended to qualify as a "church plan" under the Internal Revenue Code and the Employee Retirement Income Security Act ("ERISA"). However, the Plan has made an election to be subject to those provisions of ERISA that would otherwise not apply to a church plan. This means you are entitled to certain additional rights and benefits under ERISA, as described in this Summary. Note that the Plan continues to be administered consistent with the tenets of the Catholic Faith. Therefore, the Plan will not cover any costs or benefits that do not comply with the Ethical and Religious Directives of the Catholic Church.

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Name of Plan

Catholic Health Services of Long Island Health & Welfare Benefits Plan

Name and Business Address of Plan Sponsor

Catholic Health Services of Long Island, Inc.
d/b/a Catholic Health
992 N. Village Ave
Rockville Centre, NY 11570

Plan Sponsor's Taxpayer Identification Number

11-3403968

Plan Number

501

Type of Administration

The Plan is administered by the Plan Administrator. Please note that participant benefit accounts under the Plan are merely bookkeeping entries, no assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. Some benefits may be provided through insurance contracts. To the extent that any benefits are not provided through insurance contracts, they are paid from the Employer's general assets.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's discretionary authority includes but is not limited to, discretionary authority to interpret plan provisions and to make all determinations of facts, including factual determinations relating to eligibility for benefits, and to make all determinations that require application of facts to the terms of the Plan. The Plan Administrator's determinations shall be given deference and are final and binding on all interested parties. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Health Coverage Insurance and Funding Information

Empire BlueCross BlueShield, P.O. Box 1407, Church Street Station, New York, New York 10008-1407, is the claims processor of your medical benefits under the Plan, and Elixir, 2181 East Aurora Road, Suite 201, Twinsburg, Ohio 44087 is the claims processor of your prescription drug benefits under the Plan. If you are enrolled in the medical/prescription drug/vision component plan, you will also receive basic vision coverage. For all eligible employees other than St. Catherine's AFT Union and St. Catherine's New York State Nurses Association ("NYSNA") Union employees, Empire Blue View Vision, PO Box 8504, Mason, OH 45040-7111 is the claims processor of your basic vision benefits under the Plan.

If you are a St. Catherine's AFT Union or St. Catherine's NYSNA Union employee, Davis Vision by MetLife, 200 Park Avenue, New York, New York 10166 is the insurer and claims processor of your basic vision benefits under the Plan.

The Plan's medical, prescription drug and basic vision (for all employees other than St. Catherine's AFT Union and NYSNA Union employees) benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance carrier. The Plan's basic vision benefits provided to St. Catherine's AFT Union and St. Catherine's NYSNA Union employees are fully guaranteed under the policy of insurance issued by Davis Vision by MetLife.

Cigna Dental, P.O. Box 188037, Chattanooga, Tennessee 37422-8037, is the insurer and claims processor of your dental benefits under the Plan. The Plan's dental benefits are fully guaranteed under the policy of insurance issued by this company.

If you have purchased additional vision coverage under the Plan (in addition to the benefits that may be provided under your medical/prescription drug/vision plan), Davis Vision by MetLife, 200 Park Avenue, New York, New York 10166 is the insurer and claims processor of your supplemental vision benefits under the Plan. The Plan's supplemental vision benefits are fully guaranteed under the policy of insurance issued by this company.

Reliastar Life Insurance Company of New York (Voya Financial), 20 Washington Avenue South, Minneapolis, Minnesota 55401, is the insurer and claims processor of your life, supplemental life and dependent life insurance benefits under the Plan. The Plan's life, supplemental life and dependent life insurance benefits are fully guaranteed under the policy of insurance issued by this company.

First Reliance Life Insurance Company, 488 Madison Avenue, New York, New York 10022, is the insurer and claims processor of your long term disability, short-term disability and supplemental short-term disability benefits under the Plan. The Plan's long-term disability, short-term disability and supplemental short-term disability benefits are fully guaranteed under the policy of insurance issued by this company.

Hyatt/MetLife, MetLife Legal Plans, 1111 Superior Avenue, Cleveland, Ohio 44114-2507, is the insurer and claims processor of your legal service benefits under the Plan. The Plan's legal service benefits are fully guaranteed under the policy of insurance issued by this company.

Transamerica, P.O. Box 869094, Plano, Texas 75086, is the insurer and claims processor of your critical illness insurance benefits under the Plan. The Plan's critical illness insurance benefits are fully guaranteed under the policy of insurance issued by this company.

MetLife, Group, Voluntary & Worksite Benefits Metropolitan Life Insurance Company, 200 Park Avenue, New York, New York 10166, is the insurer and claims processor of your hospital indemnity and accident insurance benefits under the Plan. The Plan's hospital indemnity and accident insurance benefits are fully guaranteed under the policy of insurance issued by this company.

CCA, Inc., 475 Park Avenue South, 8th Floor, New York, New York 10016, is the claims processor of your employee assistance program benefits under the Plan. The Plan's employee assistance program benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance carrier.

Baker Tilly Vantagen, 1200 Abington Executive Park, Clarks Summit, Pennsylvania 18411, is the claims processor of your health care flexible spending account and dependent care flexible spending account benefits under the Plan. The Plan's health care flexible spending account and dependent care flexible spending account benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance carrier.

Affordable Care Act

This Summary includes various provisions that are required to comply with the requirements of the federal health care reform law, (the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010) and with regulations and other guidance issued under that law. Whenever this Summary refers to the "Affordable Care Act" it is referring to the PPACA, as amended, and any applicable regulations. The health care reform requirements of the Affordable Care Act generally apply only to the Plan's medical/prescription drug/vision coverage benefits. When this Summary refers to coverage that is subject to the Affordable Care Act, it means the Plan's medical/prescription drug/vision coverage.

Important Notice about Health Care Reform and Grandfathered Health Coverage

The Plan Sponsor believes that the Plan's medical/prescription drug/vision coverage options offered to employees who are employed by St. Charles Hospital and St. Catherine of Siena Medical Center and who are members of NYSNA are "grandfathered health plans" under the Affordable Care Act (Grandfathered Plan). As permitted by the Affordable Care Act, a Grandfathered Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Plan means that a plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Note that other medical coverage options offered under the Plan are not Grandfathered Plans.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Plan and what might cause a plan to change from Grandfathered Plan status can be directed to the Plan Administrator at the address provided in this Summary. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to Grandfathered Plans.

Notice of Right to Designate a Primary Care Provider

If you have selected the Plan's Empire BlueCross BlueShield POS medical/prescription drug/vision coverage option, you (or your covered family members) generally are permitted to designate a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For your covered child, you may designate a pediatrician as the primary care provider.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator at the address provided in this Summary.

Plan Year

The Plan Year is the period beginning each January 1 and ending each December 31 while the Plan is in effect.

Name, Business Address and Telephone Number of Plan Administrator

Catholic Health Services of Long Island Employee Benefits Committee
Catholic Health Services of Long Island d/b/a Catholic Health
c/o Human Resources Department
992 N. Village Ave
Rockville Centre, NY 11570
Telephone No.: (516) 705-6947

Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Type of Plan

This Plan is a form of employee welfare benefit plan called a "cafeteria plan" because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the Employer to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan. For certain benefits, because your salary is reduced before federal taxes (and, in most states, state taxes) are imposed, you pay less in taxes if you participate in the Plan. (Some benefits may require that you make after-tax contributions.)

Eligibility

If you are a regular employee of an Employer (i.e., if you are regularly scheduled to work at least 18.75 hours per week, or, with respect to certain positions scheduled to work 12 hour shifts, you are regularly scheduled to work 18 hours per week (as determined by the Employer))), you and your eligible dependents are generally eligible to participate in the Plan beginning on the first day of the month following or coincident with your completion of 60 days of continuous employment with the Employer (but not to exceed 90 days of continuous employment with the Employer) (your "Participation Date"). Notwithstanding the foregoing, for purposes of the employee assistance program, all employees are eligible as of their date of hire, and, for New York State short-term disability coverage benefits, all employees of the Employer are eligible to participate in such benefits beginning after four (4) consecutive weeks of covered New York employment for full-time employees and after twenty-five (25) days of covered New York employment for part-time employees.

Note, however, if you were previously employed by a physician practice which was acquired by a participating Employer and you immediately become employed by such participating Employer (as determined by the Plan Administrator, in its discretion), your "Participation Date" will be the date that you become employed by such participating Employer, or, if later, and required by your contract, the first day of the month following the last day of active coverage with the physician practice.

In addition, if you are a medical resident or medical fellow or, effective as of January 1, 2024, a dental resident, who becomes an employee of an Employer, your "Participation Date" will be the date on which you become an employee.

For purposes of the Plan's continuous employment requirement as it applies to the Plan's medical benefits, if you are absent from work because of a health condition, your absence will not interrupt your completion of the continuous employment requirement. That is, any period of continuous service that you complete before your health-related absence will apply toward the continuous employment requirement and will be added to any period of continuous service that you complete after you return to work following your health-related absence.

Leased employees, persons classified by the Employer as temporary employees of the Employer (as determined by the Employer), and employees covered by a collective bargaining agreement and their dependents (unless Plan participation is provided for in the collective bargaining agreement) are not permitted to participate in the Plan. A person who is not characterized by the Employer as an employee of the Employer, but who is later characterized by a regulatory agency or court as being an employee, will not be eligible for the period during which he or she is not characterized as an employee by the Employer. In addition, employees classified as "per diem" or "part-time" (including per visit employees) will not be eligible to participate in the Plan except for purposes of the employee assistance program and New York State short-term disability coverage benefits.

