

SUMMARY PLAN DESCRIPTIONS FOR WELFARE BENEFITS PLAN AND COBRA INFORMATION NOTICE

The purpose of this summary is to provide the information necessary for you to understand and make use of the extensive protection provided for you and your family through Devereux Advanced Behavioral Health's benefit program.

Servant Leadership is a philosophy and set of practices that enriches the lives of individuals, builds better organizations, and ultimately creates a more just and caring world. At Devereux, we strive to incorporate Servant Leadership into our culture and every aspect of our organizational framework, including the development and empowerment of our employees. At Devereux, we are committed to being the employer of choice, and we know that offering high-quality, affordable benefits is a key component. Devereux recognizes the value of each employee and is committed to being responsive to your needs and welfare through the implementation of supportive benefits for you and your family. Choice Benefits offers you, as a full-time employee, the option to determine your level of need for medical and prescription coverage, dental coverage, health care and dependent care spending accounts, health savings accounts, accidental death and personal loss insurance, vision insurance, accident insurance and supplemental life insurance. In addition, though not considered a part of the flex benefits package, Devereux provides you with group life insurance, long-term disability, a generous 403(b) retirement plan and business travel insurance.

The cost of medical care continues to rise and has become a financial hardship on us all. Together we can promote a partnership to effectively manage these costs. To ensure the best possible coverage, benefit cost sharing may be required depending on which options you select. Employee salaries and benefits represent approximately 70 percent of Devereux's operating expenses, and it is clear that we need to work together to control overall costs. By utilizing the Choice Benefits plan, together, we are striving to use our benefit dollars more efficiently to receive the maximum benefits for the money we spend.

Summary Plan Descriptions, as legally required for Devereux's benefit plans, consist of two components:

- (1) Insurance carrier and plan administrator documents, handbooks and other forms of plan description.
- (2) This "wrap-around document" provides overview information on all Devereux benefits and includes legally required information that may not be included in each separate insurance carrier document.

Devereux expects the plans outlined in the Summary Plan Descriptions to continue. However, Devereux reserves the right to amend, modify, revoke or terminate plans in whole or in part, at any time. The Senior Vice President of People Operations and the Benefit Review Committee review Devereux's benefits periodically. The Senior Vice President of People Operations implements benefit changes or other actions with approval by the President of Devereux.

The information provided within this document is in accordance with the Employee Retirement Income Security Act (ERISA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Newborn's and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, the Family Medical Leave Act (FMLA) and other applicable laws and regulations.

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SECTION 1: AVAILABLE PLANS AND CARRIERS/ADMINISTRATORS

The plans, other than Devereux Retirement Plan and the Devereux Cafeteria Plan, covered in this document are filed under **Plan Number 501** (Devereux Welfare Plan) and are listed below. The Devereux Retirement Plan is filed under **Plan Number 001**. The Devereux Cafeteria Plan is filed under **Plan Number 502**. The plan year begins on January 1 and ends December 31.

NAME	CARRIER/ADMINISTRATOR
A. Choice Benefits	Administered by Devereux (1)
B. National Medical Plans	Independence Blue Cross (1)
C. Medical EPO	Independence Blue Cross (1)
D. HMO Medical Plan	MVP New York (1)
E. Dental Plans	Cigna Dental (1), Cigna DMO (1)
F. Prescription Drug Plan	FutureScripts (Optum PBM) (1)
G. Health Care Flexible Spending Account	Employee Benefit Corporation (1)
H. Dependent Care Flexible Spending Account	Employee Benefit Corporation (1)
I. Health Savings Account	Optum (1)
J. Group Life Insurance	Cigna (2)
K. Long-Term Disability Plan	Cigna (2)
L. Accidental Death and Personal Loss Insurance	Cigna (1)
M. Voluntary Benefits	Cigna (1)
N. Business Travel Accident Insurance	Federal Insurance Company (3)
O. Employee Assistance Program (EAP)	Carebridge (4)
P. Work-Family Programs	Carebridge (4)
Q. Advocacy and Wellness	Health Advocate (1)
R. Devereux Retirement Plan	TIAA (5)
S. Devereux Cafeteria Plan	Employee Benefit Corporation (1)

Number in parenthesis above (), indicates the corresponding eligibility requirement/definition on the next page.

SECTION 2: BASIC ELIGIBILITY REQUIREMENTS/DEFINITIONS

Definitions

- **Full-time Employee:** A full-time employee is an employee scheduled/budgeted as full-time, continuously working 40 hours per week on average in a two week period.
- **Part-time Employee:** A part-time employee is an employee scheduled/budgeted to work less than 40 hours per week on average in a two week period.

Eligibility Requirements

(1) **Eligibility:** Full-time employees: Effective the first day of the pay period in which day 90 occurs,

provided the employee has completed active, continuous employment, and has enrolled during their 60-day enrollment period, (day 30-90). If employee does not enroll during their enrollment period, the eligibility date to elect the options will be the next Open Enrollment period (October/November) for the benefits to be effective the next plan year (January 1), unless a Qualified Family Status Change occurs which allows the employee to obtain coverage outside of open enrollment. Part-time employees working on average between 30-39 hours between their start and first year anniversary date will be offered coverage no later than the 13th month if hired on the first day of the month, or on the first of the month following 13 months of employment. Qualified part-time employees working on average between 30-39 hours and their dependent children (to age 26) are eligible for the High Deductible Health Plan (HDHP) medical benefit and may contribute to a pre-tax Health Savings Account (HSA). Dental benefits are also available.

- (2) **Eligibility:** Full-time employees: Effective automatically on the 89th day of employment, provided the employee is actively at work and continuously employed. An application is not required for the Group Life and Long-Term Disability plans. However, beneficiary assignments are necessary for the Group Life plan.
- (3) **Eligibility:** Full-time employees: Effective the first day of active employment.
- (4) **Eligibility:** All employees: Effective the first day of active employment.
- (5) **Eligibility:** Voluntary participation may begin in the first payroll period following employment after completion of a salary reduction agreement. Eligibility for enrollment in the Devereux funded plan can be found in the [TIAA Retirement Plan: Summary Plan Description](#).

Note: Active, continuous employment means the period worked without a break in service. A break in service normally would be an extended absence during the period ending with the pay period prior to the 90th day of 10 or more days. However, any unexcused absences or pattern of absences as well as a series of absences may result in a break in service. The expectation is for a full-time employee to work (including accrued time-off benefits) 80 hours in each bi-weekly period. A series of absences during the initial period resulting in four or more weeks at less than 40 hours would normally be subject to review to determine if a break in service has occurred. An employee must satisfy a new eligibility period in the event there is a break in service and the employee's employment continues.

Changes in Employment Status

Your benefit eligibility may be affected if your employment status changes. Ordinarily, full-time employees are not eligible for certain benefits until the first day of the pay period in which day 90 occurs. In certain circumstances, however, this standard waiting period may not apply. Business acquisitions, common control groups, parent subsidy arrangements and filial contracted groups may be maintained through their existing plan designs or integrated into the existing Devereux Employee Welfare Plan as part of contract negotiations. Eligibility for coverage by Devereux will be final and binding.

- **Part-Time to Full-Time**

An employee's waiting period will be waived when changing status from part-time to full-time status, provided Devereux has employed the employee for at least six months prior to the status change. They must enroll within 30 days of the status change. If the employee does not enroll during the enrollment period, the eligibility date to elect the options will be the next Open Enrollment period (October/November) for the benefits to be effective the next plan year (January 1). Time-off benefits (TOB) are also included in the waiver of the waiting period. In the

event that an employee's status change from part-time to full-time occurs on the first day of the month, the employee would be eligible for benefit coverage effective the same day. Example: If an employee changes status on July 1, he/she would be eligible for benefits on July 1, not August 1 (the first day of the month following the status change). If this same employee changed status on July 2, the employee's eligibility date would be August 1.

