PADDLE PALACE, INC.
EMPLOYEE BENEFITS PLAN &
ERISA WRAP SUMMARY PLAN DESCRIPTION

PLAN PURPOSE

Paddle Palace, Inc. (the "Employer") maintains the **Employee Benefit(s) Plan** ("the Plan") for the exclusive benefit of its eligible employees and their eligible dependents. Benefits under the Plan are currently provided under a group health insurance contract ("the Group Health Insurance Contract") entered into between the Employer and Providence, (Providence).

Plan benefits, including information about eligibility, are summarized in the Certificate of Coverage, Member Payment Summary, and Provider & Facility Directory issued by Providence, copies of which are available from your Human Resources Department, free of charge. These documents together with this document constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA"). Capitalized terms not otherwise defined in this document are defined in the Certificate of Coverage.

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

For additional information regarding the Plan, you should contact your Employer or HR Administrator or refer to the Welfare Program documents and the full insurance contracts. Copies of the documents are available from the Employer on request. If the terms of this SPD conflict with the Plan documents, the Plan documents shall govern.

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As used in this Summary Plan Description (SPD), "Your" means an active Employee as described under "Who is Eligible."

SPECIFIC PLAN INFORMATION

Plan Name:	Paddle Palace, Inc. Employee Benefit(s) Plan
Type of Plan:	A group health plan (a type of welfare benefits plan subject to the provisions of ERISA).
Plan Year:	March 1 to February 28
Effective Date:	May 1, 2025
Plan Number:	502
Insurance Company:	Providence https://www.providencehealthplan.com/
Ancillary Insurance Companies:	Standard https://www.standard.com/
Employer / Plan Sponsor:	Paddle Palace, Inc. Judy Hoarfrost 12230 SW Main St Tigard, OR 97233
Plan Funding and Type of Administration:	The Plan is fully insured. Benefits are provided under the Group Health Insurance Carrier Contract between the Employer and Providence. Claims for benefits are sent to Providence, which is responsible for paying claims. Providence and the Employer share responsibility for administering the Plan. Insurance premiums for employees and their eligible dependents are paid in part by the Plan Sponsor out of its general assets, and in part by employees' payroll deductions.
Plan Sponsor's Employer Identification Number:	93-1068052
Plan Administrator:	Paddle Palace, Inc. 12230 SW Main St Tigard, OR 97233 Attention: Judy Hoarfrost
Named Fiduciary:	Paddle Palace, Inc. 12230 SW Main St Tigard, OR 97233

Agent for Service of Legal Process:

Paddle Palace, Inc.
12230 SW Main St
Tigard, OR 97233

(503) 777-2266

Service of process may also be made on the Plan Administrator.

Important Disclaimer:

Plan benefits are provided under a Group Health Insurance Contract between the Employer and Providence. If the terms of this summary document conflict with the terms of the Group Health Insurance Contract, the terms of the Group Health Insurance Contract will control, unless superseded by applicable law.

This document addresses required DOL and ACA notices, claims procedures, rights and obligations specific to the group health plan. Please see individual certificates of coverage or policy documents for supplemental insurance plans for claims procedures, rights and obligations.

PADDLE PALACE, INC.

RESOLUTION TO ADOPT

EMPLOYEE BENEFITS PLAN &

ERISA WRAP SUMMARY PLAN DESCRIPTION

WHEREAS, Paddle Palace, Inc. has determined that it would be in the best interests of its employees to adopt an "Employee Benefit(s) Plan" allowing for medical and other benefit coverage, so-called; be it known that a vote was taken, and all were in favor.

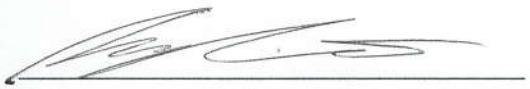
RESOLVED, that Paddle Palace, Inc. adopt an "Employee Benefit(s) Plan," all in accordance with the specifications annexed hereto; and, be it known that the "Paddle Palace, Inc. Employee Benefits Plan" was executed.

RESOLVED FURTHER, that Paddle Palace, Inc. adopt the required ERISA "Wrap Summary Plan Description," with all of the specifications annexed hereto; be it known that the "Paddle Palace, Inc. Employee Benefits Plan SPD Document" was also executed.

RESOLVED FURTHER, that the Company undertake all actions necessary to implement and administer said Employee Benefit(s) Plan, and distribute said ERISA Wrap SPD to all participants and their beneficiaries.

IN WITNESS WHEREOF, I have executed my name for the above named Company on May 1, 2025.

