Point32Health

Point32Health Services, Inc.

Health and Welfare Benefit Plan

Medical, Dental, Vision, Disability, Term Life, Travel Assistance Program, Flexible Spending Account (FSA), Employee Assistance Program (EAP), Voluntary Legal, Voluntary Benefit Plan options, Legacy Long-Term Care (LTC), and the Point32Health Health Center

For Active Employees

Effective January 1, 2024

Summary Plan Description Wrap Document for:

- **Medical: HPHC Insurance Company, Access America Value No Deductible**
- **Medical: HPHC Insurance Company, Access America Value with Deductible**
- **Medical: HPHC Insurance Company, Access America with Deductible**
- **Medical: HPHC Insurance Company, Access America HSA with Deductible**
- **Medical: Blue Cross Blue Shield of Rhode Island Medicare Advantage (Legacy Retiree plan)**
- **Dental: Delta Dental of Massachusetts**
- **Vision: EyeMed**
- **Disability (Short-term and Long-term): Unum**
- **Term Life & Accidental Death & Dismemberment (AD&D): Unum**
- **Travel Assistance Program: Unum**
- **Flexible Spending Account (FSA): Wex**
- **Employee Assistance Program (EAP): KGA**
- **Voluntary Legal: Arag**
- **Voluntary Benefit Plans: Unum**
- **Voluntary Benefit Plan Long-Term Care (Legacy LTC plan): Unum**
- **Point32Health Health Center: Premise Health**

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INTRODUCTION – About the Plan

Point32Health Services, Inc. (also referred to as the "Company" or the "Plan"), provides the following benefit plan options for employees. This document, along with other provider documents, such as insurance booklets, certificates and/or provider contracts, is the Summary Plan Description (SPD) for these Plans. These documents describe the Plan as in effect January 1, 2024. This SPD supersedes information communicated in prior booklets.

This document supplements materials for the medical, dental, vision, disability (short-term and long-term), term life, travel assistance program, flexible spending account (FSA), employee assistance program (EAP), voluntary legal, voluntary benefit plan options offered, legacy long-term care (LTC) plan, and the Point32Health Health Center.

Self-Insured Plans - Who Insures Your Benefits?

Your medical, dental, and short-term disability (STD) benefits are self-insured by Point32Health Services, Inc.

There is no insurance company to collect premiums or underwrite coverage. Instead, contributions from you and Point32Health Services, Inc. pay all benefits. The Plan uses prior claims experience and forecasts expenses to determine the amount of money needed to pay future benefits. Federal laws, not state insurance laws, govern these options.

Fully Insured Plans - Who Insures Your Benefits?

Your vision, long-term disability (LTD), term life & accidental death & dismemberment (AD&D) plans, travel assistance program, voluntary legal, voluntary benefit plans, and legacy long-term care (LTC) plans are fully insured at Point32Health Services, Inc.

A fully insured health plan is a traditional type of insurance option sponsored by an employer. The employer pays monthly and yearly premiums to the insurance company, with fixed annual amounts based on how many employees are enrolled in the plan.

Medical Plan Benefit Handbook

For information on which medical plans you are eligible for, refer to ***Eligibility and Plan Participation*** section for more information:

- Access America Value No Deductible
- Access America Value with Deductible
- Access America with Deductible
- Access America HSA with Deductible

Please refer to the Benefit Handbook terms for the words used throughout this SPD and the Benefit Handbook.

The Access America Value No Deductible, Access America Value with Deductible, Access America with Deductible and Access America HSA with Deductible medical plans meet Massachusetts Minimum Creditable Coverage standards and will satisfy the Massachusetts individual mandate to have health insurance. Please refer to the applicable Summary of Benefits and Coverage (SBC) for additional information.

Dental, Vision, Disability, Life, Travel Assistance Program, Flexible Spending Account (FSA), Employee Assistance Program (EAP), Voluntary Legal Plan, and Voluntary Benefit Plans Certificates of Coverage/Benefit Information:

For information on which plans you are eligible for, refer to ***Eligibility and Plan Participation*** section for more information:

- Dental
- Vision
- Short-Term Disability (STD)
- Long-Term Disability (LTD) (below Director)
- Long-Term Disability (LTD) (Director and above)
- Basic Term Life and Accidental Death & Dismemberment (AD&D)
- Voluntary Term Life and Accidental Death & Dismemberment (AD&D)
- Travel Assistance Program
- Flexible Spending Account (FSA)
- Employee Assistance Program (EAP)
- Voluntary Legal Plan
- Voluntary Benefit Plan Accident
- Voluntary Benefit Plan Critical Illness
- Voluntary Benefit Plan Hospital
- Point32Health Health Center

Medical Plan Claim Administrator

The claim administrator is the entity authorized by each Plan to interpret the Plan and approve or deny claims and appeals. As used in this section, the term “claim administrator” for each medical plan refers to:

Harvard Pilgrim Health Care is the Medical Plan Claim Administrator for the:

- Access America Value No Deductible
- Access America Value with Deductible
- Access America with Deductible
- Access America HSA with Deductible

Address:

Harvard Pilgrim Health Care
1 Wellness Way
Canton, MA 02021-1166

Medical Questions?

If you have any questions, contact Member Services:

Plan	Telephone Number
Access America Value No Deductible	1-888-333-4742
Access America Value with Deductible	1-888-333-4742
Access America with Deductible	1-888-333-4742
Access America HSA with Deductible	1-888-333-4742
Blue Cross Blue Shield of RI Medicare Advantage (Legacy Retiree plan)	1-781-612-1000 (Point32Health Human Resources)

Harvard Pilgrim Health Care: **Deaf and hard-of-hearing** Members who use a Teletypewriter (TTY) may communicate with the Member Services Department. For TTY service, please call 711.

This document summarizes the official Plan documents for your medical plans. The full facts and details concerning the operation of these plans are contained in official Plan documents, which are on file with Human Resources. In the event of any conflict between this section and the official Plan documents, the Plan documents will always govern. The official Plan documents will also govern over any conflicting oral representations concerning the benefits provided under these plans.