If the employee has not been employed for at least six months, the employee must complete the 90-day waiting period and will be effective on the first of the following month.

- **Full-Time to Part-Time to Full-Time**

An employee who has at least six or more months of combined full-time and part-time service and who changes from full-time status to part-time status, and then returns to full-time status **within the same plan year** will be eligible for initial enrollment or reinstatement into his/her previous full-time elections under Devereux's benefit plans. An employee who changes from full-time status to part-time status, and then returns to full-time status **within a different plan year** will be eligible to make new elections under Devereux's benefit plans. The reinstatement date for all benefits, with the exception of life insurance and long term disability coverage, will be the first of the month on or following the return to full-time status as long as the employee enrolls within 30 days of the change to full-time status; life insurance and long term disability are reactivated as of the full-time status date. In the event that the employee does not enroll within 30 days, the employee must wait until the next Open Enrollment period to enroll in welfare benefits.

An employee who returns to full-time status from part-time status within 180 days (assuming benefit eligibility was met during the initial full-time status) will retain prior Health Management Leave (HML) balance, whereas an employee who returns to full-time status from part-time status after 180 days will lose the prior HML balance.

- **Rehires**

An employee who terminates employment and returns to Devereux shall be considered a rehired employee. These employees cannot be rehired for 30 days after termination, must satisfy the 90-day waiting period for all welfare benefit plans, and enroll during their 60-day enrollment period.

- **Full-Time to Part-Time**

Employees who change from full-time to part-time status will be removed from Group Life, Long-Term Disability, and health care and Dependent Care Spending Accounts effective the day of the change in status. Welfare benefit coverage for medical, dental, mental health, AD&D, prescription benefits and Voluntary benefits will terminate on the last day of the month in which employment status changes. Conversion coverage should be offered for Life insurance and Voluntary benefits. Continuation of welfare benefits, including medical, dental, prescription coverage and health care spending account coverage should be offered through COBRA. Upon changing to part-time status, an employee could continue the medical, dental, and prescription coverage through COBRA offered through Employee Benefit Services (EBC), Devereux's Third Party Administrator. Devereux's Retirement Plan, Employee Assistance Program (EAP) and Work/Life Programs continue to be available to eligible part-time employees. Part-time employees averaging 30 or more hours per week are

eligible for Devereux's Part-Time Benefit Program.

- **ICPTR Clinical Interns/Pre-Doctoral Interns/Practical Trainees/Post-Doctoral Fellowships**

Clinical Interns and Fellowship participants are coded as full-time. Approval for participation in these programs is sought by individuals through Devereux's APA approved program, and is granted by ICPTR Committee.

The following items must be provided to ICPTR and Corporate People Operations department personnel prior to beginning the program, and will be made part of the participant's personnel file and/or confidential medical file:

- Professional license or certification (if applicable)
- State required criminal clearance and child abuse history checks
- FBI clearance
- Satisfactory drug screening results
- W-4 form
- Health screening and Mantoux test results, as required by Center licensing agency requirements.

Clinical interns and Fellows are paid a pre-determined stipend through Devereux payroll. Interns and Fellows in these select programs are eligible to enroll in Devereux insurance plans with selected coverage available on the first day of placement, provided enrollment is completed prior to the first day of placement. Additionally, participants receive the same amount of TOB and paid HML as a first year Devereux employee. This TOB time is not accrued, but rather is entered into the People Operations Management System by Corporate People Operations department personnel.

At the conclusion of the internship/fellowship program, any remaining TOB balance is paid out upon completion of the assignment, as long as the participant does not leave the program early or prior to being released by Devereux. HML is not paid at the conclusion of the program. In the event that a program participant is offered employment at a Devereux center following completion of his/her formal Internship/Fellowship program, TOB will be paid out as long as the employee does not leave the program voluntarily prior to being formally released by Devereux. HML is not carried over into intern/fellow's new hire HML bank. Once hired as an employee, TOB and HML begin to accrue in accordance with TOB accruals for new full-time employees.

- **Termination or LOA Status**

Full-time employees who terminate employment will be removed from Group Life, Long-Term Disability and Medical/Dependent Care Spending Accounts effective the day of the termination. Welfare benefit coverage for medical, dental, mental health, prescription and Voluntary benefits will terminate on the last day of the month in which employment ends. Conversion coverage should be offered for Life insurance and Voluntary benefits. Continuation of welfare benefits, including medical, dental, prescription coverage, and Medical Spending Account coverage should be offered through COBRA administered by EBC. Family Medical Leave and/or Medical Leave of Absence (Leaves certified as qualifying events under the Family Medical Leave Act as well as state related regulations and/or Devereux approved medical leave) may be approved for a combined period not to exceed nine months (12 months if hired prior to 7/1/15). At the end of

the approved period, employee benefits will terminate. Eligibility for COBRA benefits will apply in accordance with COBRA regulations. A medical leave of absence includes employees out of work due to a Long Term Disability and/or a Workers' Compensation event. Normally, an employee will remain on LOA no longer than nine months, 12 months if hired prior to 7/1/15 after which, if qualified, COBRA will be offered for applicable benefits.

Eligible Dependents of the Employee

Under Devereux's benefit plans, employees may cover their spouse, dependent children and/or domestic partner. All employees who are newly enrolling or making changes to their benefit plans are required to provide a marriage certificate, affidavit of domestic partnership, birth certificates and social security cards for spouse, domestic partner and/or children being added to the plan. Qualified part-time employees working on average between 30-39 hours and only their dependent children (to age 26) are eligible for the High Deductible Health Plan (HDHP) medical benefit, dental benefit and may contribute to a pre-tax Health Savings Account (HSA).

- **Spouse**

A spouse is defined as any two people who have been legally married; this includes same sex couples who are legally married.

- **Tax Dependent**

To be considered a tax dependent under IRC §152, a person must be the employees qualifying child or qualifying relative.

- **Qualifying Child**

Under the Devereux plan and in accordance with IRC §152, a qualifying child is limited to the following criteria:

(A) Bears a relationship to the employee; child, stepchild, adopted child or foster child

(B) Who is under Age 26 while covered; dependents will be removed from the plan on the last day of the month in which they reach age 26,

- **Qualifying Relatives**

Employees may cover other qualifying relatives under Devereux's benefit plans only if the employee is **legally** required to provide benefit coverage for the person. If an employee is trying to add a qualifying relative to the plan, a court order mandating coverage for this person must be provided. Generally, a person is your qualifying relative if that person:

- Lives with or is related to you,
- Is supported (generally more than 50 percent) by you, and
- Is neither your qualifying child nor the qualifying child of any other taxpayer

- **Domestic Partners**

Devereux offers its employees the opportunity to provide benefits to their same-sex or opposite-sex domestic partner. Under the Domestic Partner plan, we offer the domestic partner and the tax-qualified dependents of eligible Devereux employees the opportunity to be enrolled in all Devereux benefit programs. Employees have the ability to extend Devereux medical, dental, prescription, mental health coverage and Voluntary benefits to the significant person in their life, as well as children who are considered tax-qualified dependents. Also, employees can continue to obtain EAP and Work/Lifestyle benefits under the Carebridge programs offered by Devereux. Finally, any reference to a spouse in terms of family medical leave, bereavement leave or use of HML will also apply to a qualified same-sex or opposite-sex partner.

An Important Note: The IRS states that the value of some company-paid benefits for unmarried partners is taxable. It is important that you understand the tax implications of covering a domestic partner and any qualified children. We recommend that employees consult their own tax advisors to determine how this affects them.