If your employment terminates while you are a participant in the Plan (or if you cease to be an eligible employee for any other reason) and you later become an eligible employee again, you will again become a participant in the Plan on the date prescribed by your Employer pursuant to your Employer's rehire policy. Please consult your Employer for more information. However, if you are rehired (or again become an eligible employee for any other reason) during the same Plan Year and within 30 days after

your previous period of eligible employment ended, you generally will not be permitted to make a new election of benefits for that Plan Year, but your previous election of benefits will be reinstated.

Please note that your eligibility for any particular benefit is determined under Plan terms applicable to that benefit. The Benefit Booklets delivered with this Summary include information about any additional or different eligibility requirements that may apply to specific benefits.

The next section describes some special eligibility rules for medical/prescription drug/vision coverage that apply for employees who are not eligible for medical/prescription drug/vision coverage under the rules described above. If you are eligible for coverage based on the rules above, the rules in the next section will not affect you at this time so you may want to just skip to the "Dependent Eligibility" section.

Additional Eligibility Opportunities Based on Measurement Periods

If you do not qualify as an eligible employee based on the rules described in the "Eligibility" section above because you experience a material change in position or employment status during the Plan Year, you may still be eligible for medical/prescription drug/vision coverage under the Plan based on new rules that apply in determining if someone is a full-time employee for purposes of the Affordable Care Act. You will be informed by the Employer if this applies to you.

Measurement Periods for Ongoing Employees

If you lose eligibility for medical/prescription drug/vision coverage based on the rules in the "Eligibility" section because you experience a material change in position or employment status during the Plan Year, you will be considered a full-time employee for the remainder of the Plan Year (and eligible for medical/prescription drug/vision coverage for that Plan Year), if you had an average of at least 30 Hours of Service per week during a 12-month "Standard Measurement Period" that ends shortly before the Plan Year that you had a change in position or employment status. In addition, you may be eligible for medical/prescription drug/vision coverage for the next Plan Year if you had the required Hours of Service during the applicable Measurement Period.

The Plan uses a Standard Measurement Period lasting from October 15th through the next October 14th and then offers coverage to employees who experience a material change in position or employment status but who are determined to be full-time based on that Measurement Period sometime between the end of that period and the start of the next Plan Year (your "Participation Date").

Example: If you are an employee eligible for medical/prescription drug/vision coverage based on the rules described in the "Eligibility" section above, but you have a material change in your hours/position on October 1, 2020, you may still be eligible for medical/prescription drug/vision coverage. Under your new position, you only work 16 hours per week and you would not qualify for medical/prescription drug/vision coverage based on the above "Eligibility" rules. However, if you had an average of at least 30 Hours of Service per week during the Measurement Period lasting from October 15, 2018 through October 14, 2019, you would be considered a full-time employee for the remainder of the 2020 Plan Year and eligible to continue medical/prescription drug/vision coverage under the Plan as long as you continue as an employee of the Employer. In

addition, if you had an average of at least 30 Hours of Service per week during the Measurement Period lasting from October 15, 2019 through October 14, 2020, you would be considered a full-time employee for the Plan Year that begins on January 1, 2021 and you would be eligible to elect medical/prescription drug/vision coverage to be effective for the 2021 Plan Year (as long as you remain an employee of the Employer).

If you become eligible for coverage based on your hours worked during a Standard Measurement Period, note that you will be eligible only for the next Plan Year following the end of that Standard Measurement Period. To be eligible for future periods, you must again qualify based on hours worked during a later Standard Measurement Period (or based on the rules in the "Eligibility" section).

Calculating Hours of Service

For purposes of these rules, an "Hour of Service" is defined based on IRS regulations and generally includes any hour for which you are paid, or entitled to payment, for performing services for the Employer (or for certain related employers) plus any hour for which you are paid, or entitled to be paid for periods when you are not working, such as for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or other paid leaves of absence.

In determining if an employee averages at least 30 Hours of Service per week during any Measurement Period, certain periods of time are ignored (so that they do not reduce your average). This includes periods of unpaid leave for jury duty or for military service that is subject to the federal law known as USERRA as well as unpaid FMLA leave.

In computing your hours of service, for any period when you are not paid on an hourly basis, please consult your Employer to find out how your hours of service are calculated.

Because hours are tracked on a payroll period basis and the Plan's Measurement Periods do not always begin on the same date as a payroll period, if you are paid on a biweekly basis, you will be credited with Hours of Service for a Measurement Period starting on the first day of the pay period that includes the first day of the Measurement Period and ending with the last day of the last pay period that ends on or before the last day of that Measurement Period.

With respect to employees characterized as home care employees and other employees who are paid "per unit" (as determined by the Employer), the employee's hours spent "per unit" will be credited as hours of service in accordance with the reasonable rules established by the Plan Administrator.

<u>Dependent Eligibility</u>

(NOTE: This Dependent Eligibility section does <u>not</u> apply to flexible spending account benefits. For details on whether a family member's expenses can be covered under a flexible spending account, see the separate explanations of those benefits in the "Summary of Available Benefits" section.)

For purposes of benefits offered under the Plan that allow you to enroll dependents, your *spouse* is considered an eligible dependent.

Your *child (child* and other *italicized* terms used in this section are defined below*)* is eligible for coverage offered to dependents under the Plan based on the following rules:

1. Medical/Prescription Drug/Vision Coverage for Children under Age 26. For purposes of medical/prescription drug/vision benefits offered under the Plan, your eligible dependents include your *child* who is under age 26, regardless of the child's marital status, tax dependent status or student status and regardless of whether the child lives with you.

2. Medical/Prescription Drug/Vision Coverage for Children with Disabilities. For purposes of medical/prescription drug/vision benefits offered under the Plan, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable calendar year is an eligible dependent if he or she is physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 26.

3. Other Coverage.

- For purposes of dental and supplemental vision benefits offered under the Plan, your eligible dependents include your *child* who is:
    - under age 25 (effective as of January 1, 2024, under age 26); or
    - your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable calendar year if he or she is physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 25 (effective as of January 1, 2024, age 26).

- For purposes of dependent life insurance benefits offered under the Plan, your eligible dependents include your unmarried *child* who is under age 26.

- For purposes of critical illness insurance, hospital indemnity insurance, accident insurance and legal services benefits offered under the Plan, your eligible dependents include your *child* who is under age 26.

In addition, the following individuals are considered eligible dependents under the Plan:

- For purposes of medical/prescription drug/vision, dental and supplemental vision benefits only, your biological and/or adopted grandchild, if:
    - you have taken a federal tax deduction for the individual as a "Qualifying Relative" under the Internal Revenue Code in the year prior to the year in which your election to cover the individual is made and you intend to take such a deduction for the year for which coverage is sought; and
    - the individual shares your primary residence as his or her primary residence.

- Any individual not described in the above "eligible dependent" categories who is eligible to file a tax return jointly with you under Internal Revenue Code section 6013.

The following definitions apply for purposes of this Dependent Eligibility section:

Child means a natural child, a legally adopted child who is under age 18 at the time of the adoption, a child placed with you for adoption who is under age 18 at the time of the placement, a foster child (if the child is an "eligible foster child", as defined in the Internal Revenue Code), or a stepchild. *Child* also includes any other person whose welfare is your legal responsibility under a legal guardianship, written divorce settlement, written separation agreement or a court order.

Dependent for Federal Income Tax Purposes

Whether someone is your *dependent for federal income tax purposes* is determined under IRS rules. For details on the requirements for someone to be your federal income tax dependent, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* under the Plan. However, for purposes of this Plan's health benefits, note that even if your family member would not qualify as your dependent for federal income tax purposes under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for purposes of the Plan's dependent eligibility requirements.

Also, in determining if your child is your *dependent for federal income tax purposes*, a special rule applies in cases of divorce or legal separation or if you and your child's other parent live apart for all of the last six months of the calendar year if either you or the child's other parent has custody of the child and is actually entitled to claim the child as a dependent for tax purposes. In those cases, as long as at least half of the child's support for the applicable calendar year is being provided by you and the other parent (and your current spouses, if any) together, the child can be considered your *dependent for federal income tax purposes* for purposes of the Plan's health benefits.

A person otherwise qualifying as your eligible dependent will not be covered for any coverage providing benefits to dependents unless you have elected to pay and have paid the required additional contributions, if any, for dependent coverage. Also, unless otherwise required by law, note that your spouse or child will not qualify as an eligible dependent while on active duty in the armed forces of any country.

You are responsible for determining if someone qualifies as your spouse or dependent for purposes of the Plan's dependent eligibility rules, subject to the Employer's final approval. The Employer may require you to provide proof that an individual satisfies all of the Plan's eligibility requirements. Also, if at any time during a Plan Year your eligible spouse or dependent becomes ineligible for coverage, you are responsible for notifying the Employer of that change in eligibility. If, at any time, the Plan pays benefits for any person you elected to enroll in your coverage who is later determined not to qualify as your eligible dependent, the Plan may recover from you any amounts paid for such benefits, using any recovery means available under applicable law (including, but not limited to, wage garnishment).

For purposes of the Plan's coverage (other than the health care flexible spending account benefit), if a dependent (including a spouse) of an employee is also an employee, and both employees are eligible for coverage as an employee/participant, neither employee can be treated as the other employee's dependent. However, if one employee is a participant and a dependent of the employee is also an employee but is not yet eligible to participate in a benefit under the Plan, the employee's dependent may participate in the Plan as a dependent until his or her Participation Date (unless he or she otherwise ceases to be eligible for coverage).