ATTEST:



Witness

Ryan Hoarfrost

By: 

Judy Hoarfrost

SUMMARY OF PLAN BENEFITS

The Plan provides eligible employees and their eligible dependents with health insurance. These benefits are provided under the Group Health Insurance Contract with Providence. A summary of the benefits provided under the Plan is in the Certificate of Coverage issued by Providence.

The Plan, through the Group Health Insurance Contract, provides benefits in accordance with the applicable requirements of federal laws, such as Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Newborns' and Mothers' Health Protection Act (NMHPA), Mental Health Parity Act (MHPA), Women's Health and Cancer Rights Act (WHCRA), Genetic Information Nondiscrimination Act of 2008 (GINA), and the Affordable Care Act (ACA).

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them.

The Plan is fully insured. Benefits are provided under the Group Health Insurance Contract entered into between the Employer and Providence. Claims for benefits are sent to Providence, and Providence, not the Employer, is responsible for paying them. Providence is also responsible for determining eligibility for and the amount of any benefits payable under the Plan and prescribing claims procedures and forms to be followed to receive Plan benefits. Providence also has the discretionary authority to require participants to furnish it with such information as it determines is necessary for the proper administration of claims for Plan benefits.

Claims and Appeals

Providence is responsible for evaluating all benefit claims under the Plan. Providence will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If your claim is denied, you may appeal to Providence for a review of the denied claim and Providence will decide your appeal in accordance with its reasonable procedures, as required by ERISA. See the Certificate of Coverage for complete details regarding Providence's claims and appeals procedures.

Amendment or Termination of the Plan

As Plan Sponsor, the Employer has the right to amend or terminate the Plan at any time. You have no vested or permanent rights or benefits under the Plan. Plan benefits will typically change from year-to-year and you should examine the SPD provided to you each year to determine the benefits of the Plan.

Other Materials

The Certificate of Coverage (including the Member Payment Summary, and the Provider & Facility Directory) issued by Providence are part of the Summary Plan Description as attachments. Please refer to these materials for other important provisions regarding your participation in the Plan.

Who is Eligible

In order to be eligible for benefits you must be scheduled to work 35 or more hours per week. During the Employer Waiting Period, you must work the specified minimum required hours except for paid time off and hours you do not work due to a medical condition, the receipt of healthcare, your health status or disability. Providence may require payroll reports from your employer to verify the number of hours you have worked as well as documentation from you to verify hours that you did not work due to paid time off, a medical condition, the receipt of healthcare, your health status or disability.

To determine whether your spouse and dependent children are eligible to participate in the Plan, please read the eligibility information contained in the Certificate of Coverage issued by Providence.

The Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children. Also eligible is any child covered under a Qualified Medical Child Support Order (QMCSO) as defined by applicable law and determined by your Employer under its QMCSO procedures, a copy of which is available from your Human Resources Department, free of charge.

If eligible, you must complete an application form to enroll in the Plan and Providence (available from your Human Resources Department) or otherwise comply with your Employer's enrollment procedures.

Coverage will terminate if you no longer meet the eligibility requirements. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, etc. (See the Certificate of Coverage for more information.) Coverage for your spouse and dependents stops when your coverage stops. Their coverage will also stop for other reasons specified in the Certificate of Coverage.

Waiting Period

You are eligible to participate on the first day following completion of 30 consecutive days of active employment as an Eligible Employee.

Monthly Measurement Method Used For Determining Full-Time Employee Status

On Feb. 12, 2014, the Internal Revenue Service (IRS) published final regulations on the employer shared responsibility rules. The final regulations provide two methods for identifying full-time employees for purposes of offering health plan coverage and avoiding a pay or play penalty—the monthly measurement method and the look-back measurement method.

A full-time employee is an employee who was employed, on average, at least 30 hours of service per week. The final regulations treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours per service per week.

Paddle Palace, Inc. currently uses the monthly measurement method which involves a month-to-month analysis where full-time employees are identified based on their hours of service for each calendar month. This method is not based on averaging hours of service over a prior measurement period.

Patient Protections and Selection of Providers

Providence generally requires the designation of 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 information on how to select a primary care provider, and for a list of the participating primary care providers, contact Providence at https://www.providencehealthplan.com/

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Providence or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Providence at https://www.providencehealthplan.com/

SPECIAL SITUATIONS, EXTENSION OF COVERAGE

FMLA does not apply to: (1) employers that do not employ 50 or more employees during 20 or more calendar workweeks in current or preceding calendar year; (2) employees at worksites with less than 50 employees, if the employer employs fewer than 50 employees within a 75-mile radius of that worksite. COBRA does not apply to groups with less than 20 employees in preceding year.