Your Eligibility

You are eligible for domestic partner benefits if you are an eligible full-time employee.

Domestic Partner Criteria

- You and your partner live in a spouse-like relationship and have lived in this relationship for a period of 12 continuous months or more. Further, you intend to remain each other's domestic partner indefinitely
- You and your partner live in the same permanent residence and have lived in the same permanent residence together for a period of 12 continuous months or more. Further, you intend to live together in the same residence indefinitely. (Same permanent residence allows for relocations or moves, which are made together)
- In states recognizing domestic partner relationship by requiring registration, you and your partner have in fact registered
- Neither you nor your partner is legally married or the domestic partner of anyone else
- You are not related by blood in a way that would bar marriage to each other under applicable law in effect where you reside, and
- You are both at least 18 years of age and are mentally competent to enter into a legal contract

Eligible Dependents of Your Domestic Partner

You may also cover the children of your domestic partner if they meet Devereux's definition of an eligible dependent. Eligible dependents include your natural, adopted, step and foster children and the children of your domestic partner as long as they meet the following criteria:

- Under age 26 as defined by Devereux's benefit plans, and
- Considered qualified dependents

What is needed in Order to Enroll Your Domestic Partner?

An **Affidavit of Domestic Partnership** is required to enroll a domestic partner and/or your partner's children in Devereux's Health and Welfare benefit plans. By signing an Affidavit of Domestic Partnership, you and your domestic partner are acknowledging as true, a series of statements that document your relationship and agree to accept the terms of the affidavit. By signing such an affidavit, you and your domestic partner also acknowledge that accepting benefits when the relationship does not meet the necessary criteria is a fraudulent act possibly subject to legal action, repayment of any benefits including medical claims paid, and termination of employment. However, the affidavit does not automatically enroll your domestic partner in benefits or automatically name your domestic partner as a beneficiary for life insurance or retirement plan death benefits. Your Affidavit of Domestic Partnership is valid until you tell us otherwise, and will be considered invalid in the event it was entered into fraudulently.

NOTE: An Affidavit of Domestic Partnership and benefit coverage have led some courts to recognize non-marriage relationships as the equivalent of marriage when establishing and dividing joint property. There may be other implications to signing this document; you are urged

to seek appropriate advice before signing it.

If Your Domestic Partner is a Devereux Employee

If your domestic partner also works for Devereux, you cannot be simultaneously covered as both an employee and dependent under health care, prescription, and dental plans. You can enroll and be eligible for the Devereux two-employed classification if there are dependent children, or each of you may elect single coverage in your respective Devereux plans.

Common Law Marriage

State common law marriage statutes may give legal spouse status to some opposite-sex partners. In such situations, a separate affidavit and proof of relationship process is required. Only some states allow common law marriages in their state, but once created there, all US states recognize that marriage. Although common law marriage status is recognized in some states, it is **not** a domestic partner relationship. If your state recognizes common law marriage, and you believe you satisfy your state's requirements for this status, please check with your People Operations department for additional information. You may want to verify your marital status prior to your benefit enrollment process.

Pay and Your Taxes

Devereux's share of the cost of covering a domestic partner and his or her children is the same as for a spouse and children. However, unless the domestic partner meets all the criteria for being either a qualifying child or a qualifying relative, you will incur additional taxes on top of your share of the cost of coverage. This is because IRS rules require Devereux's share of the cost of the domestic partner's (and the domestic partners' dependents, if applicable) coverage to be reported to the IRS as part of your gross income. To determine incremental taxation cost, it is not as simple as looking at the cost of coverage found in the Devereux Choice Benefits Enrollment materials. In accordance with IRS rules, you will pay more in taxes when covering a domestic partner and his or her children than you would when covering a spouse and your own children for similar benefits. So, be sure to factor in the additional taxes when calculating your total cost. The Internal Revenue code does not tax the money spent on benefits for employees and employees' spouses and children, but they do tax the money spent on those same benefits for domestic partners and domestic partners' dependents unless they qualify as your dependent for federal income tax purposes. This means that the full cost of coverage (both your portion and Devereux's) for your domestic partner and his/her children is added to your income (imputed income) and subject to ordinary federal, FICA, state, local and any other payroll taxes.

SECTION 3: PLAN AND CARRIER OVERVIEW/QUICK REFERENCE

This Section provides a brief overview of the benefits available to full-time employees (and to part-time employees as indicated). Detailed information can be found in the carrier booklets and/or plan documents. In addition, this section will provide you with plan contact information such as carrier addresses, telephone numbers and if appropriate, group or policy numbers.

- A. Choice Benefits
- B. National Medical Plan
- C. HMO Medical Plan

- D. Dental Plan
- E. Prescription Drug Plan
- F. Medical Flexible Spending Account
- G. Dependent Care Flexible Spending Account
- H. Health Savings Account
- I. Group Life Insurance
- J. Long-Term Disability Plan
- K. Accidental Death and Personal Loss Insurance
- L. Voluntary Benefits
- M. Business Travel Accident Insurance
- N. Employee Assistance Program (EAP)
- O. Work-Family Program
- P. Advocacy and Wellness
- Q. Devereux Retirement Plan
- R. Devereux Cafeteria Plan

A. CHOICE BENEFITS

The Choice Benefits Plan gives you the flexibility to choose the level of each benefit you desire. Depending on the plan, you may be able to choose from several different coverage categories to elect benefits for yourself and, if applicable, your eligible dependents. You may select a different coverage category for medical, and dental coverage or you may elect to waive any coverage. If you purchase benefits, your payroll deductions will be made on a before-tax basis. With pre-tax coverage, you will not pay Federal or Social Security taxes, and in some cases state taxes, on your contributions. Domestic partner coverage is taxable unless your domestic partner is considered a tax-qualified dependent. Married couples where both spouses are full-time Devereux employees who elect non-single coverage should complete only one enrollment form under the Choice Benefits Plan. Devereux will provide coverage for each employee under the two person, family, and family coverage for two married employees of Devereux with dependents. You should compare the coverage under Choice Benefits with any other coverage that you may have available (i.e., under a spouse's plan) as you make your selections. It is important to note that you must enroll in the Choice Benefits Plan to receive benefits from Devereux.

B. MEDICAL PLANS

Devereux's National Medical Plan and Medical EPO Plan provide medical coverage for hospitalization, professional services and emergency care as well as preventive and diagnostic services, including vision. These plans are administered through **Independence Blue Cross (IBC)**. The Devereux National plan offers an Exclusive Provider Organization (EPO) option and a High Deductible Health Plan/Health Savings Account (HDHP/HSA) option. The Medical EPO offers an Exclusive Provider Organization and High Deductible Health Plan/Health Savings Account (HDHP/HSA) option. You can reach Independence Blue Cross by telephone at the number on the back of your card (**1-800-275-2583**) or access information at www.ibx.com. These medical benefits offer coverage across the country and internationally. If you are travelling internationally, contact the BlueCard Worldwide Service Center at 1-800-810-2583 or online at www.BCBS.com/bluecardworldwide. All plans provide in-network coverage only. Out of Network benefits are available only in emergency situations. All benefits under the plan are funded directly by Devereux. A surcharge of \$64.62 per pay to an annual maximum of \$1,680.12 will be assessed if a

spouse or domestic partner who has access to their own employer plan waives coverage to be covered under a Devereux plan. Mental Health and Substance Abuse benefits for employees who enroll in the Devereux National Plan or Colorado Medical EPO are managed by Magellan and offer in and out of network benefits. Mental Health benefits can be accessed by calling **1-800-220-1570**. Mental health benefits for employees who elect the HDHP plan are managed by Independence Blue Cross and offer in-network benefits only. In compliance with the Mental Health Parity and Addiction Equity Act of 2008, Devereux's Mental Health and Substance Abuse benefits provide in-network benefits with a \$20 co-pay per visit with no annual or lifetime maximums. If you or a family member is contacted to participate in the Case Management program from Independence Blue Cross (IBC), because of a recent hospitalization, critical or chronic illness, and choose **not** to engage in case management, you will be responsible for the non-utilization of service fee of \$100 per pay up to \$1,300 annually. To contact the Case Management program, please call 1-800-313-8628, and dial extension 26480.