Questions: Dental, Vision, Disability, Life, Travel Assistance Program, Flexible Spending Account (FSA), Employee Assistance Program (EAP), Voluntary Legal Plan, Voluntary Benefit Plans, Legacy Long-Term Care (LTC), and Point32Health Health Center

Plan	Telephone Number	Website
Delta Dental	800-872-0500	deltadentalMA.com
Eye Med Vision	866-804-0982 (pre-enrollment) 866-800-5457	eyemed.com
Unum Disability	866-779-1054	unum.com/employees
Unum Basic Term Life and Accidental Death & Dismemberment (AD&D)	866-779-1054	unum.com/employees
Unum Voluntary Term Life and Accidental Death & Dismemberment (AD&D)	866-779-1054	unum.com/employees
Unum Travel Assistance Program	866-779-1054	unum.com/employees
Wex Flexible Spending Account (FSA)	866-451-3399	Wexinc.com/login/benefits-login/
KGA Employee Assistance Program (EAP)	800-648-9557	My.KGALifeServices.com
Arag Voluntary Legal Plan	800-247-4184	www.araglegal.com
Unum Voluntary Benefits Plan	800-635-5597	
Unum Voluntary Benefits Long-Term Care (Legacy LTC Plan)	877-286-2852	LTCiBenefitsTeam@ltc-solutions.com
Point32Health Health Center	781-612-1751	NA

ELIGIBILITY AND PLAN PARTICIPATION

You are eligible to participate in a Point32Health Services, Inc. medical plan, dental, vision, disability, term life, travel assistance program, flexible spending account (FSA), employee assistance program (EAP), voluntary legal, and voluntary benefit plan options if you are an active part-time or full-time employee of the Company who is regularly scheduled to work for at least 20 hours per week.

You are also eligible to participate in the medical plan or dental plans if you are a non-employee active member of the Board of Directors of Point32Health Services, Inc.

Active full-time or part-time employees, temporary staff, contractors, and Board of Directors are eligible to utilize the Point32Health Center.

Legacy Plans:

- The Blue Cross Blue Shield of RI Medicare Advantage (Legacy Retiree plan) is not available to active employees and is not available for new enrollment elections or changes.
- The Long-Term Care (Legacy LTC) plan is not available for new enrollment elections.

Harvard Pilgrim Health Care Plan Providers

To obtain In-Network Covered Benefits you must receive services from a Plan Provider. Plan Providers include a large number of PCPs, specialists, hospitals, and health care facilities located within the Service Area. The Harvard Pilgrim Health Care Service Area includes the states of Massachusetts, Maine, and New Hampshire.

In addition, your Plan includes a large national network of Plan Providers located across the United States. Plan Providers are listed in the Provider Directory. You may view the Provider Directory online on the HPHC website at www.harvardpilgrim.org.

You can contact Member Services if you have any questions concerning your medical plan's service area requirement. Refer to the information above for each Plan's phone number.

Your Plan Benefits: Eligibility and Plan Participation

PLAN	ELIGIBILITY	PLAN PARTICIPATION
Medical Plans: • Access America Value No Deductible • Access America Value with Deductible • Access America with Deductible	• Active full-time or part-time • Regular work schedule: at least 20 hours per week • Employees across the U.S. may enroll in any plan. • **Services in MA, ME**	• You need to actively enroll and make before-tax payroll deduction contributions • Your cost depends on the plan and coverage level you elect and your annual salary

• Access America HSA with Deductible	**& NH** utilize **Harvard Pilgrim** network providers & facilities are covered as in-network. • **Services outside MA, ME & NH** utilize UnitedHealthcare's Choice Plus network providers & facilities are covered as in-network.	
• Delta Dental of Massachusetts	• Active full-time or part-time • Regular work schedule: at least 20 hours per week	• You need to actively enroll and make before-tax payroll deduction contributions • Your cost depends on the plan and coverage level you elect
• EyeMed Vision	• Active full-time or part-time • Regular work schedule: at least 20 hours per week	• You need to actively enroll and make before-tax payroll deduction contributions • Your cost depends on the coverage level you elect
• Disability	• Active full-time or part-time • Regular work schedule: at least 20 hours per week	• Automatically enrolled in Company paid Short-Term Disability (STD) and Long-Term Disability (LTD) • Option to elect post-tax payroll deduction contributions for additional STD buy-up. • Option to elect Long-Term Disability (LTD) Tax Choice Option
• Basic Term Life and AD&D	• Active full-time or part-time • Regular work schedule: at least 20 hours per week	• Automatically enrolled in Company paid Basic Life and AD&D • You must set up beneficiary designations
• Voluntary Term Life and AD&D	• Active full-time or part-time • Regular work schedule: at least 20 hours per week	• You need to actively enroll and make post-tax payroll deduction contributions • Your cost depends on the coverage you elect • You must set up beneficiary designations
• Travel Assistance	• Active full-time or	• Automatically enrolled

Program	part-time • Regular work schedule: at least 20 hours per week	
• Flexible Spending Account (FSA)	• Active full-time or part-time • Regular work schedule: at least 20 hours per week	• You need to actively enroll and make before-tax payroll deduction contributions
• Employee Assistance Program (EAP)	• Active full-time or part-time • Regular work schedule: at least 20 hours per week	• Automatically enrolled
• Voluntary Legal	• Active full-time or part-time • Regular work schedule: at least 20 hours per week	• You need to actively enroll and make post-tax payroll deduction contributions
• Voluntary Benefit Plans (Accident, Critical Illness, Hospital Indemnity)	• Active full-time or part-time • Regular work schedule: at least 20 hours per week	• You need to actively enroll and make post-tax payroll deduction contributions
• Point32Health Health Center	• Active full-time or part-time colleagues, temporary staff, contractors, and the Board of Directors	• No cost to employees • Any out-of-pocket cost depends on specific medical plan coverage • Copay required for contractors

Coverage for Your Eligible Dependents

You can provide your eligible dependents with medical, dental, vision, voluntary life, voluntary benefit plans plan coverage. Your eligible dependents include:

- your spouse;
- your domestic partner;
- your dependent child (or your domestic partner's child) through the end of the month in which they turn age 26;
- a disabled dependent child at any age who is incapable of self-support due to a mental or physical handicap (An employee cannot add a dependent who is age 26 or over as a disabled dependent if the disability occurred after they turned age 26).

Definition of "Spouse": In order to qualify as an eligible dependent, your spouse must be legally married to you in accordance with the law in the state in which you reside.

