

TERRI YUREK INSURANCE

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Terri Yurek Insurance Services

January 2019

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Introduction

Terri Yurek Insurance Services is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet provides information about your medical/prescription drug, dental, vision, 401K benefits, and Employee Assistance Program Benefit Programs. It serves as the Plan document and the Summary Plan Description (“SPD”) for the Terri Yurek Insurance Services Health and Welfare Benefit Plan (“the Plan”).

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with the written plan document and disclosure requirements under the Employee Retirement Income Security Act (“ERISA”) of 1974, as amended.

The “Benefit Programs” covered by this SPD are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits, the Certificate of Insurance or Certificate of Coverage and other descriptive documents relating to each Benefit Program (collectively, the “insurance certificates”) are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This SPD and Plan replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

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Plan Overview

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program.

Your Eligibility

You are eligible for the Benefit Program(s) shown in Appendix A if you are a full-time active employee normally scheduled to work 30 hours per week.

Unless otherwise communicated to you by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, part-time employees, persons hired on a seasonal or temporary basis, and other individuals who are not on the Employer payroll, as determined by the Employer, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

Unless otherwise defined by the insurance certificate for a Benefit Program, your eligible dependents include:

- your legal spouse;
- your Domestic Partner of the same sex;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan;
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support);
- a stepchild as long as you are married to the child's legal parent;
- a child for whom you are the court-appointed legal guardian;
- your Domestic Partner's child who resides with you;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

In addition, an eligible dependent who lives outside the U.S. may be restricted from coverage unless the dependent has established his or her primary residence with you. If you have any questions regarding dependent coverage under a Benefit Program, check with the Insurer or Claims Administrator.

Coverage for newly eligible dependents will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you acquire a new dependent, such as through marriage, coverage will begin on the date they become an eligible dependent (such as of the date of marriage) as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, the enrollment will be considered a late enrollment.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Employer, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children. It is your responsibility to notify the Employer if your dependent becomes ineligible for coverage.

When Coverage Begins

To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for that Benefit Program. Unless otherwise stated in those materials, your coverage begins the first of the month following 30 days of full time employment. Coverage for your eligible dependents begins on the same day as your initial eligibility provided you enroll your dependents within 31 days of eligibility. Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements to be covered under the Plan.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

Your Contribution for Coverage

Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the Employer in your enrollment materials. You may also request a copy of any required contribution amounts from the Plan Administrator.

For most benefits you pay the employee cost of Plan premiums through pre-tax or after-tax payroll deductions, depending on your election, each pay period. You must elect coverage for yourself in order to cover your eligible dependents. Your coverage for certain Benefit Programs may also be subject to deductibles, copayments, coinsurance, or other fees as described in the materials for the coverage you select.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction.

The elections you make will remain in effect until the next December 31, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer for a Benefit Program.

Late Entrant

An enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after cancelling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period to enroll in coverage.

Annual Open Enrollment Period

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and Election Form will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on December 1 and stay in effect through December 31, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit, with deductible and out-of-pocket expenses based on the policy year. You should refer to the insurance certificate and other materials provided by the Insurer to determine if a different policy year applies.

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Employer nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days of the following:

- The date you meet the Special Enrollment Rights criteria described below.
- The date you have a qualifying change in status as described below; or

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by Internal Revenue Code Section 125, or the regulations thereunder, the following events may be considered a change in status:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child's eligibility;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your Employer work location or home address that changes your overall benefit options and/or prices;
- employee's spouse's open enrollment period differs and employee needs to make changes to account for other coverage;
- a significant change in coverage or the cost of coverage;
- a reduction or loss of your or a dependent's coverage under this or another plan; or
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child;
- change in employment status to less than 30 hours of service per week on average even if reduction does not result in loss of Plan eligibility;
- eligibility for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or seeking to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period;

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes in your election must be consistent with your change in status event. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change to the Plan Administrator as soon as possible, but no later than 31 days after the event occurs.

Keep in mind that certain mid-year election change events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request

enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

Except as otherwise provided in the insurance certificate, your coverage under this Plan ends on the last day of the month in which your employment terminates or upon your death, unless benefits are extended, such as when you take an approved leave of absence.