FMLA Leave Entitlement Family and Medical Leave Act (FMLA)

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

FMLA Benefits & Protection

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

FMLA Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting FMLA Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

FMLA Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

FMLA Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

The Plan intends to comply with all existing FMLA regulations. If for some reason the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

For more information please see: https://www.dol.gov/general/topic/benefits-leave/fmla

Military Leave Coverage

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that employers must meet for certain employees who are involved in the uniformed services

As used in this provision, "Uniformed Services" means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;
- Full-time National Guard duty,
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

1) You fail to make a premium payment within the required time;
2) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
3) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your Employer.)

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan Administrator reserves the right to administer the plan in accordance with such actual regulations.

COBRA Continuation Coverage *(only applies to groups of 20+ employees in preceding year)*

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." The following are qualifying events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your eligible dependents;
- A reduction in your hours. Coverage may continue for you and/or your eligible dependents;
- Your death. Coverage may continue for your eligible dependents;
- Your divorce or legal separation. Coverage may continue for your eligible dependents;
- Your becoming entitled to Medicare. Coverage may continue for your eligible dependents; and
- Your covered dependent child's ceasing to be a dependent child under the Plan. Coverage may continue for that dependent.
- If the Plan includes retiree coverage, Employer Bankruptcy is a qualifying event.

Note: To choose this continuation coverage, an individual must be covered under the Plan on the day before the qualifying event. In addition, your newborn child or child placed for adoption with you during a period of continuation coverage will remain eligible for continuation coverage for the remaining period of coverage even if you and/or your spouse terminate continuation coverage following the child's birth or placement for adoption.

Notification Requirements

Under the law, you or the applicable dependent has the responsibility to inform the Plan Administrator, in writing, within 60 days of a divorce or legal separation or of a child losing dependent status under the Plan. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights.

Your Employer has the responsibility to notify the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

Subject to the Plan Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan will promptly notify you and other qualifying

individual(s) of their continuation coverage rights. You and any applicable dependents must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights.

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, they you will be provided with an additional 60 day enrollment period, with continuation coverage beginning on the date of such TAA approval.

Notice of Unavailability of Continuation Coverage

If the Plan Administrator receives a notice of a qualifying event from you or your dependent and determines that the individual (you or your dependent) is not entitled to continuation coverage, the Plan Administrator will provide to the individual an explanation as to why the individual is not entitled to continuation coverage. This notice will be provided within the same time frame that the Plan Administrator would have provided the notice of right to elect continuation coverage.

Maximum Period of Continuation Coverage

The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the

maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

Cost of Continuation Coverage

The cost of continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150 percent of the Plan's cost of coverage.

Premium payments for continuation coverage for you or your eligible dependent's "initial premium month(s)" are due by the 45th day after electing continuation coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elects continuation coverage. All other premiums are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by your Employer and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

1. The date the maximum continuation coverage period expires;
2. The date your Employer no longer offers a group health plan to any of its employees;
3. The first day for which timely payment is not made to the Plan;
4. The date the qualifying individual becomes covered by another group health plan. However, if the new plan contains an exclusion or limitation for a pre-existing condition of the qualifying individual, continuation coverage will end as of the date the exclusion or limitation no longer applies;

5. The date the qualifying individual becomes entitled to coverage under Medicare; and
6. The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. In order to be eligible to apply for such coverage from a carrier after ceasing participation in the Plan, you or your eligible dependents must elect continuation coverage under the Plan, continue through the maximum continuation coverage period (18, 29, or 36 months, as applicable), and then apply for coverage with the individual insurance carrier before a 63 day lapse in coverage. For more information about your right to such individual insurance coverage, contact an independent insurance agent or your state insurance commissioner.

Notice of Termination Before Maximum Period of COBRA Coverage Expires

If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

The Plan intends to comply with all applicable law regarding continuation (COBRA) coverage. If for some reason the information presented in this Plan differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the Plan (which is a type of employee welfare plan called a "group health plan") you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from a group health plan or a health insurance issuer when you lose coverage under a group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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.

GENERAL NOTICES

Benefits after Childbirth (NMHPA)

Group health plans may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, and less than 96 hours following a caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-pockets costs or to use a certain provider or facility. Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prevents discrimination by group health plans and insurance companies based on genetic information. Generally, this Plan and the insurance companies from which it has purchased coverage are not permitted to:

- Use genetic information to discriminate with respect to premiums or contributions;
- Request or require Participants and/or their Dependents to undergo genetic testing (except in specifically permitted situations);
- Collect genetic information for underwriting purposes or prior to enrollment under the Plan;
- Use genetic information to determine eligibility for coverage.