For purposes of the Plan's coverage, if a child would otherwise qualify as a dependent of more than one participant, the child may be treated as the dependent of only one participant.

For any insured coverage offered under the Plan, the terms of the insurance contract, instead of this "Dependent Eligibility" section, will determine whether any person is your dependent for purposes of that benefit (if there is any difference between the language in this Dependent Eligibility section and the terms of the contract). The Benefits Booklets provided to you with this Summary will include any additional or different dependent eligibility requirements that apply for any insured coverage.

All Qualified Medical Child Support Orders that require the Plan to provide coverage for so-called "Alternate Recipients" will be honored by the Plan in accordance with applicable law. (These orders are a type of order by a court or by an administrative agency providing coverage for children of Plan participants.) As required by applicable law, the Plan uses procedures to determine whether a medical child support order is a "Qualified Medical Child Support Order" that must be honored by the Plan. Upon request to the Plan Administrator, you may receive, without any charge, a summary of these procedures.

Participation

(a) Initial Election Period. If you are not already a participant in the Plan, to become a participant on your Participation Date, you must be an active employee of the Employer on your Participation Date and you must properly complete a designated electronic enrollment process, before your Participation Date and during the period designated by the Plan Administrator as your initial "enrollment period". For purposes of medical benefits only, you will be treated as an active employee on your Participation Date even if you are absent from work if your absence occurs because of a health condition (as determined by the Employer).

Your benefit elections made during your initial enrollment period will be effective from your Participation Date until the last day of the Plan Year in which you change your initial benefit election (see subsection (b) below) or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (see subsections (d) and (e) below).

If you fail to properly complete and submit an Election Form to the Plan Administrator during your initial election period, you will automatically receive Employer-paid employee assistance program coverage, New York State short-term disability coverage and, if you meet the eligibility requirements, basic life/accidental death & dismemberment insurance coverage, but you will not automatically participate in any other feature of the Plan.

(b) Election Periods after Initial Election Period. After you complete the initial Election Form, your initial benefit election will remain in effect indefinitely or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (as described in subsections (d) and (e) below) or until you make a new benefit election by requesting, completing and submitting a new Election Form to the Plan Administrator for a future Plan Year during the period preceding the Plan Year that is designated by the Plan Administrator as the Plan's annual "election period". Your new benefit election will be effective from the first day of the Plan Year following the election period in which you make your new benefit election until you change your election during a later election period, or you experience a Status Change, exercise a Special Enrollment right or otherwise qualify to make an election change that is permitted under the Plan. However, this automatic carry-over of previous elections does not apply to your elections to contribute to the Plan's health care flexible spending account or dependent care flexible spending account. If you fail to complete and submit a new Election Form for those benefits, you will not automatically receive coverage.

Although your benefit elections normally will carryover from one Plan Year to the next as described above, the Employer may announce before the start of a Plan Year that new elections will be required for all eligible employees to participate in benefits for that upcoming Plan Year. In such cases, a special required election period will be announced for all eligible employees to make new elections, which will take effect at the beginning of the next Plan Year. An employee who fails to make an election of available benefits for the following Plan Year during that special required election period will cease to participate in the Plan (except for purposes of any Employer-paid benefits that may be provided automatically without the need for an election, as described in subsection (a) above) at the end of the Plan Year in which the special required election period occurs.

(c) Changes of Election to Reflect Status Change. If you are currently participating in the Plan, you may, with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, change your elections by filing a Status Change Form within 31 days after a Status Change event. If you are not currently a participant in the Plan but you have satisfied all the requirements to be eligible to participate (except that you do not have a current benefit election in place), with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, you may become a participant by filing an Election Form and a Status Change Form within 31 days after a Status Change event occurs.

Under applicable law, to be permitted to make a change in your benefit elections because of a Status Change event, the Status Change event must result in you or your spouse or dependent gaining or losing eligibility for that coverage or similar coverage under the Plan, a plan sponsored by another employer by whom you are employed or a plan sponsored by the employer of your spouse or other dependent. (For dependent care flexible spending account benefits, you are also permitted to make an election change if a Status Change increases or decreases your eligible dependent care expenses and the election change corresponds to the change in expenses.)

Any change that you wish to make to your benefit elections also must be consistent with the Status Change event that occurred. The Employer will determine whether, under applicable law, a

requested change (or a new election) is consistent with the Status Change you experience. For example, if you become eligible for health coverage offered by your spouse's employer because you get married or because your spouse changes employers, you may cancel your health coverage under this Plan only if you certify to the Employer that you have actually enrolled or intend to enroll in the other plan. Under applicable law, it would not be consistent with the Status Change if you merely dropped coverage under this Plan without enrolling in the other plan. However, for purposes of group term life insurance or disability coverage, any change you wish to make because of a Status Change, such as increasing coverage, decreasing coverage or dropping coverage, will be treated as consistent with the Status Change.

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the elections are approved by the Plan Administrator, and will be effective, for health care flexible spending account or dependent care flexible spending account coverage, for the balance of the Plan Year in which the new election becomes effective or, for all other coverage, until you change your elections according to the Section entitled "Election Periods After Initial Election Period" or you experience another Status Change.

You will experience a Status Change if:

- your legal marital status changes including changes because of marriage, the death of your spouse, divorce or legal annulment;
- there is an event that causes you to gain or lose a dependent;
- you, your spouse or your dependent terminates or begins employment;
- there is an increase or reduction in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or the beginning or ending of an unpaid leave of absence) by you or your spouse or other dependent;
- you, your spouse or your dependent becomes eligible or loses eligibility for coverage under a plan offered by that person's employer because of a change in employment status (for example, if your dependent switches from salaried to hourly employment and the dependent's employer's medical plan covers only salaried employees);
- an event happens that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or similar circumstance;
- there is a change in location of the residence or worksite of you or your spouse or other dependent;
- for purposes of dependent care flexible spending account benefits, there is an event that changes the number of your dependents who are under the age of 13 or mentally or physically incapacitated; or

- for any election made on an after-tax basis, you experience any event which, in the Administrator's sole discretion, qualifies as a Status Change.

(d) Changes of Election Because of Changes in Cost or Coverage. You may make certain changes, as described below, because of changes in cost or coverage of benefits available under the Plan. You must request such an election change within 31 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion). Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the Election Form, if required, and the elections are approved by the Plan Administrator, and will be effective, for dependent care flexible spending account coverage, for the balance of the Plan Year in which the new election becomes effective or, for all other coverage, until you change your elections according to the Section entitled "Election Periods After Initial Election Period".

The rights described in paragraphs (i)-(iv) below are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan. Also, the rights described in (i)-(iv) below do not apply to elections involving a health care flexible spending account. You may not change the amount you contribute to a health care flexible spending account because of a change in cost or a change in coverage of another benefit option and you may not make an election change for any other benefit option because of a change in the cost or coverage under your health care flexible spending account or the health care flexible spending account of your spouse or dependent.

(i) Significant Cost Changes. If the amount that you are required to pay for a benefit option significantly increases (as determined by the Employer) while you are covered under that benefit, you may elect to revoke your election for that benefit and elect another similar benefit option, if one is available (as determined by the Employer). If no similar benefit option is available, you may elect to drop your coverage because of the increased cost.

If the amount that you are required to pay for a benefit option significantly decreases (as determined by the Employer) during the Plan Year, you may elect that benefit option for yourself or an eligible spouse or dependent.

Ordinarily, you may change the amount you contribute to a dependent care flexible spending account because of a significant increase or decrease in cost. However, under applicable law, if the dependent care provider who is imposing the increased cost is a close relative of yours, you cannot change your election. For this purpose, a close relative includes your parent, grandparent, child, grandchild, brother, sister, niece, nephew, stepparent, stepchild, stepbrother, stepsister, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law or brother-in-law.

You may change your elections because of a significant cost change, as described above, regardless of the reason for the increase or decrease in your cost. It does not matter whether the change in cost results from an action taken by the Employer or if it occurs because of something you do (such as switching from part-time to full-time employment if that changes the amount you have to pay for coverage).

(ii) Coverage Changes. If your coverage under a benefit is significantly curtailed during the Plan Year, you may revoke your election of that benefit and elect another benefit option that

offers similar coverage (as determined by the Employer), if any. Coverage is significantly curtailed only if there is an overall reduction of the coverage provided to all participants (as determined by the Employer).

If your coverage under a benefit is significantly curtailed during the Plan Year (as determined by the Employer), and the significant curtailment amounts to a complete loss of coverage (as determined by the Employer), you may change your elections as described in the previous paragraph. In addition, if you experience a complete loss of coverage and no other benefit option that provides similar coverage is available, you may drop the coverage entirely. A loss of coverage includes, for example, the elimination of a benefit option, the loss of availability of an HMO option in the area where you or your dependent reside, or a loss of coverage for you or a dependent under a health plan option because your expenses exceed an annual limit. The Employer, in its discretion, will determine when a curtailment of a benefit amounts to a complete loss of coverage.