Definition of "Children": For Plan purposes, your children include your legally adopted

children, children placed with you for adoption prior to legal adoption, and stepchildren and foster children who depend on you for support and maintenance. Your children also include any other children:

- for whom you have legal guardianship;
- children of a qualified domestic partner;
- who meet the IRS definition of your dependents; or
- children for whom the Company is required to provide coverage under a Qualified Medical Child Support Order (QMCSO – see below).

The age limit for children noted above is **age 26**.

Disabled Dependent Child: For Plan purposes, a disabled dependent child is your child who:

- became permanently physically or mentally disabled before his or her 26th birthday (An employee cannot add a dependent who is age 26 or over as a disabled dependent if the disability occurred after they turned age 26);
- is incapable of supporting himself or herself due to disability;
- lives with you or your spouse/domestic partner; and
- was covered under your family coverage immediately before reaching age 26.

Definition of "Domestic Partner": For Plan purposes, a domestic partner is an unmarried employee's partner of the same or opposite sex who:

- is at least 18 years of age;
- is not married to anyone and share a mutually exclusive and enduring relationship with the employee;
- is not related to the employee by blood; (not so closely related by blood as to preclude legal marriage in your state of residence); and
- meets the eligibility criteria described below.

The employee and the domestic partner must:

- share a mutually exclusive and enduring relationship with the employee;
- share a common residence for at least 6 prior consecutive months and intend to do so indefinitely with the employee;
- are financially interdependent and have agreed to assume financial responsibility for the welfare of each other;
- consider yourselves life partners and share joint responsibility for your common welfare; and
- the employee and domestic partner be committed to a life partnership with each other and have not signed a domestic partner affidavit with any other person within the last 6 months.

Note: Roommates who do not satisfy the above criteria, parents, and siblings of an employee cannot qualify as domestic partners.

Proof of Dependent Eligibility

You will be asked to provide proof of you and your dependents eligibility or continuing eligibility. If you enroll a Domestic Partner as a dependent, you will also be asked to complete a Domestic Partner Statement of Enrollment Form and attest to the effective date that shared residency began. You must provide proof when asked. This may include proof of residence, marital status, domestic partnership, birth or adoption of a child, and legal responsibility for health care coverage.

Failure to respond or provide sufficient documentation to verify the eligibility of your dependents will result in the removal of your covered dependents and you may be subject to appropriate disciplinary action. If coverage is terminated retroactively, you may be responsible for repayment of claims and any costs associated with providing coverage to the ineligible dependent.

As part of health care reform, the Plan is required to request and provide the IRS with Social Security numbers for all dependents covered by a Point32Health Services, Inc. medical plan. As of January 1, 2009, all plan administrators, third-party administrators, or insurers must provide the Centers for Medicare and Medicaid Services (CMS) with Social Security numbers (SSN) for those members covered under the health plan. Reporting dependent SSNs to CMS is mandatory, and the failure to provide information subjects plans and insurers to significant penalties. Federal and certain state governments may assess a financial penalty for a dependent if the IRS cannot confirm they are enrolled in a minimum essential coverage medical plan. Please verify that the correct Social Security numbers for your covered dependents are provided.

When Your Coverage Begins

NEW EMPLOYEES

New employees receive benefit plan enrollment information on or shortly after their first day of employment with Point32Health Services, Inc. The enrollment information contains:

- descriptive information about the Plan's benefit plans
- benefit plan contribution rates
- enrollment instructions

If you are a new employee and need assistance with plan enrollment or other benefits-related issues, please contact the Benefits Team at Benefits-HR@point32health.com.

If you want to participate in a Company-sponsored medical, dental, vision, disability, term life, flexible spending account (FSA), voluntary legal, and voluntary benefit plan options, you must enroll within **30 days** of the date that you are hired. If you enroll within **30 days** of the date that you are hired, coverage for you and your eligible dependents will begin as of your hire date.

New Hire	Annual Open Enrollment Effective Date	Qualified Life Event
Effective the date of hire	January 1	Effective the date of the Qualified Life Event

Actively at Work
You must be actively at work on the date your coverage begins. You are considered to be "actively at work" if you are performing the duties of your job at the Company's place of business or at any other place that the Company's business requires you to go including approved remote work locations. If you are not actively at work on the date that your participation would otherwise begin, your participation will be postponed until you are actively at work.

New Hire Election Opportunity:
The medical, dental, vision, flexible spending account (FSA), voluntary legal, or voluntary benefits plan options you select within **30 days** of your hire date will be effective as of your date of hire and will remain in place throughout the plan year. If you do not enroll in these plans within **30 days** of your hire date, you will have to wait until the next annual open enrollment period to enroll unless you experience an IRS qualified life event (as described below). With an IRS qualified life event, you are allowed to enroll in or make changes to certain benefits within **30 days**. No mid-year enrollments or changes to coverage are allowed that do not meet IRS requirements.

New Hire Life Insurance Evidence of Insurability (EOI):

- If you enroll in voluntary term life coverage (for yourself or your spouse/domestic partner) within **30 days** of your hire date and elect an amount above the guaranteed issued amount, you must complete **Evidence of Insurability (EOI)**. Once your New Hire event is closed, you will receive an announcement in Workday to complete the EOI questions. You will then submit the EOI, and Unum will determine your eligibility for the additional coverage on-line. You will receive an instant response as to whether you are approved, denied or more information is needed. Your coverage for the optional coverage will take effect if and when your application is approved.

Mid-Year or Open Enrollment Life Insurance Evidence of Insurability (EOI):

- If you do not enroll in voluntary term life coverage (for yourself or your spouse/domestic partner) within **30 days** of your hire date and wish to do so mid-year or during Open Enrollment, you must complete **Evidence of Insurability (EOI)**. Once your mid-year event or Open Enrollment event is closed, you will receive an announcement in Workday to complete the EOI questions. You will then submit the EOI, and Unum will determine your eligibility for the additional coverage on-line. You will receive an instant response as to whether you are approved, denied or more information is needed. Your coverage for the optional coverage will take effect if and when your application is approved, or effective January 1 if approved prior to January 1 for Open Enrollment.

Coverage Levels

You can choose one of the following levels of coverage for your medical, dental, or vision plan benefits:

- Employee only;
- Employee plus child or children;
- Employee plus spouse/domestic partner; or
- Family

Paying for Your Benefits

You and the Company share the cost of your medical and dental plan benefits. The cost to you will depend on:

- the level of coverage you select;
- the medical or dental plan you select; and
- your annual salary.