Coverage for your covered dependents ends on the date your coverage ends, or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

If your coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage may also be rescinded for failure to pay required premiums or contributions as required by the Plan.

Coverage may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent. You will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of absence, you will need to make payment arrangements prior to the start of your leave. Your payments will be made on an after-tax basis, unless you are on paid leave, in which case your premium payments will continue to be deducted on a pre-tax basis. You should discuss with Human Resources or your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, coverage may continue for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) starting on the date your military service begins.

Coverage for other benefits can be found in the insurance certificates furnished by the Insurer for the respective Benefit Programs in which you have enrolled and will be governed by the provisions of USERRA.

Your Health Care Coverage

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

The following health care Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Medical/Prescription Drug
- Dental
- Vision

Participation

To become a participant in the above Benefit Program(s), you must meet all eligibility requirements and enroll in coverage. You may also enroll your dependents if they are eligible dependents as defined in the Insurer's benefits booklets. You will automatically receive identification cards for you and your enrolled dependents when your enrollment is processed.

Benefits Provided

The benefits provided under each Benefit Program are more fully described in the Certificate of Insurance/Coverage and other benefits booklets provided by the Insurer.

Your health care benefits are delivered through a network of participating physicians, hospitals, and other providers who have agreed to provide services at a negotiated cost.

You may choose from several types of medical plans or programs of benefits under this Plan, including:

- an HMO (Health Maintenance Organization)
- a PPO (Preferred Provider Organization).

When you use network providers, the Plan pays the negotiated amount of covered expenses (after meeting any deductible) to your provider and there are no claim forms to complete. Certain medical options, such as an EPO or HMO, require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network health care providers (at no cost to you), contact the Insurer at the telephone number or website shown on your identification card.

Certain medical options, such as an HMO or POS, may require you to select a primary care physician ("PCP") to coordinate your care. If so, you may designate any PCP who participates in the network and who is available to accept you or your family members. For dependent children, you may designate a pediatrician as the PCP. You do not need prior authorization from the Insurer or your PCP to obtain access to obstetrical or gynecological care from a network professional who specializes in obstetrics or gynecology. The network 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 information on how to select a PCP, and for a list of participating primary care physicians, contact the Insurer at the telephone number or website shown on your identification card.

You may choose from several types of dental plans or programs of benefits under this Plan, including:

- a DPPO (Dental Preferred Provider Organization)

When you use network providers, the Plan pays the negotiated amount of covered expenses (subject to applicable deductible and coinsurance) to your provider and there are no claim forms to complete. The provider will not balance bill you for the discount provided on the claims. Certain dental options, such as a DMO, may require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network dental care providers (at no cost to you), contact the Insurer at the telephone number or website shown on your identification card.

Source of Payments

Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown in your enrollment materials. Your premiums will be deducted from your pay on either a pre-tax or after-tax basis, depending on your election.

Limitations and Exclusions

The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in- network and out-of-network services.

Continuation of Health Care Coverage through COBRA

If your health care coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Health care coverage may continue at your own expense for a specific length of time. See the section entitled "Your HIPAA/COBRA Rights" for additional information. Please note that if your Employer has less than 20 employees, Federal COBRA legislation may not apply to you, but you may instead be eligible for COBRA benefits available through your state. Contact your Insurer for additional information as these provisions vary from state to state.

For More Information

If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.

Participation

You must meet all eligibility requirements for coverage in order to become a participant. Enrollment in basic coverage is automatic.

Benefits Provided

The benefits and amounts of coverage provided under each Benefit Program are more fully described in the materials provided to you by the Insurer. Life insurance benefits are paid in the event of the death of a covered participant. AD&D benefits are paid if a covered participant becomes dismembered or seriously injured as the result of a covered accident. You will need to designate a beneficiary to receive benefits in the event of your death.

Source of Payment

Group Term Life Insurance and AD&D benefits are paid by the Insurer and are guaranteed under the applicable insurance contracts. The Company pays the full cost of your basic coverage. You are not required to make any contributions.