Address: **Independence Blue Cross, Colorado Medical EPO**
P.O. Box 660044
Dallas, TX 75266

Telephone #: (877) 393-6740

Website: www.ibx.com

Group Name: Devereux

C. HMO MEDICAL PLAN

HMOs offer coverage for preventive care, diagnostic services, hospitalization, professional services, pharmacy and emergency care. Benefits are available for routine care, regular checkups and wellness programs. Mental Health and Substance Abuse benefits for HMO members are managed through their HMO plan coverage. All benefits under the plan are funded through an insurance contract. The HMO option is available to New York employees only.

Address: **MVP Health Plan – New York employees only**
625 State Street
Schenectady, NY 12301

Telephone #: (800) 318-8575

Website: www.mvphealthcare.com

Group #: MVPCOMM

D. DENTAL PLANS

Cigna Dental PPO

- Offers two plan options.
- Under both Plans A and B, diagnostic and preventative services are covered at 100%. **Plan A** offers the highest level of coverage with most other services being covered at 60-70%; **Plan B** offers a slightly lower level of coverage with most other services being covered at 50%. Maximum benefit is \$2,000 per person per calendar year for services provided by Cigna Advantage dentists, and \$1,000 per person per calendar year for services provided by Cigna DPPO and Non-Participating dentists.
- The Dependent Orthodontic maximum is \$1,500 lifetime per patient for services provided by Cigna Advantage dentists and \$1,000 lifetime per patient for services provided by Cigna

DPPO and Non-Participating dentists for participants in Plan A. The Dependent Orthodontic maximum is \$1,000 lifetime per patient for services provided by Cigna Advantage dentists and \$750 lifetime per patient for services provided by Cigna DPPO and Non-Participating dentists for participants in Plan B.

- The Adult Orthodontic maximum is \$1,000 lifetime per patient for participants in Plan A and \$750 lifetime per patient for participants in Plan B.
- Annual Deductible – Diagnostic and Preventive services are exempt from deductible. Any amounts applied toward the deductible in October, November or December of a calendar year will be carried over to satisfy the deductible amount of the next calendar year.
 - Plan A - \$50 per person (not to exceed \$150 per family). There is a separate \$50 lifetime deductible for Orthodontics.
 - Plan B - \$75 per person (not to exceed \$225 per family). There is a separate \$75 lifetime deductible for Orthodontics.
- Cigna’s plan gives employees a choice to obtain dental care from three types of providers: Advantage Dentists, PPO Dentists, or Non-participating Dentists. Advantage Dentists offer the lowest cost, PPO Dentists are part of the broadest network, or you may choose to obtain care from a Non-participating Dentist (but you may pay more for your care).
- Payment for services performed for you:
 - Cigna Advantage Dentists – payment is calculated by Cigna on a reduced Maximum Plan Allowance or the fee charged, whichever is less, providing employees more value for their dental benefit amount. Participating Dentists who are DPO dentists have agreed to accept the DPO Allowed Amount as full payment for services covered by the Contract. If your Dentist is a DPO, the Patient Payment is generally the difference between the Cigna payment and the DPO Allowed Amount (i.e., copayments, deductibles, charges where service performed exceed the benefit maximum, and charges for services not covered by the Contract).
 - Cigna DPPO Dentists – payment is calculated by Cigna based on a Maximum Plan Allowance or the fee charged, whichever is less. Participating Dentists who are Cigna DPPO Dentists only have agreed to accept the allowed amount as full payment for services covered by the Contract. Cigna advises you of any charges not payable by Cigna for which you are responsible
 - Non-Participating Dentists – You are responsible for payment of the Non-Participating Dentist’s total fee, which may include amounts in addition to the allowed amount and services not covered by the Contract.

You may find a listing of participating providers by utilizing Cigna’s website. You can visit any type of dentist in the same benefit year. Once you reach the \$1,000 maximum benefit, however, you must see a Cigna Advantage Dentist in order to receive the additional \$1000 maximum benefit. All benefits under the plan are self-funded, paid directly by Devereux.

Claims Address:

Cigna Dental

P.O. Box 188037

Chattanooga, TN 36422-8037

(800) CIGNA24

www.mycigna.com

3342208

Telephone #:

Website:

Group#

Cigna Dental Maintenance Organization (DMO)

- All diagnostic and preventative services are covered at 100%. Basic Services are covered at 90%, Major services at 60% and Orthodontia at 50%. There is no maximum benefit per person per calendar year for services and no deductible.
- All dental services must be provided by a primary care dentist selected from the network of participating DMO dentists.
- Services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by Cigna Dental. If payment to the specialty dentist is based on a negotiated fee, then the member's copayment for the service will be based on the same negotiated fee. If payment is on another basis, then the copayment will be based on the dentist's usual fee for the service, and reviewed for reasonableness.
- DMO members may visit an orthodontist without first obtaining a referral from their primary care dentist.

You may find a listing of participating providers by utilizing Cigna's website. All benefits under this plan are funded through an insurance contract.

Claims Address:

Cigna Dental

P.O. Box 188037
Chattanooga, TN 36422-8037

Telephone #:

(800) CIGNA24

Website:

www.mycigna.com

Group #:

3342208

E. PRESCRIPTION DRUG PLAN

The Devereux Prescription Drug Plan is administered by FutureScripts (Optum Pharmacy Benefit Manager), (BriovaRx Specialty Rx) for participants **in the Dev Medical EPO plan**. Out of Pocket Maximum:

- **\$3,300 for Single, \$4,950 for Employee/Child and \$6,600 for Family.**
- Generic drugs are covered at 85% with a minimum co-pay of \$5
- Formulary drugs are covered at 65% with a minimum co-pay of \$10
- Non-formulary drugs are covered at 50% with no minimum co-pay
- Mandatory Step Therapy Program:
 - Generic Step Therapy: Generic drug utilization will be required prior to the dispensing of a brand drug. Specialty Preferred Plan Step Therapy Program: Promotes the use of well-supported, preferred drug options in key therapeutic categories; covers the non-preferred drug when claims data shows preferred drug trial failed during previous 12 months.
 - Specialty Advanced Control Formulary promotes the use of well-supported, preferred drug options in key therapeutic categories where multiple manufacturers exist.
- Smoking Cessation Medications: Devereux will pay 100% of a 168 days' annual supply of Generic Over-the-Counter (OTC) medications, Generic Zyban and Generic Chantix to assist in smoking cessation. Even though these medications are available over the counter a physician's prescription is necessary to process the co-pay at 0%.
- Contraceptives – Devereux will cover 100% of Generic and Single Source Brands (until

generic is available). Quantity Limits may apply and a prescription is required.

- **Filling Prescriptions:**

- Emergency prescriptions and your first maintenance prescription can be filled by at any participating retail pharmacy for an initial 30-day period. Refills at a retail pharmacy are allowed for antibiotics and allergy serums only.
- After the initial fill, additional prescriptions must be refilled through CVS Pharmacy or mail service to receive benefits. For mail order prescriptions, employees may receive up to 100 consecutive day supply with the exception of specialty pharmacy drugs (biotech drugs) which are only dispensed in 30-day quantities through BriovaRx.