You pay the full cost of your vision, voluntary life, flexible spending account (FSA), voluntary legal, and voluntary benefit plan benefits. The cost to you will depend on:

- the level of coverage you select;
- your annual salary.

Because the **medical, dental, vision and flexible spending account (FSA) plans** are administered through a cafeteria plan arrangement in accordance with Section 125 regulations of the Internal Revenue Code, you pay your share of the cost through convenient before-tax payroll deduction contributions. These contributions come out of your pay before federal and (in most cases) state and local taxes are deducted, so they will reduce your taxable income.

- The payroll deduction cost to you will depend on the plan, level of coverage you choose, and your annual salary (contact the Benefits Team at Benefits-HR@point32health.com for more details).
- Contributions taken in arrears will also be made on a before-tax basis (exception for year-end processes when a new calendar year begins).
- Also, per this regulation, you are allowed to enroll or change coverage only during the annual open enrollment period. Exceptions are allowed if you experience a qualified life event and enroll or change your coverage due to the special enrollment rules.
- According to the IRS regulations, the “value of the coverage” attributable to the domestic partner is taxable unless your domestic partner and/or domestic partner’s children meet IRS rules to qualify for tax-free coverage. The amount of taxable income (Imputed Income) is based on the market value of the coverage purchased for these additional family members. To assist employees with Imputed Income, Point32Health Services, Inc. provides a gross up contribution to employees who have elected to cover a domestic partner under the medical, dental and vision plans.

This information is not intended as tax advice, but rather to alert you of potential tax ramifications and IRS rules. It is recommended that you consult with a qualified tax advisor to

fully understand the tax issues involved in providing coverage for your domestic partner and/or their children.

You will receive a description of each plan's payroll deduction cost when you are hired and during the annual open enrollment period. You can also visit the Point32Health Services, Inc. Employee Benefits Site or contact the Benefits Team at Benefits-HR@point32health.com for additional information concerning the cost of Plan participation.

Annual Open Enrollment Period

In the fall of each year, the Company sponsors an annual open enrollment period. During this period, you can elect to enroll in, change, or cancel your plan coverage.

Unless otherwise notified, if you do not make any changes during the annual open enrollment period, your current coverage will automatically continue with the exception of required annual elections for flexible spending account (FSA) and health savings account (HSA).

Any change you make during the annual open enrollment period (for example, adding a new dependent) will go into effect on the next January 1. This election will remain in effect for the next calendar year unless you have a Qualified Life Event.

For example, assume that you elect to cancel your medical plan coverage during the annual open enrollment period. This election will go into effect on January 1 and will remain in effect for the calendar year. You cannot change this election until the next annual open enrollment period unless you have a Qualified Life Event.

Qualified Life Event – Special Enrollment Rules

In general, you cannot enroll in, change, or cancel your medical, dental, vision, flexible spending account (FSA), voluntary legal plan, or voluntary benefit plans coverage during the year, unless you have a Qualified Life Event (as defined under Section 125 of the tax code) or qualify under the Health Insurance Portability and Accountability Act (HIPAA) "special enrollment rules." *Any changes in coverage due to "special enrollment rules" will take effect on the date that correlates to the special enrollment.*

For Plan purposes, you are considered to have a Qualified Life Event and you, or your eligible dependent may enroll for medical coverage within **30 days** in the event of:

- your marriage, divorce, enter into domestic partnership, or termination of a domestic partnership;
- the death of your spouse, domestic partner, or child;
- the birth or adoption or placement of a child;
- spousal or domestic partner gain or loss of current coverage;
- you, your spouse, or domestic partner taking an unpaid leave of absence;
- a dependent's involuntary loss of other health care coverage; or
- a court's order for you to cover a child under a Qualified Medical Child Support Order (QMCSO – see below for details).

In addition, you or your eligible dependent may enroll for medical, dental, or vision coverage within **60 days** after either of the following events:

- You or your dependent are eligible under a state Medicaid plan or state children's health insurance program (CHIP) and the Medicaid or CHIP coverage is terminated.
- You or your dependent becomes eligible for a premium assistance subsidy under a state Medicaid plan or CHIP.

Qualified Medical Child Support Order (QMSCO)

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order. You should notify Human Resources and elect coverage for the child as soon as reasonably possible following the issuance of a QMCSO.

A QMCSO is a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that satisfies all of the following:

- The order specifies your name and last known address, and the child's name and last known address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- The order specifies each plan to which it applies.

A QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit not otherwise provided under the policy. You can obtain a copy of the rules governing QMCSOs from Human Resources.

Effective Date

Your election to enroll in, change, or cancel your medical, dental, vision, flexible spending account (FSA), voluntary legal, or voluntary benefits plan coverage will go into effect as of the date of the change, provided that you make this election within **30 days** of that date of the change.

For example, assume that you have "Employee only" coverage, and you get married during the year. In this case, you can choose to cover your new spouse, if you make this election within 30 days of your date of marriage.

If you do not enroll in or make changes to your plan coverage within **30 days*** of the date that a Qualified Life Event occurs, you will have to wait until the next annual open enrollment period to enroll in or make medical, dental, vision, flexible spending account (FSA), voluntary legal, or voluntary benefits plan coverage changes.

*Within **60 days** for medical, dental, or vision coverage change if the change is due to:

- becoming newly eligible for a CHIP or Medicaid premium subsidy; or
- the loss of Medicaid or CHIP coverage.

Cancelling Coverage

If you have a Qualified Life Event, you can also elect to cancel your medical, dental, vision, flexible spending account (FSA), voluntary legal, or voluntary benefits plan coverage within **30 days** in the event. If you elect to cancel your coverage, you cannot restore it until the next annual open enrollment period, unless you have another Qualified Life Event.

Leaves of Absence

Family and Medical Leave Act (FMLA*):
You and your covered eligible dependents can continue benefits during an authorized Family and Medical (FMLA) leave of absence. If you are in an unpaid status or receiving disability pay, the contributions you would otherwise have paid towards the cost of your coverage will be suspended. If premiums are not paid while on leave, your coverage may be terminated for non-payment and re-instated upon your return to work. (Please refer to ***How to Pay Your Contributions During Your Leave*** section described below.)
*Family and Medical Leave Act

You may return to active coverage after a family or medical leave without any pre-existing condition limits or waiting periods, even if you didn't continue benefits during the leave.