Genetic information includes any information about (i) an individual's genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual.

Women's Health & Cancer Rights Act (WHCRA)

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

- all stages of reconstruction of the breast on which the mastectomy was performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurances shown in the Benefit Description will apply.

Discrimination Based on Health-Related Factors Prohibited

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

HIPAA Privacy Issues

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

Neither this Plan nor the Employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Qualified Medical Child Support Orders

A qualified medical child support order ("QMCSO") is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide coverage to a child or children of an Employee. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

(a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);

(b) Promptly notify the Employee and the child (or child's guardian) of the receipt of any medical child support order, and the group medical plan's procedures for determining whether a medical child support order is a QMCSO; and

(c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Employee and the child of such determination.

State Medicaid Programs

Eligibility for coverage or enrollment in a State Medicaid Program will not impact your eligibility or a Spouse's or Dependent's in this Plan. Payment of benefits shall be in accordance with any assignment of rights as required by any State Medicaid Program.

If a Welfare Program available under this Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such Welfare Program will govern unless the language fails to comply with applicable laws and regulations.

Special Rules for Maternity and Infant Coverage

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child

to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

Special Rules for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the plan or coverage. For answers to specific questions regarding your particular health plan's policy, contact the Plan Administrator.

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be

able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

See more information at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/chipra/model-notice.pdf

Claims Procedures for the Plan

Except as provided below, claims for benefits under each Plan that is either insured or self-insured will be reviewed in accordance with procedures contained in the policies, contracts, summary plan descriptions or other written materials for such Plan benefits. All other general claims or requests should be directed to the Claims Administrator. If a claim under the Plan is denied in whole or in part, the Claims Administrator will notify you or your beneficiary in writing of such denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive and binding.

Claims Procedure for Benefits Based on Determination of Disability

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

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

- if applicable, an explanation for disagreeing with or not following the views of health care professionals or vocational experts, or with a disability benefit determination made by the Social Security Administration;
- the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim (or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist); and
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and, if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to

the claimant's medical circumstances (or a statement that such explanation will be provided free of charge upon request).

You will receive a benefit denial notice within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

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

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

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

Claims Procedures for Group Health Plans

The following claims procedures shall apply specifically to claims made under any group health plan under this Plan. To the extent that these procedures are inconsistent with the claims procedures

contained in the policies, contracts, summary plan descriptions or other written materials for the group health plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials shall supersede these procedures as long as such other claims procedures comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, as applicable to the Plan.

Benefit Determinations

Post-Service Claims

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

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

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

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day

time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Claims

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

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

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

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

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

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined

above, your request will be decided as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

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

Claim Denial Notices

If your claim for benefits is denied in whole or in part, you or your beneficiary will receive notification regarding the claim denial within the applicable time period described above. This denial notice will include the reasons for the denial, reference to the Plan provision supporting the denial, a description of the Plan's appeals procedures and other relevant information regarding the claim decision.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

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

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

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

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

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

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

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

Urgent Care Claim Appeals

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

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

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

External Review

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

Medicare Part D Notification Requirements

Employers sponsoring a group health plan with prescription drug benefits are required to notify their Medicare-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is "creditable" or "non-creditable." This notification must be provided **prior to October 15th each year**. Also, following the plan's annual renewal, the employer must notify the Centers for Medicare & Medicaid Services ("CMS") of the creditable status of the drug plan.

Below you will find information that summarizes these requirements in more detail.

What are the Medicare Part D Notification Requirements About?

Medicare Part D, the Medicare prescription drug program, generally imposes a lifetime penalty for late enrollment if an individual delays enrolling in Part D after initial eligibility (for example, after reaching age 65), unless the individual continues to be covered by an employer's group medical plan because of active employment or COBRA, and coverage under the plan is "creditable" (meaning equal to or better than coverage provided under a Part D standard plan).

Employers that provide prescription drug benefits are required to notify Medicare-eligible individuals annually as to whether the employer-provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay Part D enrollment.

Also, the employer must annually notify CMS as to whether or not the employer plan is creditable.

Medicare Part D Participant Notice

In order to assist employers in their compliance obligations, CMS has issued participant disclosure model notices for both creditable and non-creditable coverage, which can be found at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters

These model notices, when appropriately modified, will serve as a proper notice for purposes of this requirement. Spanish notices are also provided at the above link.

Special Enrollment Rights

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

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

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

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

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

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

ADDITIONAL INFORMATION

Compliance with State and Federal Mandates

With respect to the benefits and as applicable, the Plan will comply with the requirements of all applicable laws. If for some reason the information presented in this Wrap SPD differs from the actual requirements of any law, the Plan reserves the right to administer the Plan in accordance with those requirements.