Plan Limitations and Exclusions

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

Coverage Continuation

If your Group Term Life Insurance coverage ends for any reason other than death, you may have a right to continue your insurance under an individual policy (if this benefit is applicable). You should consult your Certificate of Insurance for additional information about continuing your coverage as there may be time limits for making this decision once your coverage under the Plan ends.

For More Information

Consult your Certificate of Insurance or benefits booklets for additional questions about your coverage.

Your Employee Assistance Program (“EAP”)

The EAP Benefit Program is fully insured and administered by the Insurer listed in Appendix A.

Participation

You are automatically enrolled in the EAP after you meet all eligibility requirements for coverage as described in the Insurer’s materials. No action is required on your part to participate.

Benefits Provided

The benefits provided under the EAP are more fully described in the materials provided to you by the Insurer. The EAP offers short-term counseling and referral services to you and your eligible dependents.

Source of Payment

Benefits under the EAP are paid by the Insurer and are guaranteed under the applicable insurance contract. The Employer pays the full cost of your coverage. You are not required to make any contributions.

Plan Limitations and Exclusions

You should refer to the materials provided by the Insurer for information concerning any limitations or exclusions that may apply to your coverage.

For More Information

If you have a question about the EAP, you should consult your Certificate of Insurance or other materials provided by the Insurer.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

IMPORTANT: The Employee Retirement Income Security Act (ERISA) is a Federal law. This Summary Plan Description is issued in accordance with ERISA and may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

Terri Yurek Insurance Services is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Plan Administrator

Terri Yurek Insurance Services
13240 Evening Creek Dr S # 305
San Diego, CA 92128
858-391-8544

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the “Named Fiduciary” for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

Plan Year

The Plan Year is January 1 through December 31.

Note: An insured benefit may use a policy year that differs from the Plan Year, with deductible and out-of-pocket expenses based on the policy year. Please refer to the insurance certificate and other materials provided by the Insurer to determine if a different policy year applies to certain annualized benefits.

Type of Plan

This Plan is called a “welfare plan”, which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) is:

EIN: 12-3456789

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.
Funding	The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy.

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Employer shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from its general assets, either as mandated by law or as the Employer deems advisable. In addition, the Employer shall have the right to alter, modify, or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.

Insurers/Claims Administrators

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan Documents always control, even if their terms conflict with information given to you by an Insurer or other service provider.

Medical/Prescription Drug Benefits

Health Plan of California
P.O. Box 123456
Notown, CA 54321
Phone 1-888-555-5555

Dental Benefits

Health Plan of California
P.O. Box 123456
Notown, CA 54321
Phone 1-888-555-5555

Vision Benefits

Health Plan of California
P.O. Box 123456
Notown, CA 54321
Phone 1-888-555-5555

Agent for Service of Legal Process

For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:

Terri Yurek Insurance Services
13240 Evening Creek Dr S # 305
San Diego, CA 92128
858-391-8544

Service of Legal Process may also be served on the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator or, where applicable, the Insurer, has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator or Insurer.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits to Others

The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud

No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Employer will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with State and Federal Mandates

Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: ERISA, COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to discriminate with respect to health insurance premiums, contributions or other restricted purposes).

Refund of Premium Contributions

For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan.

Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan

The Employer expects that the Plan will continue indefinitely. However, the Employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures/Coordination of Benefits

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Claims and Appeals

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer's decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program's provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal. You will also be provided a statement advising that you are entitled to bring civil action in Federal court under Section 502(a) of ERISA.

Exhaustion Required

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

Non-Duplication of Benefits / Coordination of Benefits

If you (or an eligible dependent) are covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

The Insurer is responsible for ensuring that eligible expenses are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

The Insurer may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer has a right to subrogation and reimbursement. Subrogation applies when the Insurer has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer of each fully insured Benefit Program. The Insurer shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer to facilitate enforcement of its rights and interests.

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

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 (if applicable).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable) and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Description and Summary of Material Modification) and do not receive it 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, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules.