Other Leaves of Absence (non-FMLA*):
While you are on a temporary authorized leave of absence, you and your covered eligible dependents can continue benefits for a non-FMLA leave of absence. If you are in an unpaid status, the contributions you would otherwise have paid towards the cost of your coverage will be suspended. If premiums are not paid while on leave, your coverage may be terminated for non-payment and re-instated upon your return to work. (Please refer to ***How to Pay Your Contributions During Your Leave*** section described below. For personal leave of absence, please refer to ***Personal Leave of Absence*** section described below)
*Family and Medical Leave Act

You may return to active coverage after a leave of absence without any pre-existing condition limits or waiting periods, even if you didn't continue benefits during the leave.

Military Leave: You may elect to continue benefits coverage during a temporary authorized leave of absence. If you are in an unpaid status, the contributions you would otherwise have paid towards the cost of your coverage will be suspended. If premiums are not paid while on leave, your coverage may be terminated for non-payment and re-instated upon your return to work. (Please refer to ***How to Pay Your Contributions During Your Leave*** section described below.)

You may return to active coverage after a leave of absence without any pre-existing condition limits or waiting periods, even if you didn't continue benefits during the leave.

Reservists who are called to active duty with the Armed Forces of the United States have

special benefit continuation and reemployment rights under the law (refer to ***Administrative Information***). In addition, the federal Family and Medical Leave Act (FMLA) was amended to add two new leave rights related to military service, effective January 16, 2009:

- **Active-Duty Leave:** Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" due to the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active-duty status, in support of a contingency operation.
- **Injured Service Member Leave:** An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. The employee is entitled to a combined total of 26 weeks for all types of FMLA leave in the single 12-month period.

Personal Leaves of Absence

While you are on an approved personal leave of absence, you and your covered eligible dependents can continue benefits for a personal leave of absence at the active employee contribution rate by paying premiums during the leave. If premiums are not paid while on leave, your coverage may be terminated for non-payment and re-instated upon your return to work.

How to Pay Your Contributions During Your Leave

You will be responsible to make up your benefit deductions when you return to a paid status. This may be done by check or payroll deduction. The benefits department will be able to provide you with the amount owed.

There are two ways in which you can pay for your coverage while you are on leave:

1. You can pay your contributions during your leave via check. Checks should be made payable to "Point32Health Services, Inc." and mailed to:

   Point32Health Services, Inc.
   Attention: Benefits
   1 Wellness Way
   Canton, MA 02021-1166

- 2. You can pay your contributions upon your return to work.

If you choose to pay your contributions when you return to work, you will receive a notification from Benefits informing you of the amount you need to repay. You may be given the option to pay this amount either via Payroll or to write a check for the whole amount.

If you do not return from your leave of absence, you will be responsible for any benefit contributions you have not made during your leave. The Plan will deduct the amount you owe from your last check. If you do not receive a last check, a bill will be sent directly to your home, and you will be required to pay the entire amount within 14 calendar days. If full payment is not

made within the required timeframe, benefits coverage for you and your covered dependents may be terminated.

You should contact Benefits for more information concerning the continuation of your coverage during a layoff or leave of absence.

When Coverage Ends

Circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of any benefits for you and your family include (coverage will terminate retroactively to the date you and your family members are no longer eligible for coverage):

- You and your family members no longer meet the Plan's eligibility requirements, including the requirement for minimum hours,
- You are a Subscriber, Domestic Partner, or a Spouse and you no longer live, work, or reside in the Network Contracting Area,
- You choose to drop coverage,
- Your employment ceases (coverage ends on your termination date),
- You fail to make any required contributions (e.g., while on a leave of absence), or
- Point32Health Services, Inc. terminates the Plan.

Note: If you or any of your dependents lose coverage under the Plan, certain rights to continue health care coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) are outlined in the *COBRA Continuation of Coverage* section.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- You commit an act of misrepresentation or fraud, or
- You commit an act of physical or verbal abuse unrelated to your physical or behavioral health condition which poses a threat to any Provider, any Point32Health Services, Inc. Member, or Point32Health Services, Inc. or any Point32Health Services, Inc. employee.

Note: The Plan will not cover services you receive after your coverage ends even if you were receiving Inpatient or Outpatient care when your coverage ended; or you had a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends. Point32Health Services, Inc. has the right to demand that you pay back benefits Point32Health Services, Inc. paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

HOW YOUR MEDICAL PLANS WORK

Point32Health Services, Inc. offers you several medical plans to choose from based on your eligibility.

If you enroll for medical plan coverage, you are automatically provided with retail and mail order prescription drug coverage.

It is important for you to understand each Plan so you can choose the best Plan for you and your family's needs, and once covered, understand the coverage provided. For more detailed information on each plan, refer to the applicable Plan's Benefit Handbook at:

- Access America Value No Deductible
- Access America Value with Deductible
- Access America with Deductible
- Access America HSA with Deductible

To contact Member Services, refer to the ***Introduction*** section for each Plan's phone number.

Medical Plan Pre-Existing Conditions

There are no "pre-existing condition" exclusions under your medical plan

You should always consult with your physician about when and where to get care. You can also contact Member Services if you have any questions concerning your medical plan's provider network.

Member Services can provide you with a list of all network hospitals and physicians.

ADMINISTRATIVE INFORMATION

ERISA

This section contains important information about the administration of your benefit plans. It also describes your benefit rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), if applicable.

If you have any questions about the administration of your benefit plans or your rights under ERISA, please contact the Benefits Team at Benefits-HR@point32health.com.

Important Facts About Your Plan

This section contains descriptive information about your benefit plans.

COMPANY
As used in this Summary Plan Description (SPD), the terms “Company” or “employer” refer to Point32Health Services, Inc. and any of its subsidiaries or affiliated companies that have adopted the applicable benefit plan(s) for their employees.

PLAN ADMINISTRATOR
The Plan Administrator for all of your benefit plans is:

Point32Health Services, Inc.
1 Wellness Way
Canton, MA 02021-1166

Phone Number: 781-612-1000

VP of Human Resources on behalf of the Plan Administrator

PLAN SPONSOR
The Plan Sponsor for all your benefit plans is:

Point32Health Services, Inc.
1 Wellness Way
Canton, MA 02021-1166

EMPLOYER IDENTIFICATION NUMBER
The Employer Identification Number (EIN) for Point32Health Services, Inc. is 04-2985923.