- All benefits under the plan are funded directly by Devereux.

Address:	Independence Blue Cross FutureScripts 1901 Market Street Philadelphia, PA 19103-1480
Telephone #:	1-800-Ask-Blue
Website:	www.ibxpress.com
Group#	163726

F. MEDICAL FLEXIBLE SPENDING ACCOUNT

You may elect to contribute before-tax dollars to a Medical Flexible Spending Account (FSA). You can request reimbursement for qualified medical expenses incurred during your period of coverage in a plan year by you, your spouse, your domestic partner if a tax qualified dependent, or any other qualified dependents. Your dependent does not need to be enrolled in Devereux's welfare benefits in order to be eligible under the FSA.

Qualified Dependents

Generally, a person is your qualifying child if that person:

- Is your child, stepchild, foster child, brother, sister, step-brother, step sister, or a descendant of any of them;
- Lived with you for more than half of the year;
- Did not provide more than half of his or her own support for the year; and,
- Was under age 26 at the end of the year, or was any age and permanently and totally disabled.
- If you are divorced or legally separated, your children are considered qualified dependents if they receive more than one-half of their support from you and your spouse or former spouse combined, even if they do not live with you.

Qualified Medical Expenses

To be eligible for reimbursement, your medical expenses must qualify as deductible medical expenses under Internal Revenue Code § 213. The term "deductible medical expenses" includes expenses incurred for the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body." You cannot be reimbursed for expenses for cosmetic surgery or procedures that are purely elective in nature. Also, you cannot

be reimbursed for expenses for procedures that are merely beneficial to your general health. The expenses must be related to the treatment of a specific condition. The determination of whether an individual's expenses qualify under Internal Revenue Code § 213 is based on the facts in each case. You may want to consult your tax advisor for further information on the types of medical expenses that qualify.

To determine how much of your pay to have deducted and contributed to a medical FSA, you should estimate the amount of medical and dental expenses you expect to incur in your period of coverage in a plan year, which will not be covered by any insurance or be reimbursed by any other plan or program. Plan your election carefully since you will forfeit any unused funds over the \$500 carry-over that remains in your account at the end of the designated time period.

When a Qualified Medical Expense Is Incurred

You may be reimbursed only for qualified medical expenses you incur during your applicable period of coverage. Expenses are incurred when the medical care is provided, not when you are formally billed or when you pay for the medical care. For example, if you pay \$2,000 in November 2019 for orthodontia services to be provided between November 2019 and May 2020, the entire \$2,000 is not considered incurred in 2019. You may be reimbursed in 2019 only for that portion of the \$2,000 that was paid for services actually provided in 2019. You would have to wait until 2020 to be reimbursed for that portion of the \$2,000 that was paid for services actually rendered in 2020.

Carry-Over of Funds

The IRS allows participants to carry-over up to a maximum of \$500 into the new plan year. Therefore, in 2019 you can carry-over up to \$500 into 2020. There is no longer a grace period of two and a half months to incur and submit payment.

Maximum Reimbursement Amount

The maximum amount you can elect to have deducted from your pay and contributed to a medical FSA is \$2,700. The maximum amount you can be reimbursed for any period of coverage is the amount of your pay that you have authorized to have deducted and contributed to your medical FSA for the period of coverage. The maximum amount is available at any time during the period of coverage, even if the amount has not yet been contributed to your account.

Example: You elect to have \$100 per month deducted and contributed to your medical FSA and your period of coverage is the plan year. The total amount that will be deducted for your period of coverage will be \$1,200 (\$100 x 12 months). Thus, \$1,200 is your maximum reimbursement amount for medical expenses incurred for that period of coverage. You can be reimbursed for the full \$1,200 at any time within the period of coverage. Eligible medical expenses in excess of \$1,200 will not be reimbursed. If your eligible expenses are less than \$1,200, you may carry over up to \$500 in the next calendar year.

G. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Another one of the optional benefits offered through the plan is the dependent care Flexible Spending Account (FSA). You may elect to contribute before-tax dollars to a dependent care

FSA. You can request reimbursement from your dependent care FSA for eligible dependent care expenses that were incurred during your period of coverage for the care of a qualifying dependent.

Qualifying Dependents

In order to be eligible for reimbursement, your dependent care expenses must relate to the care of a qualifying dependent. For purposes of the dependent care FSA, the following individuals are qualifying dependents:

- A qualifying child under age 13 whom you can claim as a dependent. If the child turned 13 during the year, the child is a qualifying person for the part of the year he or she was under age 13.
- Your disabled spouse who is not able to care for himself or herself and lived with you for more than half the year.
- Any person not able to care for himself or herself, who lived with you for more than half the year and either (a) was your dependent or (b) would have been your dependent except that:
 - The person had gross income of \$4,150 or less in 2018, indexed by IRS
 - He or she filed a joint return or
 - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's tax return.

Eligible Dependent Care Expenses

To be eligible for reimbursement, your dependent care expenses must meet all of the following conditions:

- They must be incurred in order to enable you and your spouse, if you are married, to be gainfully employed or to actively search for gainful employment.
- They must be incurred during your period of coverage in the plan year and while you have a dependent care expense election in effect.
- They must be for one of the following types of care:
 - Care in your home for a qualifying dependent
 - Care outside of your home for a dependent child under age 13, excluding overnight camp. Generally, educational expenses are not eligible dependent care expenses. However, expenses incurred for nursery school or day care prior to first grade, including incidental amounts for meals or educational expenses, are eligible dependent care expenses.
 - Care outside of your home for a spouse or other qualifying dependent that is physically or mentally incapable of self-care, provided he or she regularly spends at least eight hours a day in your home.
 - If care is provided at a "dependent care center," in order to be an eligible dependent care expense, the facility must (1) comply with local and state laws for dependent care centers, (2) receive payments or grants for services, and (3) regularly care for more than six non-residents.
 - Eligible dependent care expenses do not include expenses for food, clothing, education or expenses for services provided by a dependent child under age 19, or any person for whom you or your spouse can take an exemption on your income tax return.

Maximum Benefits

The maximum amount you can elect to have deducted from your pay and contributed to a dependent care FSA, and the maximum amount of reimbursement you may receive for a plan year, is the lesser of \$5,000 (\$2,500 if you are a married person filing a separate return or your earned income limitation). If you are not married, your earned income limitation is your pay for the year. If you are married, your earned income limitation is the lesser of your pay or your spouse's pay for the year. For purposes of the earned income limit, if your spouse is a full-time student or incapable of self-care, he or she will be deemed to earn \$200 per month if you have one qualifying dependent and \$400 per month if you have two or more qualifying dependents.

- The maximum amount you can be reimbursed at any time is the amount in your dependent care FSA at that time.
- Plan your election carefully since you will forfeit any unused funds remaining in your account at the end of the year.

Important Considerations

In order to exclude the amount of your dependent care expense reimbursements from your gross income, you will have to furnish the Internal Revenue Service (IRS) with the name, address and taxpayer identification number of the care or service provider. This information will have to be included on a schedule, which is attached to your income tax return. If the provider is a tax exempt organization, you only have to provide the name and address and indicate that the provider is a tax-exempt organization. If the IRS determines for any reason that you are not eligible to exclude these reimbursements from your gross income, you will be responsible for the payment of any taxes due on these amounts plus any applicable interest and/or penalties. In deciding whether it is to your advantage to participate in the dependent care FSA, you need to consider another method of tax relief. Internal Revenue Code § 21 provides a tax credit for eligible dependent care expenses, as defined above. Generally, you cannot take advantage of both the exclusion from gross income of amounts reimbursed from your dependent care FSA and the tax credit, because (1) you cannot use any expenses that are reimbursed under this plan to compute a tax credit and (2) the maximum amount of eligible expenses that can be used to compute the tax credit (i.e., \$3,000 for one dependent versus \$6,000 for two or more) must be reduced by the amount you excluded from gross income under this plan. You should carefully review your personal circumstances and consult with your tax advisor to determine which method of tax relief is most advantageous.