If the Employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year (as determined by the Employer), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

(iii) Changes in Coverage of Dependents Under Other Plans. You may also change your elections to correspond to certain changes made under another employee benefit plan. For example, if your spouse's employer has a cafeteria plan with an election period that is different from this Plan's annual election period, you may change your benefit elections to correspond to the changes elected by your spouse during his or her employer's annual election period. Also, if another employer sponsors a cafeteria plan that allows participants to make changes during a Plan Year, such as the ones permitted by this Plan, and a permitted change under that other plan affects you or your eligible dependent, you may elect changes to your coverage under this Plan, as long as your change corresponds with the change made under that other plan. For example, if your spouse revokes a benefit election for a medical plan offered by his or her employer because of an increase in cost, you could change your elections under this this Plan to elect coverage for your spouse.

(iv) Loss of Other Group Health Coverage. If you or your eligible spouse or dependent loses coverage for any group health coverage sponsored by a governmental entity or an educational institution (as determined by the Employer), you may change your election of benefits to elect coverage for the affected individual.

(e) Other Election Changes. Except as otherwise provided below, if you are entitled to an election change described below, you must request the change within 31 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

(i) Orders Requiring Coverage. If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical coverage for your child, you, or, if required by the order, the Plan Administrator, may change your health coverage elections (to the extent permitted by the Plan Administrator, in its discretion) to provide such coverage and you, or if required by the Order, the Plan Administrator, may change the amount of your salary reduction

contributions to cover the cost of such coverage. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order and you provide evidence to the Employer that such coverage is actually being provided, subject to the Employer's approval, you will be permitted to change your election to stop providing medical coverage for your child.

(ii) Medicare or Medicaid Enrollment. If you or your spouse or dependent becomes enrolled in Medicare or Medicaid, subject to the Employer's approval, you may change your election to cancel or reduce medical coverage for that individual. If you or your spouse or dependent loses eligibility for Medicare or Medicaid, again subject to the Employer's approval, you may change your election to commence or increase medical coverage for that individual.

(iii) Revoking Medical Coverage to Enroll in Marketplace Coverage. If you have an enrollment opportunity to enroll in a Qualified Health Plan through an exchange or marketplace established under the Affordable Care Act ("Marketplace Coverage"), you may change your benefit elections under this Plan to cancel medical coverage under this Plan but only if you (and all dependents whose coverage under this Plan is being cancelled) are also enrolling in Marketplace Coverage. Cancelling coverage under this Plan based on this rule will be permitted only if the Marketplace Coverage (for all covered persons whose coverage under this Plan is being cancelled) is effective no later than the next day after coverage under this Plan would terminate because of the cancellation of coverage. The Plan may rely on your reasonable representation that all covered persons whose coverage is being cancelled have enrolled in or will enroll in Marketplace Coverage to be effective no later than the deadline indicated in the previous sentence, but the Employer, in its discretion, may also require additional documentation of the Marketplace Coverage. Note that this rule applies only to medical coverage (not including any Health FSA) and does not allow you to change your election of benefits for any other coverage offered under the Plan. Also, note that you are permitted to enroll in Marketplace Coverage only during the annual Marketplace enrollment period or based on a Marketplace special enrollment opportunity. Details about the enrollment periods for Marketplace Coverage are available at: www.HealthCare.gov.

(iv) FMLA Leave. If you take leave under the Family and Medical Leave Act of 1993 (FMLA), you may make certain election changes that are permitted by the Employer in accordance with the FMLA.

(v) Paying for COBRA Coverage. If you or your spouse or dependent becomes eligible for continued health coverage under the Employer's health plan as provided under COBRA or any similar state law, you may change your election to pay for that COBRA coverage with salary reduction contributions.

(f) Special Enrollment Periods for Employees and Dependents. If you decline enrollment in the Plan's medical coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's medical coverage if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing towards your or your dependents' other non-COBRA coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan's medical coverage. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you or your eligible dependent are covered under Medicaid or a State Children's Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and any affected dependent in this Plan's medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. Also, if you or your eligible dependent become eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days after the date a government agency determines that you are eligible for that financial assistance.

If you are eligible to make a special enrollment election described in this section, you may elect coverage under any medical coverage options for which you are eligible under the Plan. If you are eligible for more than one medical coverage option and you are currently enrolled in one coverage option, you may change to a different medical coverage option that is available to you. Benefits elected during a special enrollment period become effective no later than the first day of the first month that starts after you properly elect coverage. However, for a special enrollment election based on a birth, adoption or placement for adoption, your coverage would be effective starting on the date of the birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator at the address provided in this Summary.

Termination of Participation

Coverage for a participant generally terminates on the earliest of the following dates:

(a) For purposes of the medical/prescription drug/vision, dental and supplemental vision benefits, the last day of the month in which the participant terminates employment. With respect to all other benefits under the Plan, the day on which the participant terminates employment.

(b) Except for certain leaves of absence, for purposes of the medical/prescription drug/vision, dental and supplemental vision benefits under the Plan, last day of the month in which the participant ceases to qualify as an eligible employee of the Employer. With respect to all other benefits under the Plan, the day on which the participant terminates employment (except for certain leaves of absence).

(c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid or, if later and if contributions are discontinued because the participant is no longer an eligible employee, the last day of the month in which the participant ceases to be an eligible employee.

(d) Except to the extent required by law, the day the participant reports for active duty as a member of the armed forces of any country.

(e) The day all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

Coverage for an eligible dependent of a participant generally terminates on the earliest of the following dates:

(a) The day on which the participant terminates employment. However, for purposes of medical/prescription drug/vision, dental and supplemental vision benefits, coverage terminates on the last day of the month in which the participant terminates employment.

(b) Except for certain leaves of absence, the day on which the participant terminates employment. However, for purposes of medical/prescription drug/vision, dental and supplemental vision benefits, the last day of the month in which the participant ceases to qualify as an eligible employee of the Employer (except for certain leaves of absence).

(c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid or, if later and if contributions are discontinued because the participant is no longer an eligible employee, the last day of the month in which the participant ceases to be an eligible employee.

(d) Except to the extent required by law, the day the eligible dependent reports for active duty as a member of the armed forces of any country.

(e) The day all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

(f) The day on which the eligible dependent ceases to be an eligible dependent for reasons other than the attainment of a certain age.

(g) The last day of the calendar year in which an eligible child dependent attains age 26, unless otherwise eligible to continue participation in the Plan pursuant to the "Dependent Eligibility" Section..

Coverage under the Plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.

For coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may occur in only two situations. First, as indicated above, if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with

respect to the Plan, or makes an intentional misrepresentation of a material fact. In that case, the Plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the Plan. See the "Continuation and Conversion Rights" and "COBRA Notice" sections of this Summary for more details.

Also, if you take a leave of absence from employment with the Employer because of military service and your health coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue health coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in the COBRA notice section of this Summary and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different and the special COBRA coverage limits that apply to health care flexible spending accounts do not apply to USERRA continuation coverage under a health FSA. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the date coverage would terminate under the Plan's normal termination provisions for a reason other than your military service (2) the last day of the 24-month period beginning on the date your military leave of absence begins; or (3) the day after the date on which you fail to timely apply for or return to a position of employment with the Employer. Please contact the Employer if you have questions about coverage during periods of military service.

If you are an employee who is regularly scheduled to work at least 18.75 hours per week for the Employer (or, for union employees, such other amount as indicated in a collective bargaining agreement) and you are on an approved leave of absence that is not an FMLA absence, your coverage will not terminate because of the leave of absence as long as you pay your share of any required contributions on time (as determined by the Employer). Such an approved leave of absence can last up to a certain time as determined by the Employer's internal leave policy. If you do not return to work when your leave of absence ends or if you fail to pay any required contributions on time, coverage will be terminated, subject to any COBRA rights or any other provision of this Plan that may provide for continued coverage. Continuation under this provision is dependent upon your compliance with all reasonable requests for documentation of your status.

In some cases, the measurement period rules described in the "Additional Eligibility Opportunities Based on Measurement Periods" section of this Summary may provide that you will remain eligible for continued medical coverage during a period when you are not actively at work but are on approved leave. If those provisions require that coverage continue during an applicable stability period for a period that is longer than would otherwise apply under other terms of the Plan, including under the rules described above in this "Termination of Participation" section (as determined by the Employer), those Measurement Period provisions will prevail.

Summary of Available Benefits

The following benefits are available under the Plan. Any salary reduction contributions you will be required to make to obtain any elected benefit will be determined by the Employer, and will be communicated to you from time to time. Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect you or require a change to your elections or benefits, you will be notified.

Medical/Prescription Drug/Vision Coverage. If you are eligible to participate in the Plan, you may purchase medical/prescription drug/vision coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time. If you are an eligible employee who is a member of a collective bargaining unit covered under a collective bargaining agreement and who is eligible to participate in the medical/prescription drug/vision coverage under the Plan pursuant to the terms of a collective bargaining agreement, and you decline medical/prescription drug/vision coverage when offered, you may be eligible for additional pay ("Opt-Out Credits"), as described in the Opt-Out Credit section below.

Medical coverage under the Plan will comply with the reconstructive surgery requirements of the Women's Health and Cancer Rights Act of 1998.

Dental Coverage. If you are eligible to participate in the Plan, you may purchase dental coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time. If you are an eligible employee who is a member of a collective bargaining unit covered under a collective bargaining agreement and who is eligible to participate in the dental coverage under the Plan pursuant to the terms of a collective bargaining agreement, and you decline dental coverage when offered, you may be eligible for additional pay ("Opt-Out Credits"), as described in the Opt-Out Credit section below.