AGENT FOR SERVICE OF LEGAL PROCESS
Legal process may be served on the Plan Administrator at the address shown above. Legal process may also be served on the insurance carrier for a plan (if applicable).

NOT A CONTRACT OF EMPLOYMENT
You should be aware that your participation in the benefit plan(s) described in this handbook does not mean that your employment with the Company is guaranteed for any length of time.

PLAN DOCUMENTS
This Summary Plan Description (SPD) summarizes the official plan documents for your benefit plans. You should refer to the official plan document for more information about the operation of or benefits provided under a specific plan or program. You can obtain a copy of the official plan document, without charge by contacting Human Resources. *In the event of any conflict between the information summarized in this Summary Plan Description (SPD) and the official plan documents, the plan documents will always govern. The plan documents will also govern over any conflicting oral representations concerning the benefits provided under a specific plan or program*.

PLAN CONTINUANCE
Point32Health Services, Inc. reserves the right to change, amend or terminate the benefit plan(s) described in this Summary Plan Description (SPD) at any time. No participant has the right to any benefits from a plan following its termination, except that no amendment or termination may deprive you or an eligible dependent of any of the benefits to which you or an eligible dependent is entitled under a plan which have become due and payable under the terms of the plan through the date of such amendment or termination.

Any material amendment or termination of a plan will be adopted by formal action taken by the Point32Health Services, Inc. Board of Directors.

TYPE OF PLAN
Your medical, dental, vision and Point32Health Health Center plans are considered to be group health plans under current federal regulations.

PLAN YEAR
The Plan Year for each of the benefit plans described in this Summary Plan Description (SPD) is the same as the calendar year.

PLAN NAMES, PLAN NUMBERS, AND PLAN FUNDING
The official plan names, Plan Identification Numbers (PINs), and funding status for the benefit plans described in this Summary Plan Description (SPD) are as follows:

Plan Name	Plan Number	Funding Status	Policy Number (if applicable)
Access America Value No Deductible	521	**These plans are self-insured by the Company**. • The medical and dental plans are funded in part by participant contributions, and in part by the Company. • The company paid short-term disability, company paid term life & accidental death and dismemberment (AD&D) plans are	1772680000
Access America Value With Deductible	521		1772690000
Access America with Deductible	521		1772700000

		funded by the Company. • The short-term disability buy-up and voluntary term life & accidental death and dismemberment (AD&D) plans are fully funded by participant contributions.	
Access America HSA with Deductible	521		1772710000
Delta Dental of Massachusetts	521		9666-9901
Unum Short-Term Disability	521		955794
EyeMed Vision	521	**These plans are fully insured by the Company.** Point32Health pays monthly and yearly premiums to the insurance company, with fixed annual amounts based on how many employees are enrolled in the plan. • The vision plan is fully funded by participant contributions. • The company paid long-term disability plan and Unum Travel Assistance Program are funded by the Company. • Unum Term Life & ADD, Unum Legacy LTC, Arag voluntary legal plan, and Unum voluntary benefit plan options are fully funded by participant contributions.	1034377
Unum Long-Term Disability	521		425544
Travel Assistance Program	521		01-AA-UN-762490
Unum Term Life & Accidental Death and Dismemberment (AD&D)	521		NA
Long-Term Care (Legacy LTC)	521		NA

Arag Voluntary Legal Plan	521		NA
Unum Voluntary Benefit Plans	521		NA
Wex Flexible Spending Account (FSA)	521	**Not Self Insured or Fully Insured** • The Flexible Spending Accounts (FSA) are fully funded by participant contributions. • The company paid EAP plan is funded by the Company.	NA
KGA Employee Assistance Program (EAP)	521		NA
Point32Health Health Center Active colleagues, temporary staff, contractors, and Board of Directors are eligible to utilize the Point32Health Center.	522		NA

Claim Denial and Appeal

If your claim for benefits under any of the benefit plans described in this Summary Plan Description is wholly or partially denied, you will receive a written notification of the denial and the reasons for it. This notice will include:

- the specific reasons for the denial;
- the plan provisions on which the denial is based;
- a description of any additional material that is required; and
- an explanation of the plan's appeal procedure.

CLAIM ADMINISTRATORS

Your appeal of a denied claim should be addressed to the applicable plan's Claim Administrator. The following table shows the name, address, or telephone number of each Claim Administrator:

Plan or Program	Claim Administrator's Contact for Filing Appeal
Medical Plans	HPHC Appeals and Grievances Department 1 Wellness Way Canton, MA 02021 Telephone: 1-888-333-4742
Dental Plan – Delta Dental of Massachusetts	800-872-0500
Vision Plan – EyeMed	866-800-5457
Disability Plans – Unum	866-779-1054
Term Life Insurance Plans – Unum	866-779-1054
Unum Voluntary Benefits Long-Term Care (Legacy LTC Plan)	877-286-2852
Flexible Spending Accounts – Wex	866-451-3399
Voluntary Legal Plan – Arag	800-247-4184
Voluntary Benefit Plans – Unum	800-635-5597
Point32Health Health Center	Point32Health Services, Inc. Attn: Human Resources 1 Wellness Way Canton, MA 02021-1166 781-612-1000ext. 21053

Refer to the applicable Benefit Handbook, or Certificates for additional Claim Appeals and Complaints section.

Point32Health Health Center Grievance and Complaint Process

Internal Grievance/Complaint Process: You may file a grievance or complaint by phone, in person, by mail, or by electronic means to Human Resources.

If an oral or written grievance or complaint is received, Human Resources will send a written acknowledgement of receipt of your grievance to you or your authorized representative, if any, within fifteen (15) business days of receipt.

Human Resources will provide you or your authorized representative, if any, a written response to your grievance or complaint within thirty (30) business days of receipt of the oral or written grievance.

Written Decision
In the event that your grievance or complaint involves an adverse determination, Human Resources' written response will include an explanation of the adverse determination which identifies the specific information upon which the adverse determination was based.

An appeal concerning denied payment of a claim should be filed with your medical insurance company.