In addition, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose PHI to the Plan Sponsor for plan administration purposes. Plan administration purposes means administration functions performed by the Plan Sponsor on behalf of the HIPAA Plans, such as claims processing, coordination of benefits, quality assurance, auditing and monitoring. Plan administration purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) disclosed to it by the HIPAA Plans (or an Insurer with respect to the HIPAA Plans), the Plan Sponsor will:

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

- Ensure that any agents, including subcontractors, to whom it provides PHI received from the HIPAA Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the HIPAA Plans any use or disclosure of PHI of which it becomes aware that is inconsistent with the permissible uses or disclosures;
- Make PHI available in accordance with the individual rights of access under the HIPAA Privacy Rules;
- Make an individual's PHI available for amendment, and incorporate any amendments, as required by the HIPAA Privacy Rules;
- Make available the information required to provide an accounting of disclosures to individuals, as required by the HIPAA Privacy Rules;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with HIPAA's requirements;
- If feasible, return or destroy all PHI received from the HIPAA Plans that the Plan Sponsor still maintains in any form and retain no copies of this information when no longer needed for the purpose for which disclosure was made, except that, if this return or destruction is not feasible, limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure adequate separation between the HIPAA Plans and the Plan Sponsor is established.

In addition, the Plan Sponsor will reasonably and appropriately safeguard ePHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the HIPAA Plans. The Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Plans;
- Ensure that adequate separation between the HIPAA Plans and the Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the HIPAA Plans any security incident of which it becomes aware.

Your COBRA Continuation Coverage Rights

Continuing Health Care Coverage through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the “qualifying event.” These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child’s birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

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

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

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

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled

family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation, or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To

continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage by completing and returning your COBRA enrollment form.

NOTE: If you have a new child during the COBRA continuation period by birth, adoption or placement for adoption, your new child is entitled to the status of a qualified beneficiary. As such, your new child is entitled to receive coverage upon his or her date of birth, date of adoption or date placement for adoption is made and you become legally obligated to provide support for the child, provided you enroll the child within thirty (30) days of the child's birth/adoption/placement.

Cost of COBRA Coverage

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent COBRA coverage election. You elect coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Employer terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of healthcare coverage in certain circumstances for Employers with 20 or more employees. Small Employers may be subject to individual state COBRA provisions.

Dependent

The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Your “child” includes:

- Your biological child;
- Your legally adopted child (including any child under age 18 placed in the home during a probationary periods in anticipation of the adoption where there is a legal obligation for support;
- A child for whom you are the court-appointed legal guardian; or
- An eligible child for whom you are required to provide coverage under the terms of a QMCSO or NMSN, as defined below.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. Your employer also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, refer to your insurance certificate.

Employee

A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

Election Form

The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Insurer

Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. 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 mother's or newborn's attending provider, 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Participant

An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

Adoption of the Plan

The Terri Yurek Insurance Services Health and Welfare Benefit Plan, as stated herein, is hereby adopted as of 12/01/2018. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this _____ day of _____, 201X .

BY: _____

TITLE: _____

APPENDIX A

BENEFIT PROGRAMS OFFERED: MEDICAL/PRESCRIPTION DRUG, DENTAL, VISION

BENEFIT PROGRAM/ EFFECTIVE DATE OF COVERAGE	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	BENEFITS PROVIDED	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
401K Qualified Retirement Plan 01/01/2019	PAYBACK INSURER/CLAIMS ADMINISTRATOR	XX-XXXXXXXX	See Plan/SPD and Basic Plan Document provided by Insurer.	See Plan/SPD and Basic Plan Document provided by Insurer.	See Plan/SPD and Basic Plan Document provided by insurer.
GROUP MEDICAL INSURANCE HMO 01/01/2019	HEALTH PLAN OF CA INSURER/CLAIMS ADMINISTRATOR	W1234567	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP DENTAL INSURANCE 01/01/2019	HEALTH PLAN OF CA INSURER/CLAIMS ADMINISTRATOR	W1234567	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP VISION BENEFITS 01/01/2019	HEALTH PLAN OF CA INSURER/CLAIMS ADMINISTRATOR	W1234567	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.