Opt-Out Credits for Eligible Collective Bargaining Unit Employees. If you are classified by the Employer as an eligible employee who is a member of a collective bargaining unit covered under a collective bargaining agreement and who is eligible to participate in the medical/prescription drug/vision coverage and, if applicable, dental coverage under the Plan pursuant to the terms of a collective bargaining agreement, and you decline the Plan's medical/prescription drug/vision coverage, and if applicable, dental coverage, you are eligible to receive Opt-Out Credits in the form of additional taxable compensation in an annual amount determined by the terms of the collective bargaining agreement, payable during the Plan Year in one or more payments during the Plan Year according to a schedule established by the collective bargaining agreement. The amount payable for waiving coverage will be determined by the terms of the collective bargaining agreement.

Supplemental Vision Coverage. If you are eligible to participate in the Plan, you may purchase supplemental vision coverage on an after-tax basis. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Basic Life/Accidental Death & Dismemberment and Supplemental Life Insurance Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense basic life/accidental death & dismemberment insurance coverage. In addition, you may purchase additional supplemental life insurance coverage on an after-tax basis. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Dependent Life Insurance Coverage. If you are eligible to participate in the Plan, you may purchase dependent life insurance coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Long-Term Disability Coverage. If you are eligible to participate in the Plan, you may purchase long-term disability coverage on an after-tax basis. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Short-Term Disability Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense New York short-term disability coverage and, if you are eligible for supplemental short-term disability coverage, you may purchase additional short-term disability coverage on an after-tax basis. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Legal Services Plan Coverage. If you are eligible to participate in the Plan, you may purchase legal services plan coverage on an after-tax basis. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Critical Illness Insurance Coverage. If you are eligible to participate in the Plan, you may purchase critical illness insurance coverage on an after-tax basis. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Hospital Indemnity Insurance Coverage. If you are eligible to participate in the Plan, you may purchase hospital indemnity insurance coverage on an after-tax basis. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Accident Insurance Coverage. If you are eligible to participate in the Plan, you may purchase

accident insurance coverage on an after-tax basis. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any after-tax contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Employee Assistance Program Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense, employee assistance program coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Health Care Flexible Spending Account. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed $3,200 (for the Plan Year beginning in 2024) per Plan Year, credited to your health care flexible spending account (Health FSA). The Plan's maximum contribution amount is required by federal law. The maximum amount is adjusted by the IRS each year based on inflation. The Plan's maximum contribution amount will also be automatically adjusted each year based on the new maximum announced by the IRS unless the Employer specifies a lower limit during the applicable enrollment period.

You can receive amounts from this Account as reimbursement for eligible medical expenses (as defined in the Plan) incurred during the Plan Year and while you are a participant in the Health FSA.

Generally, eligible medical expenses are expenses that you or your eligible dependent (determined as described below) have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of medical expenses (including legally obtained prescription drugs, over-the-counter medicines and menstrual care products), and that have not been taken as a deduction in any year. In addition, eligible medical expenses must satisfy any other additional requirements as the Plan Administrator may impose, in its discretion, and as communicated to you in writing in advance of the Plan Year, including, but not limited to, a requirement that the expense relate to medical claims that are consistent with the tenets of the Catholic Faith. Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

For purposes of Health FSA reimbursements, "dependent" includes:

(1) your spouse (as determined under federal law);

(2) your biological, adopted or step-child or your eligible foster child if the child will be younger than 27 on the last day of the calendar year in which the expense is incurred (even if the child is not your dependent for tax purposes);

(3) any person who is expected to be your *dependent for federal income tax purposes* (as defined below) for the calendar year in which the expense is incurred; and

(4) any individual not described above who is eligible to file jointly with the participant under Internal Revenue Code section 6013.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Health FSA benefits. However, for purposes of the Health FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for Health FSA benefits. The Plan Administrator always has the right to require documentation that an individual qualifies as your spouse or dependent for health FSA purposes and to deny benefits if you fail to provide adequate documentation when required. If you have any question about whether someone qualifies as your dependent for purposes of the Health FSA, you should consult a tax advisor.

To be reimbursed from your Health FSA, you must submit to the Plan Administrator a request for reimbursement on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than 90 days after Plan Year in which the expenses were incurred.

Please note that amounts held in your Health FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited, unless the amount is eligible to be carried over to the next Health FSA Plan Year, as described below.

Health FSA Carryover Feature

The Health FSA includes a "carryover" feature which provides that a portion of your unused balance in the Health FSA at the end of a Plan Year (up to 20% of the maximum amount of salary reduction contributions permitted under the Internal Revenue Code to a Health FSA for the applicable original Plan Year (as adjusted for inflation for each calendar year) ($640 for the Plan Year beginning in 2024, subject to annual adjustments for inflation for later years)) will not be forfeited but will instead be carried over to the next Plan Year (if you are still an eligible employee on the first day of the next Plan Year).

Note that you can still elect to contribute the maximum amount permitted under the Health FSA for each Plan Year (currently, $3,200 per Plan Year) even if you have an amount that is carried over from a previous year, so the carryover amount does not reduce the amount you can contribute each year. It just increases the amount available to you for the year.

You also should be aware that carried over amounts can still be used to pay expenses from the original Plan Year, as long as you submit your request for reimbursement before the deadline for submitting claims for that original Plan Year. For example, if you contributed $2,500 to your health FSA for the Plan Year ending December 31, 2023, but you received only $2,100 of your $2,500 contribution for eligible expenses you submitted by December 31, 2023, your $400 unused balance would be carried

over to the next Plan Year and could be used to reimburse expenses incurred during that next Plan Year. However, if you still have expenses for the Plan Year that ended on December 31, 2023 that you need to submit for reimbursement, you still may submit those reimbursement requests and be paid up to $400 for those expenses, as long as you submit your request by the deadline for submitting expenses for that Plan Year.

Of course, if the $400 that was eligible for carryover is paid out to reimburse you for expenses incurred during the second Plan Year, it will no longer be available to pay expenses incurred during the first Plan Year. For that reason, it is important that you submit all requests for the first Plan Year first to make sure they are reimbursed first.

The carryover feature applies to the Health FSA only. It does not apply to the Plan's Dependent Care FSA.

Qualified Reservist Distributions

If you are called or ordered to active duty in a United States reserve component for a period of 180 days or longer or for an indefinite period (or for a shorter period that is later expanded to 180 days or longer), and the amount you have received in reimbursements from your Health FSA for the Plan Year is less than the amount you have contributed, you may request a Qualified Reservist Distribution of your unused balance (the difference between what you have contributed and the amount of reimbursements you have received). The distribution generally would be treated as taxable compensation to you. You must request the distribution before the end of the Plan Year during which you are called or ordered to active duty. If you request a distribution, you may continue to submit claims for expenses incurred before you made your request, but you may not submit claims for expenses incurred after that date. Your request must include a copy of the document that orders or calls you to active duty (if not already provided to the Employer). If you qualify for a Qualified Reservist Distribution, the distribution will be made within a reasonable period (no later than 60 days) after you request it. Once you receive a distribution equal to your entire unused balance, you will no longer be a participant in the Health FSA for that Plan Year and will not be able to submit or be reimbursed for any additional claims for eligible medical expenses. To request a Qualified Reservist Distribution or for more information, you should contact the Plan Administrator at the address provided in this Summary.

Dependent Care Flexible Spending Account. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed $5,000 per calendar year or, for married participants filing separately, $2,500 per calendar year, credited to your dependent care flexible spending account (Dependent Care FSA). You can receive amounts from this Account, in cash, as reimbursement for Employment Related Expenses incurred during the Plan Year.

The amount of any reimbursement for Employment Related Expenses may not exceed the amount credited to your Account at the time of your reimbursement request. Generally, under federal law, Employment Related Expenses are expenses for household services and expenses related to the care of a "Qualifying Individual", which you incur to enable you to work.

"Qualifying Individual" is defined under federal law and currently means someone who is:

(1) your child (including a stepchild), brother, sister, stepbrother or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13, who has the same principal residence as you for at least half of the calendar year and who does not provide at least half of his or her own support for the current calendar year,

(2) your spouse (for purposes of federal law) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year or

(3) your *dependent for federal income tax purposes* (as defined below) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Dependent Care FSA benefits. However, for purposes of the Dependent Care FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for Dependent Care FSA benefits.

The Plan Administrator always has the right to require documentation that an individual qualifies as a Qualifying Individual under the above rules and to deny benefits if you fail to provide adequate documentation when required or if the Administrator determines that expenses for any person are not eligible for reimbursement. If you have any question about whether someone qualifies as your dependent for purposes of the Dependent Care FSA, you should consult a tax advisor. Also, note that the determination of whether someone is a Qualifying Individual must be made each time expenses are incurred. For example, if your child is age 12 at the start of the calendar year, otherwise eligible expenses for that child can be reimbursed under the Dependent Care FSA only for services provided before the child's 13th birthday (unless the child is mentally or physically incapable of taking care of himself or herself).

The amount of reimbursements that you may receive from your Dependent Care FSA on a tax-free basis in a calendar year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. Thus, for example, if you have $5,000 in your Dependent Care FSA and you and your spouse have Earned Income of $20,000 and $4,000, respectively, you can receive $4,000 worth of reimbursement from the Account on a tax-free basis, and you will be taxed on $1,000 worth of the reimbursement you receive. If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have Earned Income for each month that he or she is a full-time student or incapacitated. The amount of deemed earnings will be $250 a month, if you provide care for one Qualifying Individual, or $500 a month, if you provide care for more than one Qualifying Individual.