Address: **Employee Benefit Corporation**
1350 Deming Way, Suite 300
Middleton, WI 53562

Telephone #: 800-346-2126

Website: www.ebcflex.com

H. HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a tax-exempt custodial bank account that you set up with a qualified HSA trustee (Optum) to pay or reimburse certain medical expenses you incur.

- You may only enroll in a HSA if you are enrolled in the High Deductible Health Plan (HDHP).
- These funds can be used to pay for any qualified medical expenses, including deductibles and co-pays.
- You will receive a Master Card Debit Card to access funds issued through Optum Bank. Checks are available at a fee. Interest is paid on accounts.
- Whatever contributions you and/or Devereux make to your account that are not used are rolled over each year to use later or to invest for the future. There is no maximum on what you may save or invest and you may use the funds anytime for qualified medical expenses without incurring taxes.
- You may withdraw funds for any non-medical reason at any time, but those distributions will be taxed. If you are under age 65 there will also be a penalty assessed.
- Unlike the health care Flexible Spending Account (FSA), you are not limited to the \$500 carry-over. There is no “use it or lose it” provision with an HSA. HSA dollars are rolled over year to year to be used for qualified medical expenses. Even if you decide to leave Devereux, you will not lose your HSA money.
- **Contribution Limits – 2019**
 Single - \$3,500
 Family - \$7,000
 If you are over age 55, you can contribute an additional \$1,000.

HSA’s are not available once you turn 65 if you select any Medicare Provisions, including Part A, which is automatic if you elect Social Security benefits.

Address: **Optum Bank**
 11000 Optum Circle
 Eden Prairie, MN 55344

Telephone #: 1 -844-326-7967

Website: www.Optum.com

I. GROUP LIFE INSURANCE

Devereux provides term life insurance to all full-time employees automatically on the 89th day of active continuous employment provided the employee is actively at work. The Group Life Insurance Plan is underwritten and administered by **Cigna**. The plan provides employees with basic life insurance equal to two times their annual base salary up to a maximum of \$200,000. Devereux pays the full cost of this plan.*

If you terminate employment with Devereux, you should contact Cigna to learn about your right to convert group coverage to an individual policy. All benefits under the Plan are funded through

* As required by law, employees will pay taxes on any life insurance amount in excess of \$50,000.

an insurance contract with Cigna.

Address: **Cigna**
1601 Chestnut Street, 2 Liberty
Philadelphia, PA 19192
Telephone #: (800) CIGNA24
Website: www.mycigna.com
Group#: FLX980446

J. LONG-TERM DISABILITY PLAN

Devereux provides long-term disability insurance to all full-time employees working a minimum of 40 hours each week automatically on the 89th day of active continuous employment provided the employee is actively at work. For employees earning less than \$80,000, after you have been disabled for a period of 90 calendar days, the plan replaces 60% of your monthly income up to a maximum benefit of \$6,000 per month. Employees with annual earnings of \$80,000 or more receive coverage replacing 66 2/3% of their monthly income to a maximum benefit of \$10,000 per month. All benefits under the plan are funded through an insurance contract with Cigna.

Address: **Cigna**
1601 Chestnut Street, 2 Liberty
Philadelphia, PA 19192
Telephone #: (800) CIGNA24
Website: www.mycigna.com
Group#: LK980340

K. ACCIDENTAL DEATH AND DISMEMBERMENT

Devereux provides all full-time employees with the option to purchase voluntary Accidental Death and Dismemberment (AD&D) insurance effective the 1st day of the pay period in which day 90 occurs, provided the employee is actively at work and has been continuously employed. This plan is underwritten, administered by, and funded through an insurance contract with Cigna, and offers protection against losses from covered accidents. The Choice Benefits program allows you to purchase this insurance on a before-tax basis. You pay 100% of the cost of coverage.

Address: **Cigna**
1601 Chestnut Street, 2 Liberty
Philadelphia, PA 19192
Telephone #: (800) CIGNA24
Website: www.mycigna.com
Group#: OK980463

L. VOLUNTARY BENEFITS

Devereux provides all full-time employees with the option to purchase the following voluntary benefits effective the 1st day of the pay period in which day 90 occurs, provided the employee is actively at work and has been continuously employed. This plan is underwritten, administered by, and funded through an insurance contract with Cigna. You pay 100% of the cost of coverage

after taxes.

Cigna Term Life Insurance

- Available in \$10,000 increments for all Employees; new hire may elect up to \$200,000 of Guaranteed Issue.
- Available in \$5,000 increments for spouse/domestic partner, new hires may elect up to \$50,000 of Guarantee Issue for spouse/domestic partner.
- \$10,000 flat amount for children.

Address: **Cigna**
1601 Chestnut Street, 2 Liberty
Philadelphia, PA 19192

Telephone #: (800) CIGNA24

Website: www.mycigna.com

Group#: FLX980447

Cigna Voluntary Group Accident

- Pays a scheduled benefit for off the job accidental injuries that result within 90 days of the accident
- Benefits are available for Employee and dependents

Address: **Cigna**
1601 Chestnut Street, 2 Liberty
Philadelphia, PA 19192

Telephone #: (800) CIGNA24

Website: www.mycigna.com

Group#: AI960881

Cigna Voluntary Short Term Disability

- Plan 1 pays 60% of your weekly covered earnings to a maximum amount of \$1,500 after a 14 day waiting period. Benefit pays for 11 weeks and then coordinates with Long Term Disability if applicable.
- Plan 2 pays 60% of your weekly covered earnings to a maximum amount of \$1,500 after a 28-day waiting period. Benefit pays for 9 weeks and then coordinates with Long Term Disability if applicable.

Address: **Cigna**
1601 Chestnut Street, 2 Liberty
Philadelphia, PA 19192

Telephone #: (800) CIGNA24

Website: www.mycigna.com

Group#: VDT980193

M. BUSINESS TRAVEL ACCIDENT INSURANCE

Devereux provides all full-time employees with Business Travel Accident Insurance (Accidental

Death and Personal Loss benefit) effective the first day of active employment. This plan, underwritten and administered by **Federal Insurance Company**, covers losses sustained during any authorized Devereux related business trip. Devereux pays the full cost of this plan.

Benefit:	Officers	\$400,000
	Trustees	\$300,000
	Directors	\$300,000
	Chaperons	\$150,000
	All Others	\$100,000

All benefits under the plan are funded through an insurance contract with Federal Insurance Company.

Address: **Federal Insurance Company**
One Liberty Place
1650 Market Street
Philadelphia, PA 19103-7301
Telephone #: 215-569-9660 (within PA), 800-252-4670 (emergency)
Website: www.chubb.com
Policy Number: 6408-45-06

N. EMPLOYEE ASSISTANCE PROGRAM (EAP)

Devereux provides an Employee Assistance Program (EAP) to all employees and their families through Carebridge. Carebridge provides telephonic and face-to-face support for emotional and relationship concerns, substance abuse, and helpful information for the triggers of everyday stress such as parenting, childcare, eldercare and finances.

The plan offers up to five counseling sessions per related event. Services are available from licensed clinical staff 24 hours/7 days/365 days per year. Devereux pays the full cost of the plan; you are not responsible for any payment under the plan.