COBRA Continuation of Coverage

If health care coverage for you or an eligible dependent end for one of the reasons described in this section, you may be able to continue your coverage for a limited period under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

You may elect COBRA continuation if your coverage ends under one or more of the following plans:

- Medical Plan;
- Dental Plan;
- Vision Plan;
- Healthcare Flexible Spending Account;
- Point32Health Health Center access*

*Temporary employees are eligible for Point32Health Health Center COBRA continuation coverage only if they were paid via the Company payroll and enrolled in a Company-sponsored medical and/or dental plan prior to the date that their coverage would otherwise have ended.

Qualified Life Event
A covered person becomes eligible for COBRA continuation coverage if they experience a qualified life event. A *qualified life event* is defined as:

- your death;
- your termination of employment for any reason other than gross misconduct;
- a reduction in your work hours;
- your divorce, legal separation, or end of domestic partnership;
- an eligible dependent's loss of coverage due to your becoming entitled to Medicare; or
- your dependent child's coverage ends because they no longer meet the definition of "eligible dependent" (for example, due to age).

Birth or Adoption: For COBRA purposes, an "eligible dependent" includes a child who is born or adopted after you became eligible for COBRA continuation coverage.

It is your responsibility to notify the COBRA Administrator concerning a divorce, legal separation, end of domestic partnership, or the loss of a dependent child's eligibility under the plan. This notice must be provided within **60 days** of the date that the qualified life event (e.g., divorce) occurs. This is explained under *Notification and Election Period* (see below).

COST OF COBRA COVERAGE
You or the other covered person (if applicable) must pay the entire premium* for COBRA coverage. This premium includes the amount that the Company would otherwise have paid on your behalf and is equal to 102% of the cost of plan coverage.

*If you are involuntarily terminated (for reasons other than gross misconduct), you should contact the COBRA Administrator concerning your eligibility (if any) for partially subsidized COBRA premiums.

DURATION OF COBRA COVERAGE
A person who is eligible for COBRA continuation coverage is called a *qualified beneficiary*. As the following

table shows, the duration of COBRA coverage depends on the nature of the qualified life event:

DURATION OF COBRA COVERAGE		
Qualified Life Event	**Qualified Beneficiaries**	**Maximum Period of Coverage**
• Termination of employment for any reason other than gross misconduct • Reduction in work hours	Employee, spouse*, and eligible dependent children	18 months
• Military service (see discussion below)	Spouse* and eligible dependent children	24 months
• Divorce, legal separation, or end of domestic partnership • Employee's entitlement to Medicare • Employee's death	Spouse* and eligible dependent children	36 months
• Dependent child loses coverage because they are no longer an "eligible dependent"	Dependent child	36 months
Disability Extension: You or another qualified beneficiary may be eligible for up to an additional 11 months of COBRA continuation coverage (for a total of 29 months' coverage) if you or the other qualified beneficiary is determined by Social Security to be disabled: • at the time your termination of employment occurs; or • within 60 days of the date that you became eligible for COBRA coverage.		

*Including same-sex spouses and qualified domestic partners

Note: Although not legally required, the Plan provides COBRA-like continuation coverage to domestic partners and children of domestic partners if they lose coverage due to the employee's termination of employment, termination of the domestic partnership, or, in the case of children of a domestic partner, ceasing to meet the eligibility criteria as a dependent. The remainder of this COBRA section will refer to this COBRA-like coverage as COBRA coverage.

Second Qualifying Event

Generally, COBRA coverage is available for a maximum of 18 months for employment termination or reduction of work hours. This period may be extended for your spouse, domestic partner, and eligible dependent children in the event of:

- your death during the 18-month continuation period; or
- your divorce, legal separation, or end of domestic partnership during the 18-month continuation period.

The maximum period of COBRA continuation coverage (including any extension for the reasons listed above) is 36 months. This 36-month period is measured from the date of the first qualified life event (i.e., the event that originally gave rise to COBRA coverage).

Military Service

The spouse and eligible dependent children of Point32Health Services, Inc. employees who voluntarily or involuntarily go on active duty with the Armed Forces of the United States are eligible for up to 24 months of COBRA continuation coverage. For example, this would apply if you were an employee reservist who is called to active duty.

For more information on veterans' benefit and reemployment rights, see ***USERRA*** section.

Pre-existing Condition
COBRA continuation coverage for you or another qualified beneficiary ends when you or the other person becomes covered under another group health plan. However, a special rule applies if:

- you or the other covered person becomes covered by another health plan; **and**
- that plan contains a pre-existing condition limitation or exclusion that affects you or the other covered person.

In the above case:

- the affected person's COBRA continuation coverage may be continued until the date that it would otherwise have ended; **provided that**
- the medical plan will be the *primary provider* for the pre-existing condition only and the *secondary provider* for all other services covered by the plan.

WHEN COBRA COVERAGE ENDS
COBRA continuation coverage will end at the end of the maximum period of coverage, which in most cases is 18 or 36 months from the date of the qualified life event. However, COBRA coverage may end earlier if:

- your COBRA coverage premiums are not paid on a timely basis;
- you or another qualified beneficiary becomes entitled to Medicare* or becomes covered by another group health plan* that does not contain a pre-existing condition exclusion (see above);
- the Company discontinues all Company-sponsored group health plans.

*This applies only if you or the other covered person becomes entitled to Medicare or covered by another group health plan *after* COBRA continuation coverage has been elected

NOTIFICATION AND ELECTION PERIOD
You or your qualified beneficiary (if applicable) will receive a written notice of the right to elect COBRA continuation coverage if:

- you terminate employment;
- you are affected by a layoff or reduction in work hours;
- your death occurs during active employment.

Please remember that it is **your responsibility** to notify the COBRA Administrator concerning a divorce, legal separation, end of domestic partnership, or loss of a dependent child's eligibility status under your medical plan. This notification should be provided to the COBRA Administrator within **60 days** of the date that the qualified life event (e.g., divorce) occurs. You or the other covered person (if applicable) will then receive a written notice of the right to elect COBRA continuation coverage.

Election Period
If your healthcare coverage ends for one of the above reasons, you may elect to continue your coverage by contacting the COBRA Administrator within **60 days*** of the date that your coverage would otherwise have ended (or within 60 days of the date you receive notification of your right to elect continued coverage, if later).