Employment Related Expenses that are incurred for services outside your household may be reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under thirteen years of age (category (1) in the above definition of Qualifying Individual), or (ii) another Qualifying Individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center (as defined below), the Center must comply with applicable laws and regulations of a state or local government. A "Dependent Care Center" is any facility that provides care for more than six individuals who do not reside at the center and receives a fee, payment or grant for providing services for any of the individuals.

No reimbursements will be made for Employment Related Expenses for services rendered by any person for whom you or your spouse (or your eligible dependent who is eligible to file jointly with you under Internal Revenue Code section 6013) is entitled to a deduction on your federal income tax return for the applicable calendar year or who is your child (including a stepchild or a foster child) who will be under the age of 19 at the end of the year.

To be reimbursed from your Dependent Care FSA, you must submit a reimbursement request to the Plan Administrator on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit such requests no later than 90 days after the Plan Year in which the expenses were incurred.

If your employment terminates during the Plan Year (or if you cease to be eligible to participate in the Dependent Care FSA for any other reason), your contributions to your Dependent Care FSA will cease, but, if you still have a balance credited to your Dependent Care FSA, you may still submit claims for reimbursement for eligible expenses incurred during the rest of the Plan Year, until your account balance is exhausted. The rules and deadlines for submitting requests for reimbursements are the same as those that apply for active eligible employees.

Please note that amounts held in your Dependent Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts which you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the tax credit available. Attached as an Exhibit is a notice which further explains the dependent care tax credits and the income exclusions. The notice also provides a worksheet to help you determine which tax reduction method is more beneficial for you.

Dependent Care FSA benefits are not subject to the federal law known as ERISA, so the "Your Rights under ERISA" section of this Summary does not apply to these benefits.

<u>Continuation and Conversion Rights</u>

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your

health care continuation or conversion rights, please contact the Plan Administrator. Also, please review the next section regarding continuation coverage under the federal law known as "COBRA".

Continuation Coverage Under COBRA (COBRA Notice)

This "COBRA Notice" section of your Summary Plan Description applies to employees and covered spouses and dependents who have health coverage under the Plan. For purposes of this notice, "Plan" refers only to the medical/prescription drug/vision, dental, supplemental vision, employee assistance program benefits and health care flexible spending account benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

You're getting this notice because you are covered under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. (Both you and, if you are married and your spouse is covered by the plan, your spouse should take the time to carefully read this notice.)

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)

You must give notice of some qualifying events.

For all other qualifying events (<u>divorce</u> of the employee and spouse or a <u>dependent child's losing eligibility for coverage</u> as a dependent child (other than due to the attainment of a certain age)), you must notify the Plan Administrator by reporting a qualifying life event on the Benefit Portal (www.mychbenefits.org) within 60 days after the later of (1) the date the qualifying event occurs or (2) the date that coverage would otherwise end because of the qualifying event. You must

send notification to the Plan, along with any required documentation via mail, email or fax as provided below:

To:	Catholic Health Services of Long Island d/b/a Catholic Health c/o Human Resources Service Center: MyHR
By Mail:	3 Huntington Quadrangle, Suite 301S, Melville, NY 11747
By Email or Benefit Portal:	MyHR@chsli.org or online on the Benefit Portal
By Fax:	(516) 705-2828

Please submit your election changes online on the Benefit Portal (www.mychbenefits.org), and submit documentation of the event that occurred, such as a photocopy of a divorce order showing the date of the divorce. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided above or by calling (516) 705-6947.

Note: If your dependent loses coverage under the Plan due to the attainment of a certain age, there is no need to notify the Plan Administrator. The Plan will offer COBRA continuation coverage automatically to your dependent if he or she has become ineligible due to attainment of a certain age.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. (NOTE: The rest of this paragraph applies to health plans other than the health care flexible spending account plan. For the rules that apply for the health care flexible spending account, see the "*Special Rules for Health Care Flexible Spending Accounts*" section below.) COBRA coverage generally lasts for 18 months if the qualifying event is employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of

COBRA continuation coverage. To notify the Plan Administrator of a disability determination, you should follow the same procedures described above under "*You Must Give Notice of Some Qualifying Events*". Your notice must include documentation of the Social Security Administration's decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event. However, regardless of the deadline described in the previous sentence, your notice must be provided no later than the date your COBRA coverage would terminate without a disability extension.

Second qualifying event extension of 18-month period of COBRA continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event (following the same procedures described above under "*You Must Give Notice of Some Qualifying Events*"). This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but this extension is available only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Special rules for health care flexible spending accounts

For a health care flexible spending account (Health FSA), COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs. COBRA under the Health FSA cannot be extended beyond that time for any reason.

EXAMPLE: Assume that an employee elected to contribute a total of $1,200 to her Health FSA account for a Plan Year and then her employment terminates six months after the beginning of the Plan Year. By that time, she has contributed $600 to her FSA account through payroll deductions. Assume that she has already received $800 in reimbursements from her account for eligible expenses she paid before her employment terminated. In that case, the maximum benefit she could receive from her account for expenses incurred for the rest of the Plan Year is $400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of $588 or less before her termination date, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more

than the amount she would be required to pay ($612).

Any deadlines or other rules for filing a request for reimbursement under the Health FSA, will continue to apply if you elect continuation coverage under the Health FSA. Review the Health FSA details in this Summary for more information.

Additional continuation coverage election period for "TAA-eligible individuals"

In addition to the other COBRA rules described in this section of your Summary Plan Description, there are some special rules that apply if you are classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.)

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than six months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this Notice, your coverage period will be measured from the date of your TAA-related loss of coverage.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the

1 https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

If you have questions or need more information about COBRA continuation coverage under the Plan or to report any address changes, please contact the Plan Administrator at the address or phone number provided above.

Emergency Medical Care

If you believe you need emergency medical care, you should not forego that care because you believe it will not be covered by the Plan. Also, in accordance with the No Surprises Act, if you are covered under the Plan's medical coverage, the Plan must cover services, supplies, and treatment for the stabilization, evaluation, and/or initial treatment of an emergency medical condition when provided on an outpatient basis at a hospital emergency room or department or at a freestanding independent emergency department ("Emergency Services") without prior authorization and with in-network cost-sharing. In addition, the No Surprises Act prohibits balance billing by nonpreferred providers. As a result, your responsibility for Emergency Services will be limited to your deductible and coinsurance amounts.

Patients to Evaluate Care

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any practitioner. Each patient should evaluate the quality of care and act accordingly. No Plan provision expressed in this Summary or the Plan documents should be interpreted to restrict the access to or delivery of medically necessary services. A patient's decision to forego such care should not be based on his or her interpretation of this Summary Plan Description or the Plan documents.

Health Information Privacy

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. If you are an employee and you are covered under any of the Plan's health benefit options, you should have received a copy of the Plan's Privacy Notice with this Summary (if you did not previously receive one). In addition, a copy of the Plan's current Privacy Notice is always available upon request. Please contact the Plan Administrator at the address indicated later in this Summary if you would like to request a copy of the Notice or if you have questions about the Plan's privacy policies. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Medical Benefits Following Childbirth

The Plan and any health insurance company insuring health benefits under the Plan, 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 vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, the Plan and any health insurance company may not, under federal law require that a provider obtain authorization from the Plan or health insurance company, if any, for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

Claims Procedures

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and for certain medical benefits, the applicable requirements of regulations issued under the Affordable Care Act and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures generally will apply instead of the claims procedures described in this Summary. This Claims Procedure section includes descriptions of the minimum requirements for claims procedures that apply to insured benefits, but full details of claims

procedure rules for insured benefits are described in the insurer's Benefit Booklet that describes the specific insured benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims, including claims for dependent care flexible spending account benefits, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator (or an insurer) provide notice to a claimant about any right under ERISA will not apply to such a claim.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Claims can be filed by you or your spouse, dependent or beneficiary if you believe you are eligible for any benefit under this Plan (the procedures use the term "claimant" to refer to the individual filing the claim). Claimant also includes any properly authorized representative (as determined by the Reviewer) designated by you pursuant to the Plan's procedures. Please see the "Third Party Rights – Designating an Authorized Representative" Section below for more information on how to designate an authorized representative under the Plan's claims procedures.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act that is not a Grandfathered Plan and for purposes of any disability benefits that are subject to ERISA, "adverse determination" also includes any rescission of coverage. A rescission of coverage generally is a retroactive termination of coverage because of fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a "rescission" and is therefore an adverse determination that is subject to these claims procedures will be determined by the Reviewer based on applicable law.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. Claims should be submitted promptly after an expense is incurred. Unless a different deadline expressly applies in this Summary or under a Benefits Booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial

claim is submitted later than one year after the date the expense was incurred. Please review the applicable Benefits Booklets or insurance contract for the specific deadline applicable to each Benefit. (For deadlines for submitting flexible spending account reimbursement requests, see the "Summary of Available Benefits" section of this Summary.)

The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, using the following procedures.

For purposes of these procedures, "health benefit" or "health claim" refer to benefits or claims involving medical/prescription drug/vision, dental, supplemental vision, employee assistance program or health care flexible spending account coverage. Also, a benefit or claim is considered a "disability benefit" or "disability claim" for purposes of these procedures if the benefit or claim, including claims for accidental death and dismemberment benefits, requires that the Plan or an Insurer make a determination of whether a claimant has experienced a disability.