Address: **Carebridge Corporation**
40 Lloyd Ave
Malvern, PA 19355
Telephone#: (800) 437-0911
Website: www.myliferesource.com (Devereux code ADC53)
Group#: ADC53

O. WORK-FAMILY PROGRAMS

Devereux provides all employees a work-family program that consists of childcare services, eldercare services, and personal care services. Child and eldercare care services consist of dependent care resources and referral programs to help manage issues related to childcare resourcing and assistance with aging parents. This plan, provided through **Carebridge**, provides assistance with the following childcare needs in the **Kinderbridge** division:

- Child care centers

- Family and Group day care homes
- In-home care
- Nannies and au pairs
- Vacation, weekend and business trip care
- Summer care
- Nursery/Preschool

The Elderbridge division of **Carebridge provides counselors to assist** in matters such as:

- Caregiver supports, stress and time management, long-distance caregiving
- Health care options, costs, geriatric assessments, Medigap insurance
- Entitlements/eligibility for Medicare, Medicaid, Social Security
- Nursing facilities crisis planning, hospice care, long term care insurance
- Elder housing choices, costs, contracts, evaluations

In addition, **Carebridge provides Personal Care** services including consultation and information on matters such as:

- Continuing education
- Personal financial management
- Relocation guidance
- Time management

Carebridge services are accessible to you via a toll free phone number (800-437-0911). Carebridge counselors are trained to provide you with the broadest set of options, the most helpful literature, and committed partnership as you search for the best answers for child and elder care problems. Additional resources can be found on Carebridge’s website.

Address:	Carebridge Corporation 40 Lloyd Avenue Malvern, PA 19355
Telephone #:	1-800-437-0911
Group#:	ADC53
Website:	www.myliferesource.com (Devereux code ADC53)

P. HEALTH ADVOCATE

Health Advocate, an employer-paid program, can help you resolve benefit issues, assist with insurance related concerns, help you find a doctor, hospital or schedule tests, and work with you to estimate the cost of care. Health Advocate will also provide wellness coaching, online health tracking tools, coaching tutorials and the Personal Health Profile (PHP). Health Advocate is an independent company not affiliated with the insurance carrier or Devereux. All information is strictly confidential.

Devereux’s Health and Wellness Program is coordinated through Health Advocate and runs from October 1 through September 30 each year. Employees who participate in the Health and Wellness Program qualify the following plan year for a 10% discount on their medical premiums in the Dev Medical EPO program or for a contribution to their Health Savings Account (HSA) if

they participate in the High Deductible Health Plan (HDHP). Employees participating must receive a total of 85 points, complete a Personal Health Profile (PHP) and the tobacco affidavit to satisfy the program requirements.

The Devereux Wise and Well Health and Wellness Program is a voluntary wellness program available to all full-time employees who enroll in medical benefits through Independence Blue Cross. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008 and the Health Insurance Portability and Accountability Act, as applicable among others. If you choose to participate, you will be required to complete a PHP that asks a series of questions about your health-related activities and behaviors.

The information from your PHP will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through Health Advocate. You are also encouraged to share your results with your doctor. Devereux does not have access to your PHP or medical information. We are required by law to maintain the privacy and security of your personally identifiable health information. Although, the Devereux Health and Wellness Program may receive and use aggregate information to design programs based on identified health risks in the workplace.

Address: Health Advocate
3043 Walton Road
Plymouth Meeting, PA 19462

Telephone #: 1-866-695-8622

Website: www.healthadvocate.com/devereux

Q. DEVEREUX RETIREMENT PLAN

The Devereux Retirement Plan is a defined contribution plan that operates under Section 403(b) of the Internal Revenue Code. The benefits are provided through **TIAA**. If eligible, you may participate in the Plan as of the first payroll period following your date of hire, provided you have completed a salary reduction agreement, an enrollment form with investment elections and a beneficiary designation. These forms can be completed online or on paper. Employee contributions are remitted to TIAA after each pay period during the Plan Year.

You will participate in the Plan for purposes of Employer Contributions beginning in the year that you satisfy the eligibility requirements to receive such contributions, regardless of your work location (center), provided you complete 1,000 hours of service for the Plan Year (including the Plan Year in which you satisfy the eligibility requirements) and are employed on the last day ending in the final pay period of the plan year, other than for the two exceptions outlined below. However, your eligibility to begin to receive Employer Contributions and the contribution level (as a percentage of compensation for qualified hours worked) depends on your work location (center) and employment hire date.

If you (a) were a participant in the Plan prior to termination of employment, and (b) are subsequently reemployed within 12 months of the termination of employment, you will be

eligible to again participate in the Plan for purposes of Employer Contributions as of the first day of the first month following your reemployment provided you have met the requirements for participation described above, and have been credited with at least 1,000 hours of service in the Plan Year (including the Plan Year in which you satisfy the eligibility requirements). If applicable, you will be placed in the same group in which you were enrolled prior to departure.

Address: **TIAA**
730 Third Avenue
New York, NY 10017

Telephone #: (800) 842-2776

Website: www.tiaa.org/devereux

R. DEVEREUX CAFETERIA PLAN

The Plan is a cafeteria plan governed under Section 125 of the Internal Revenue Code (the Code). This plan is sometimes referred to as a Section 125 or flexible benefit plan and allows pre-tax deductions:

- To fund your contribution toward the health care Flexible Spending Account sponsored by Devereux.
- To fund your contribution toward the dependent care Flexible Spending Account sponsored by Devereux.

Initial Election

If you do not enroll in any benefits during your eligibility period, you will be deemed to have elected to receive the full amount of your pay in cash compensation, and you will not be permitted to elect any of the benefit coverages until the next plan year, except as provided below in the Irrevocability of Election and Forfeitures section. Your election will have prospective effect only; it will not be retroactive.

Irrevocability of Election and Forfeitures

It is very important that you consider carefully what benefits you choose and how much you elect to contribute to the health care and dependent care Flexible Spending Accounts. Except in the event of a qualified family status change, you are not allowed to revoke or change your elections within a plan year, and you will forfeit any unused amounts remaining in your spending accounts. This is often referred to as the "use it or lose it rule." The amounts forfeited will be used first to pay the expenses of the plan and then returned to Devereux.

Plan Administrator **Devereux**
2012 Renaissance Boulevard
King of Prussia, PA 19406
(610) 520-3000

Claims Administrator: Employee Benefits Corporation
1350 Deming Way, Suite 300
Middleton, WI 53562-4640

Phone: 1-800-346-2126, Fax: 608-831-4790

Website: www.ebcflex.com

SECTION 4: General Plan and Administrative Information

A. GENERAL INFORMATION

The online benefits enrollment forms, the individual plan booklets/materials, Summary of Benefit Coverages (SBC's), and this summary constitute the Summary Plan Descriptions (SPD's) for Devereux's welfare benefit plans as required under the Employee Retirement Income Security Act (ERISA). In order for you to best understand and utilize the benefit programs available at Devereux, you should become familiar with this summary and the descriptions provided by each plan. Each center has designated People Operations staff available to provide clarification and/or additional information:

PLAN SPONSOR:

Devereux
2012 Renaissance Boulevard
King of Prussia, PA 19406

Devereux includes: The Devereux Foundation, Devereux Colorado, Communities Connected for Kids, Heartland for Children and Quality Health Staffing

EMPLOYER ID NUMBER:

The Devereux Foundation	23-1390618
Devereux Colorado	84-0406820
Communities Connected for Kids	46-0908479
Heartland for Children	02-0619609
Quality Health Staffing	82-4576650

**BUSINESS TELEPHONE #:
PLAN ADMINISTRATOR/
AGENT FOR SERVICE OF
LEGAL PROCESS:**

(610) 520-3000
Devereux
Senior Vice President, People Operations
2012 Renaissance Boulevard
King of Prussia, PA 19406

PLAN YEAR:

January 1 through December 31

B. OPEN ENROLLMENT PERIOD

An Open Enrollment period is provided annually for all eligible employees to make changes to their flexible benefits program. Normally, the Open Enrollment period for all full-time employees will occur in October/November with all changes being effective January 1. The Open Enrollment period will not be less than 10 consecutive days. Your center People Operations office will notify you in advance of the Open Enrollment period by utilizing the center's standard posting and notification procedures. The Open Enrollment period is the only time, other than a qualified family status change, when you can elect, change, or revoke your optional benefit elections for the plan year. We request that you make benefit selections and confirm your dependent and beneficiary information is correct each year during Open Enrollment through Oracle Self-Service. You must enter Oracle Self-Service to enroll in the Flexible Spending Account, dependent care account and Health Savings

Account each year. If you do not enter Oracle Self-Service during Open Enrollment and make benefit selections, the benefits that you had previously enrolled in will remain in effect with the exception of Flexible Spending, dependent care Accounts and Health Savings Accounts. You also must complete the Spouse Waiver each year if you have a spouse/domestic partner enrolled. If this is not completed during Open Enrollment you will be assessed the Spousal Surcharge.