If you (or the other covered person, if applicable) do not choose to continue coverage within the 60-day* election period, the right to elect COBRA continuation coverage will end.

*If you are involuntarily terminated (for reasons other than gross misconduct), the COBRA Administrator will notify you concerning your eligibility (if any) for an extension of this 60-day election period. You can contact the COBRA Administrator if you have any questions about your COBRA election period and when it ends.

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for workers displaced by the impact of foreign trade who, as determined by the U.S. Secretary of Labor, are eligible for a "trade readjustment allowance" or "alternative trade adjustment assistance" ("eligible TAA individuals"). Under this tax credit, if you're an eligible TAA individual, you're eligible for a health insurance tax credit of up to 65% of qualified health insurance premiums, including COBRA coverage. If you are in this situation, you will be notified.

The Trade Act of 2002 also created a special COBRA right applicable to TAA individuals. TAA individuals are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they didn't already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the TAA individual becomes eligible for assistance under the Trade Act of 2002. Nonetheless, this election may not be made more than six months after the date the TAA individual's group health plan coverage ends.

If you qualify or may qualify for assistance under the Trade Act of 2002, contact the COBRA Administrator for additional information. You must contact the COBRA Administrator promptly after qualifying for assistance under the Trade Act of 2002 or you will lose your special COBRA rights.

If you have questions about this tax credit or your extended ability to elect COBRA coverage, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act of 2002 is also available at www.doleta.gov/tradeact.

Uniformed Services Employment and Reemployment Rights ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Under USERRA:

- You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed services, and (1) you ensure that your employer receives advance written or verbal notice of your service; (2) you have five years or less of cumulative service in the uniformed service while with that particular employer; (3) you return to work or apply for reemployment in a timely manner after conclusion of service; and (4) you have not been separated from service with a disqualifying discharge or under other than honorable conditions. If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service, or, in some cases, a comparable job.

- If you are a past or present member of the uniformed services, have applied for membership in the uniformed services, or are obligated to service in the uniformed services, then an employer may not deny you initial employment, reemployment, retention in employment, promotion, or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for your eligible dependents for up to 24 months while in the military.
- If you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (for example, pre-existing condition exclusions) except for service-connected illnesses or injuries.
- Service members may be required to pay up 102% of the premium for the health plan coverage. If coverage is for less than 31 days, the service member is only required to pay the employee share, if any, for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **www.dol.gov/vets**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

You should contact Human Resources immediately upon being called to active duty. A Human Resources Business Partner will assist you with benefit plan continuation, reemployment, and other issues related to your military service.

Your Rights as a Plan Participant

As a participant in the Point32Health Services, Inc. benefit plans described in this Summary Plan Description (SPD), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA)*, if applicable.

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit 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 health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualified life 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 pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

OBTAINING A COPY OF YOUR SUMMARY PLAN DESCRIPTION (SPD)
If you wish to receive a copy of your SPD, please contact your Plan Administrator.

Privacy of Health Information

HIPAA Privacy Rights: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the unauthorized use or dissemination of your medical records by the Company, *Plan* administrators, insurance companies, or health care providers.

Under the HIPAA regulations, your personal medical records may be used for health purposes only. This means that:

- Your medical records may not be used by the Company for employment, personnel, or other non-health related reasons without your written consent;
- Your medical records may not be disclosed without your written consent (except to the extent required by physicians and other health care providers to provide treatment);
- You have the right to inspect your own health care information, and request changes if you believe the information is inaccurate; and
- You have the right to restrict the use and disclosure of your own health care information.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits discrimination in group health plan coverage based on genetic information. GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and is effective for plan years beginning after October 9, 2009. HIPAA prevents a plan from imposing a pre-existing condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits or premiums based on any health factor (including genetic information).

GINA prohibits group health plans from:

- **Basing premiums on genetic information.** However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.
- **Asking or requiring you to undergo a genetic test.** However, your health care provider may request a genetic test. In addition, genetic testing information may be requested to determine payment of a claim for benefits. However, the plan may request only the minimum amount of information necessary to determine payment. There is a research exception that permits a plan to request (but not require) that you or a covered family member undergo a genetic test.
- **Collecting genetic information (including family medical history) before or in connection with enrollment, or for underwriting purposes.** Plans are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a health risk assessment. There is an exception for incidental collection, provided the information is not used for underwriting. The incidental collection exception is not available if it is reasonable for the plan to anticipate that health information will be received in response to a collection unless the collection explicitly states that genetic information should not be provided.

Under GINA, your genetic information may be disclosed only if you consent to this disclosure in writing.

You can contact the Human Resources Department for a more complete description of your HIPAA and GINA health information privacy rights. You can also contact Member Services if you have any questions

concerning these rights. See “Introduction” for each Plan’s phone number.

Women’s Health and Cancer Rights Act of 1998 (WHCRA)

A federal law, the Women’s Health and Cancer Rights Act of 1998, was enacted requiring group health plans that provide coverage for mastectomies to provide the following mastectomy-related benefits to plan participants:

- Reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

These benefits will be subject to the same deductibles and coinsurance or co-payment provisions consistent with those established for other benefits under your health plan. Coverage for these benefits or services will be provided in a manner determined in consultation with your attending physician.

DEFINITIONS

Please refer to the applicable Benefits Handbook, or Certificate terms for the words and terms used throughout this SPD.

Benefits Handbook

The document, and any future amendments, that describes the Access America Value No Deductible, Access America Value with Deductible, Access America with Deductible, and Access America HSA with Deductible. To see Benefits Handbook documents for each Plan, refer to:

- Access America Value No Deductible
- Access America Value with Deductible
- Access America with Deductible
- Access America HSA with Deductible

For additional plan information refer to:

- Dental
- Vision
- Short-Term Disability (STD)
- Long-Term Disability (LTD) (below Director)
- Long-Term Disability (LTD) (Director and above)
- Basic Term Life and Accidental Death & Dismemberment (AD&D)
- Voluntary Term Life and Accidental Death & Dismemberment (AD&D)
- Travel Assistance Program
- Flexible Spending Account (FSA)
- Employee Assistance Program (EAP)
- Voluntary Legal Plan
- Voluntary Benefit Plan Accident
- Voluntary Benefit Plan Critical Illness
- Voluntary Benefit Plan Hospital
- Point32Health Health Center