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations 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 a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. For any claim for benefits under coverage that is subject to the Affordable Care Act that is not a Grandfathered Plan, the Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

(A) For any pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(B) For any post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services or other benefits already provided (or any other health benefit claim that is not a pre-service claim).

(c) Disability Benefit Claims. For any disability benefits claim, the Reviewer will notify the

Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial;

(ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information that the Claimant must provide to perfect the claim (including an explanation of why the information is needed);

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;

(v) A statement of the Claimant's right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial and a description of any time limit that would apply under the Plan for bringing such an action.

In addition, for a denial of health benefits, the following will be provided to the Claimant:

(vi) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and

(vii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).

(viii) For an adverse determination concerning an urgent care health claim involving, the notice will also include information about the expedited process that applies to such claims and the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not

later than three days after the oral notification.

For any claim for disability benefits, the notice will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and also will include the following:

(ix) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(x) If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(xi) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

(xii) 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.

Reviews of Initial Adverse Determinations

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

(a) Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after you receive notice of the initial denial of the claim. The decision on review will be made within a reasonable time but no later than 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other

information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) For purposes of any medical coverage that is not a Grandfathered Plan and for claims for disability benefits, the Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:

(A) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by or on behalf of the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision

as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(B) For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within a reasonable time but not later than 45 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

(i) a description of its decision;

(ii) a description of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claim for benefits;

(v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA section 502(a) and a description of any time limit that applies under the Plan for bringing such an action (including, for disability benefit claims, the date that any applicable time limit

for bringing such an action would expire);

(vi) if applicable, a statement describing any voluntary appeal procedures offered by the Plan and about the Claimant's rights to obtain information about such procedures

(vii) in addition to items (i)-(vi) above, for any notice of adverse determination regarding health benefits, the following will be provided:

(A) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(B) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request; and

(viii) in addition to items (i)-(vi) above, for claims for disability benefits, the notice of Adverse Determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices and will include:

(A) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(B) If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

Additional Requirements for Non-Grandfathered Medical and Disability Claims

For any adverse determination involving medical coverage that is provided under a plan that is not

a Grandfathered Plan under the Affordable Care Act, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Also, for all claims involving coverage that is subject to the Affordable Care Act that is not a Grandfathered Plan and for disability benefit claims, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the determination will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits other than health benefits, the period for making the determination on appeal will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant's Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan's Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim involving medical coverage that is not a Grandfathered Plan, you will be deemed to have exhausted the Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the Plan's claim procedures (and applicable regulations unless the Plan's failure to adhere to those requirements is a minor violate (as defined below). If are you are deemed to have exhausted the Plan's internal claims and appeals process based on the preceding sentence, in addition to the right to pursue any available remedy under ERISA, you will have the right to pursue any remedy under any available external review process provided under federal or state law.

Also, for claims for disability benefits, you will be deemed to have exhausted the Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the requirements of applicable requirements of applicable regulation unless the Plan's failure to adhere to those requirements is a "minor violation" (as defined below).

For purposes of this Section, the Plan's failure to satisfy applicable claim procedure regulations is a "minor violation" if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this minor violation exception applies, you may request a written explanation of the violation from the Plan, and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

For claims involving medical coverage, if an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon your receipt of the notice.

For claims involving disability benefits, if a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, the claim will be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. In such cases, within a reasonable time after the Plan's receives the decision, the Plan will provide you with notice of the resubmission.

External Review

(a) <u>External Review Process</u>. For purposes of any coverage that is subject to the Affordable

Care Act that is not a Grandfathered Plan, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with the interim procedures for federal external review in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance. The Plan will begin complying with any new requirements for external review guidance on or before the date that those requirements become applicable to the Plan.

(b) Availability of External Review. External review is not available for all adverse determinations. For example, external review is not available for an adverse determination based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan. External review is available only for:

(i) any final internal adverse determination (or an initial internal adverse determination on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal adverse determination that involves a rescission of coverage;

(iii) items and services within the scope of the requirements of the federal law known as the No Surprises Act (i.e., emergency services provided by a nonpreferred provider, air ambulance services provided by a nonpreferred provider, ancillary services, and other non-emergency services), except that external review is not available when:

(A) adjudication of the claim results in a decision that does not affect the amount the participant or covered dependent owes;

(B) the dispute only involves payment amounts due from the Plan to the provider; or

(C) the provider has no recourse against the participant or covered dependent; or

(iv) Any other final adverse determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

(c) Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives notice of an adverse determination for which external review is available.

(d) Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the time the health care item or service was provided;

(ii) The adverse determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe the reasons external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the Claimant receives the notice.

(e) Referral to Independent Review Organization. External reviews are conducted by independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan will contract with at least three different IROs. The Plan will take action against bias and to ensure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Under a contract between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse

determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving any information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(A) The Claimant's medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating provider;

(D) The terms of the Plan, unless the terms are inconsistent with applicable law;

(E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(G) The opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.

(vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.

(vii) The IRO's notice will include:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;

(F) A statement that judicial review may be available to the Claimant; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA.

(viii) The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by the Claimant, Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(f) Effect of External Review Decision. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse determination, the Plan will provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

(a) Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an adverse determination that otherwise qualifies for external review (as described above) and that is:

(i) An adverse determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under the Plan's normal procedures for urgent care claims would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited

internal appeal; or

(ii) A final adverse determination, if the Claimant has a medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse 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.

(b) Procedures for Expedited External Review.

(i) In General. The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review. The Plan will immediately send the Claimant a notice of its eligibility determination that meets the preliminary review notice requirements described above.

(iii) Referral to IRO. Upon a determination that a request is eligible for external review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide review as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

Third Party Rights – Designating an Authorized Representative

Occasionally, third parties who are not covered persons (e.g., concerned family members) assist covered persons with maximizing their rights under the Plan. The Plan Administrator encourages the use by covered persons of all resources that will help them use the Plan in the way that is best for them as covered persons.

Unfortunately, sometimes third parties attempt to enforce Plan rights of covered persons for the third party's own benefit or for the benefit of some other party (such as a provider of medical services). For the protection of the Plan and its participants, the Plan has developed authorized representative rules to ensure that participants and other covered persons have the benefit of using representatives to assist them in using the Plan, but that protect participants from third parties who are not truly representatives of the covered person. These rules require that the representative have a duty to the covered person and not to outside interests.

An authorized representative may act on behalf of a covered person with respect to a benefit claim or appeal under these claims' procedures. A person designated by any means other than through a Plan

provided Appointment of Authorized Representative Form signed by the covered person (including, but not limited to, a person designated pursuant to a document satisfying the requirements of a durable power of attorney for health care under the laws of New York) will not be recognized as an authorized representative under the Plan, except as follows: a covered person's spouse, or court-appointed guardian or conservator may act as the authorized representative of the covered person; a parent may act as the authorized representative of an eligible dependent child; and a licensed health care professional with knowledge of the medical condition of a covered person may act as the authorized representative of the Claimant in case of an urgent care claim.

If you wish to have an authorized representative assist you, please contact the Plan Administrator at the address or phone number in the SPD, to obtain an Appointment of Authorized Representative Form and related authorization materials and procedures.

Insured Benefits and State Law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Termination or Amendment of Plan

The Plan Sponsor expects to maintain the Plan indefinitely as a program of employee benefits. However, the Plan Sponsor has the right, in its sole discretion, to terminate or amend any provision of the Plan at any time. Therefore, no Plan participant (including any future retiree or retiree who has already retired) has a right to the continued enjoyment of any particular benefit under the Plan after a Plan termination or amendment affecting those benefits.

No Right to Continued Employment

No provision of the Plan or this Summary shall be interpreted as giving any employee any rights of continued employment with the Employer or in any way prohibiting changes in the terms of employment of any employee covered by the Plan.

Non-Assignment of Benefits; Payments to Providers

No participant or beneficiary may transfer, assign or pledge any Plan benefits. Notwithstanding any provision of any Benefits Booklet or other document describing the benefits offered under the Plan, no benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. Also, no benefit under the Plan will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts

of any person. The Administrator may, in its discretion, elect to make a direct payment to a provider of services for which benefits are available under a Component Plan and such direct payment to the provider by the Plan shall not be considered an assignment or alienation under the Plan or any Component Plan, and neither the direction by a Plan participant, or any eligible or covered dependent to make such payment nor the payment itself shall be construed as an assignment of benefits or as a recognition by the Administrator of the validity of any attempted alienation or assignment of benefits under the Plan nor will any such payment confer on the payee any rights besides the right to receive the payment in the amount of that specific payment.

The Plan will honor any Qualified Medical Child Support Order (QMCSO) that provides for Plan coverage for an Alternate Recipient, in the manner described in ERISA §609(a) and in the Plan's QMCSO Procedures.

Coordination of Benefits

The coordination of benefits provisions described in the Benefits Booklets delivered to you with this Summary, as interpreted by the Plan Administrator (or insurer, if applicable) in its discretion, control all coordination of benefits situations involving the Plan and other payers.

Subrogation/Right of Reimbursement

As a condition of receiving medical, dental, supplemental vision, disability or any other benefits under the Plan, all covered persons, including all covered dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person, organization or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to the "make whole" doctrine, the "common-fund" doctrine or other similar common-law subrogation rules or legal theories.