No Contract of Employment

Nothing in this Plan shall be construed as a contract of employment between the Employer and any employee or Participant, or as a guarantee of any employee or Participant to be continued in the employment of the Employer, nor as a limitation on the right of the Employer to discharge any of its employees with or without cause.

Medical Loss Ratio Rebates under the Public Health Service Act

In certain circumstances under the Medical Loss Ratio Standards in § 2718 of the Public Health Service Act, rebates may be paid to this Plan based on the insurance carrier's medical loss ratio. Insurance carriers are required to provide Participants with a written notice of a rebate at the time the rebate is paid to the Plan. Any rebate received by the Employer may be retained by the Employer. Any portion of the rebate attributable to Participant contributions will be used for the benefit of the Participants. This may be done by, for example, lowering the Plan costs for those Participants who are enrolled during the next Plan Year, applying the rebate towards the cost of administering the Plan, implementing a wellness or other program to help reduce plan costs, providing additional taxable income to the Participants, or using the rebate in any other reasonable manner.

Subrogation

Because the Plan is entitled to reimbursement of medical expenses owed by a third party, the Plan has the right to seek repayment of these expenses from the responsible third party. This means that the plan is subrogated to any and all rights, recovery or causes of actions or claims that a Participant or Dependent may have against any third party.

The Plan may enforce its subrogation rights by requiring the Participant to assert a claim to any insurance or other benefits to which the Participant or a Dependent may be entitled.

Once a Participant or Dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. And, at that time, the Participant (and the Participant's attorney, if applicable) will be required to sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or Dependent to any payment, amount or recovery from a third party.

Each Participant and Dependent consents and agrees that they will not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights.

Additional Information Contained in Attached Benefit Descriptions

The following additional information about the Benefits is included in the Benefit Descriptions for the benefit (if applicable):

- Any additional procedures for enrolling in the Plan;
- A summary of benefits, though this may be provided as a separate document;
- A description of any premiums, deductibles, coinsurance or copayment amounts. The schedule of your contributions, if any, to the premium payment will be provided to you by the Employer;
- A description of any annual or lifetime caps or other limits on benefits;
- Whether and under what circumstances preventive services are covered;
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers (if any). If there is a network, the Benefit Description will contain a general description of the provider network and you will receive automatically, without charge, a list of providers in the network from the carrier or administrator;
- Whether and under what circumstances coverage is provided for any out-of- network services;
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- Any services requiring preauthorization or utilization review as a condition to obtaining a benefit service;
- A summary of the claim procedures. However, if the claims procedures are not included in the Benefit Description, a copy will be provided to you automatically, without charge from the insurance carrier or administrator;
- Provisions describing the coordination of benefits with the benefits provided under another similar plan in which you or another plan participant are enrolled;
- Any additional information not covered by this SPD about subrogation, coordination of benefits, or reimbursement rights that prevent duplicate payments for your health care; and
- Any other benefit limitations and exclusions.

PADDLE PALACE, INC.

Schedule A

OTHER COVERAGE OPTIONS UNDER THE PLAN*:

NAME OF COVERAGE

DENTAL INSURANCE:
Standard https://www.standard.com/

*The Employee contributions necessary to obtain the coverage options set forth in this Schedule A above will be communicated by the Employer to Eligible Employees at the time of Enrollment and in Schedule B. The required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option above.

PADDLE PALACE, INC.

Schedule B

FORMULA FOR EMPLOYEE CONTRIBUTIONS UNDER THE PLAN

The following description of the Employee Contribution per Participant may be expressed as a percentage of monthly cost, or as a flat monthly dollar amount. If the formula for Employee contributions varies by class of Employees, the Employer Sponsor assumes full responsibility for its Employer contribution design.*

Name of Benefit Plans To Be Offered		Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
Providence	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
Standard	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%

ER = Employer Contribution
EE = Employee Contribution

*An asterisk in the premium column means there are multiple rates based on age, sex, or other demographics. Please refer to specific insurance carrier premium rate sheets for individual maximum elective contribution.

In no event shall the existence of any Employer contributions for monthly premium costs, as indicated above, be construed to require the Employer to pay or otherwise be liable for any deductible, coinsurance, co-payment or other cost-sharing amounts related to the applicable medical care coverage option elected by the Participant.

PADDLE PALACE, INC.

Schedule C

PARTICIPATING AFFILIATED EMPLOYERS

(Companies under common ownership)

The following organizations and entities shall be Participating Employers under the Plan:

Name of Participating Employer

None