Also, each participant and each covered person, as a condition for and consequence of receiving medical, disability or any other benefits under the Plan with respect to any amount that is subject to this subrogation provision, agrees as follows:

(1) The participant and each covered person (or their attorneys or other authorized representatives) will promptly inform the Plan of any settlement agreement and to provide reasonable advance notice of any plans for the disbursement of any settlement funds to the Participant or covered person (or to any other person on behalf of the covered person);

(2) The participant and each other covered person (or their attorneys or other authorized representatives) will hold any settlement funds received with respect to a claim that is subject to the Plan's subrogation rights in trust for the benefit of the Plan until all obligations to the Plan under this subrogation provision are satisfied (or to disburse such funds to the Plan to satisfy any obligations to the Plan under this subrogation provision);

(3) The participant and each other covered person (or their attorneys or other authorized representatives) will maintain and treat any settlement funds received by or on their behalf, as Plan assets, to the full extent of any benefits paid by the Plan with the Participant or other covered person being a trustee of Plan assets with respect to such amounts until the covered person's obligations under this subrogation provision are satisfied; and

(4) The participant and each other covered person (or their attorneys or other authorized representatives) agree that the Plan has an equitable lien on any settlement funds payable to or on behalf of the Participant to the full extent of any benefits paid by the Plan amounts until the covered person's obligations under this subrogation provision are satisfied in full.

Unclaimed Benefits

Benefit payments made by check to a participant or beneficiary must be cashed within one year of issue. If a benefit payment check is not presented for payment within one year of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture.

Insurance Contracts

The Employer has the right to enter into contracts with one or more insurance companies for the purpose of providing any Benefits under the Plan and to replace any such insurance company from time to time. If any Benefit is intended to be provided under an insurance contract, a participant or other covered person may look only to the insurance company for payment of that benefit.

Any amounts payable by an insurance company with respect to or because of a contract entered into by the Employer (other than amounts payable on behalf of a covered person pursuant to a claim covered by the insurance contract), including but not limited to dividends, retroactive rate adjustments, medical loss ratio payments, experience adjustments or refunds of any type or any amount payable by the insurance carrier because of a court judgment, settlement agreement or arbitration decision in response to actual or potential litigation, arbitration or any other dispute between the insurance company and the Employer shall be the property of, and shall be retained by, the Employer, except to the extent, if any, that

the Plan Administrator determines that a portion of any such amount is required to be treated as Plan assets under applicable law. To the extent that any portion of such a payment is required to be treated as Plan assets, as determined by the Plan Administrator, that amount will be used to pay reasonable Plan expenses or to provide Benefits or will be used for any other purpose that is consistent with applicable law regarding the use of such assets

Your Rights Under ERISA

As a participant in the Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA):

- You can examine, free of charge, at the Plan Administrator's office and at other locations, all of the Plan documents, including insurance contracts, if any, collective bargaining agreements and copies of all documents filed by the Plan (such as detailed annual reports) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- You can obtain copies of all Plan documents governing the operation of the Plan, by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

- In some cases, the law may require the Plan Administrator to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. As described above, if your claim for a Plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision, without charge and have the Plan review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials from the Plan and do not receive them within 30 days, you may file suit in 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 after review and reconsideration by the Plan or is 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 considering the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse Plan funds, if any, 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.

You may have the right to continued health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, 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.

Further Information

If you have further questions regarding the Plan or this Summary Plan Description, please contact the Plan Administrator at (516) 705-6947.

EXHIBIT: Dependent Care Tax Credit vs. Dependent Care FSA

If you have qualifying dependent care expenses, you may be able to choose one or both of two ways to reduce your taxes. You may be able to obtain a tax credit (which is a direct reduction in the amount of taxes you otherwise would owe) or you may be able to reduce your taxable income by contributing to a dependent care flexible spending account (Dependent Care FSA). This worksheet will help you decide which is better for you.

DEPENDENT CARE TAX CREDIT

If you qualify for the tax credit, you are allowed to deduct from the taxes you owe a percentage of the lesser of (1) your actual qualifying dependent care expenses or (2) $3,000 if you have one dependent or $6,000 if you have two or more dependents. The percentage is based on your adjusted gross income for the year (including your spouse's income if you file a joint return). The following chart will help you determine your percentage.

If your adjusted gross income is		The percentage of the cost of dependent care you can deduct from your taxes is:
over	to	
$0	$15,000	35%
$15,000	$17,000	34%
$17,000	$19,000	33%
$19,000	$21,000	32%
$21,000	$23,000	31%
$23,000	$25,000	30%
$25,000	$27,000	29%
$27,000	$29,000	28%
$29,000	$31,000	27%
$31,000	$33,000	26%
$33,000	$35,000	25%
$35,000	$37,000	24%
$37,000	$39,000	23%
$39,000	$41,000	22%
$41,000	$43,000	21%
$43,000	unlimited	20%

Example: An employee's adjusted gross income for the year is $34,000 and the employee spends $2,600 each year for day care for one dependent. When you compare $2,600 with the $3,000 allowed for one dependent, the lesser of the two amounts is $2,600. To find the employee's allowable percentage, you use the above chart. Since the employee's adjusted gross income is $34,000, the employee's percentage will be 25%. Therefore, the amount the employee will be able to deduct from his or her taxes will be $2,600 x 25% or $650.

INCOME EXCLUSION (DEPENDENT CARE FSA CONTRIBUTIONS)

Instead of the Dependent Care Tax Credit, each year you may elect to have a designated amount taken out of your paycheck before taxes and put into your Dependent Care FSA. This amount must be used during the year to pay for qualifying dependent care expenses. You will not have to pay taxes on the amount you put into the FSA that will be used to pay your qualifying dependent care expenses. If, however, either you or your spouse has Earned Income (as defined in the Plan) of less than $5,000, your income exclusion will be limited to the Earned Income of you or your spouse, whichever is less. Note that your maximum Dependent Care FSA contribution for any calendar year is $5,000 ($2,500, if you are married but file a separate federal income tax return), regardless of the number of qualifying dependents.

Example: The following is an example of an employee's comparison of the Dependent Care Tax Credit and the Dependent Care FSA. Assume the employee is married and the employee and spouse together expect to have $75,000 in adjusted gross income (AGI), and they expect to have $3,000 in qualifying dependent care expenses for the year for one qualifying child. They plan to file a joint federal income tax return. After taking the standard deduction ($25,900), their federal taxable income would be $49,100. Assume they live in a state that uses the same definition of taxable income as the IRS and a 5% tax rate. (Note that state income tax rates vary from zero to about 13% and states may use different definitions of taxable income. The federal tax rates and standard deduction amounts in this example are for the 2022 tax year.)

	Using the Tax Credit	Using the FSA
Federal Taxable Income (without Dependent Care FSA)	$49,100	$49,100
Subtract: Dependent Care FSA contribution	(0)	(3,000)
Federal Taxable Income	$49,100	$46,100
Taxes		
Federal (10% of first $20,550 of taxable income + 12% of amounts from $20,550 up to $83,550)	$5,481	$5,121
Social Security and Medicare (7.65% of AGI (minus Dependent Care FSA contributions))	5,737	5,508
State (5.0% of taxable income)	2,455	2,305
Total	$13,673	$12,934
Subtract: Tax Credit (20% of $3,000)	(600)	(0.00)
Total Taxes	$13,073	$12,934

In this example, the employee would pay $139 less in taxes by using the Dependent Care FSA. Of course, this is just one example. Other employees might pay lower taxes using the tax credit, so you should perform the calculations using your own estimated income, qualifying expenses and filing status. Also, note that participation in the FSA may affect other tax credits or deductions that you may qualify for, such as the Earned Income Tax Credit or the Child Tax Credit. You should consult with a tax advisor to determine which approach is best for you.

CALCULATE YOUR TAX CREDIT

Use the following chart to determine if you should use the Dependent Care Tax Credit or the Dependent Care FSA.

	Using the Tax Credit	Using the Income Exclusion (FSA)
Federal Taxable Income (before Dependent Care FSA)	$_____.	$_____.
Subtract: Dependent Care FSA contribution		($_____.)
Taxable Income	$.	$.
Taxes		
Federal* (_____%)	$_____.	$_____.
State* (_____%)	_____.	_____.
Social Security (generally 7.65% of total wages B remember to subtract FSA contributions for the second column)	_____.	_____.
Total	$_____.	$_____.
Subtract: Tax Credit (% from chart on previous page based on your adjusted gross income X your expected qualifying dependent care expenses)	($_____.)	
Total Taxes	$.	$.

*Federal and state tax rates vary depending upon your taxable income and filing status. Estimate your tax liability or check with your tax consultant. Also, note that Pennsylvania and New Jersey, unlike other states, do not exclude Dependent Care FSA contributions from state income tax.

USE OF BOTH DEPENDENT CARE TAX CREDIT AND INCOME EXCLUSION

You may use both the Dependent Care Tax Credit and the Dependent Care FSA (although not for the same qualifying dependent care expenses.) However, any amounts that you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the $3,000 or $6,000 Dependent Care Tax Credit figure, whichever is applicable.

Example: An employee's adjusted gross income for the year is $34,000 and the employee spends $2,600 during the year for qualifying day care for one dependent. The employee elects to contribute $1,200 into a Dependent Care FSA to pay for a portion of the dependent care expenses. When you compare the employee's remaining dependent care expenses of $1,400 with $1,800 ($3,000 - $1,200), the lesser of the two amounts is $1,400. Given the employee's adjusted gross income of $34,000, the employee's percentage from the chart is 25%. Therefore, the amount the employee may deduct from the employee's taxes will be $1,400 x 25% or $350.

ALWAYS DISCUSS THESE ISSUES WITH YOUR TAX ADVISOR.