C. PLAN COST

Depending upon the benefit plan choices you make, the cost of Devereux's benefits program may be paid by Devereux in full, shared by the employee and Devereux, or paid in full by the employee. The following benefits are paid in full by Devereux:

- Group Life Insurance
- Long-Term Disability
- Employee Assistance Plan
- Work-Family Programs
- Business Travel Accident Insurance
- Health Advocacy

The following welfare benefits are paid in part by Devereux and in part by employee contributions:

- National Medical Plan
- HMO Medical Plan
- Dental Plan
- Prescription Drug Plan

Each year, Devereux determines its plan subsidy and the applicable contributions toward each plan based on actual and projected claim costs and administrative expenses incurred under the plans. The actual Devereux subsidy and employee contributions may change from year to year. Devereux reserves the right to change employee contributions during a plan year should circumstances warrant. Currently, Devereux pays approximately 75% of the total cost for these plans. This percentage is not used to determine contributions for any specific plan or level of coverage. Actual contribution amounts for each plan and level of coverage are provided in Oracle Self-Service, online at benefits.devereux.org and available through your People Operations department.

The following benefits are paid fully by employee contributions:

- Accidental Death and Dismemberment
- Health Care Flexible Spending Account (FSA) and Dependent Care Flexible Spending Account (FSA)
- Health Savings Account (HSA) if enrolled in High Deductible Health Plan (HDHP). If enrolled in the Health and Wellness Program, Devereux contributes \$5.00 per individual and \$10 per family per pay into your HSA.
- Voluntary benefits.

Full-time employees will have applicable contributions withheld from their pay for HSA in conjunction with the HDHP, National Medical Plan, Dental, and health care and dependent care FSA on a before-tax basis. All voluntary contributions withheld for retirement contributions may be made on a before-tax basis or an after-tax (Roth) basis. All contributions for Voluntary benefits will be deducted on an after-tax basis.

D. QUALIFIED CHANGE IN STATUS

You may revoke your election and make a new election for the rest of a calendar year if both the revocation and the new election are due to and consistent with a change in status that affects eligibility for coverage under an employer's plan, or for the dependent care FSA, affects the amount of Eligible Dependent Care Expenses you will pay. You must submit documentation verifying the change in status and make the change online within **30** days of the following changes:

- A change in your, your spouse's, your domestic partner's, or your dependent's employment status that causes that person to become or cease to be eligible under the cafeteria plan or other benefit plan of that person's employer, such as a reduction or increase in hours of employment that causes the employee to become eligible or cease to be eligible for benefits.
- Significant changes in health plan cost or coverage levels.
- One of the following events that changes your, your spouse's, your domestic partner's, or your dependent's employment status: a termination or commencement of employment, a strike or lockout, a commencement or return from a paid or unpaid leave of absence, or a change in work site
- An event that changes your, your spouse's, your domestic partner's, or your dependent's coverage including loss of coverage, gain of coverage, a court order giving or removing custody, or a court order ordering or removing coverage.
- An event that changes the number of your dependents, including marriage or where you provide an affidavit that your domestic partner relationship has ended.
- A change in your, your spouse's, your domestic partner's, or your dependent's place of residence or work.

You must submit your documentation verifying the change in status and make the change online within **60** days of the following changes:

- An event that changes the number of your dependents, including birth, adoption, placement for adoption, or death of a spouse or dependent.
- An event that changes your, your coverage, your spouse's coverage, your domestic partner's coverage, or your dependent's coverage including obtaining or losing Medicare or Medicaid coverage.
- An event that changes the number of your dependents, including divorce, legal separation, or annulment.
- An event that causes your dependent to cease to satisfy the requirements for dependent coverage due to attainment of age/Employment status.
- As amended by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), an event which causes the employee or dependent(s) to become eligible for a CHIP or Medicaid premium subsidy assistance program or cease to be eligible for such benefits.

Election Change to Correspond to Dependent's Coverage

If your dependent changes his or her coverage under his or her employer's plan outside of this plan's open enrollment period, or outside of this plan's coverage period, then you may prospectively change your election under this plan. Your election change under this plan must be due to and consistent with the change made by your dependent. The change made by your dependent must be made during his or her plan's open enrollment period or under the Internal Revenue Code § 125 rules (generally, the change is permitted mid-year and your dependent pays the premium on a pre-tax

basis). You must request the enrollment change under this plan within 30 days of the date your dependent changed his or her election under his or her employer's plan.

Enrolling a Child Covered by a Qualified Medical Child Support Order

A court or state child support agency may issue an order requiring you to provide health coverage for your children. If the order is "qualified" under applicable law, Devereux's health plans will honor the order. This type of order is known as a Qualified Medical Child Support Order, or QMCSO. You or the plan administrator may change your election under this plan to add coverage for any child enrolled in Devereux's health plans pursuant to a QMCSO. In addition, if a QMCSO is issued requiring your child's other parent to provide health coverage, you may (but are not necessarily required to) change your election under this plan to drop coverage for that child. You must request an election change due to a QMCSO within 30 days of receiving the QMCSO.

Significant Cost Changes

If your share of the cost under Devereux's health plans changes significantly, you may be permitted to revoke an existing election and make a new election. You will be advised if this ever occurs. If your portion of the cost for coverage under Devereux's health plans increases or decreases as a result of an adjustment in the cost of coverage, the amount of your salary reduction will automatically change to reflect the difference.

You may not change your election under the health care FSA due to a significant cost change under an employer's health plans. However, if your eligible dependent care expenses increase significantly during a plan year due to a cost increase by a provider who is not related to you, you may change your dependent care FSA election accordingly. You must request the change within 30 days of the cost increase.

Significant Coverage Changes

If any of the plans providing optional benefits under this plan are amended mid-year in a way that constitutes a significant coverage change, you will be permitted to make certain election changes. You may not change your election under the health care FSA due to such coverage changes. However, if your dependent care arrangements change mid-year in a significant way, you may be able to change your election under the dependent care FSA. Contact the plan administrator for additional details.

Enrolling in Medicare or Medicaid

You may change your election to drop or reduce coverage for a person who enrolls in Medicare or Medicaid. You must request the change within 60 days of enrollment. You also may change your election to add or increase coverage for a person who is losing eligibility for Medicare or Medicaid, as long as that person is eligible under the plan providing the optional benefit in which he or she is being enrolled. You must request the change within 60 days of losing the other coverage.

Enrolling in Children's Health Insurance Program (CHIP)

As amended by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), you may change your election to drop or reduce coverage for a person who enrolls in CHIP. You must request the change within 60 days of enrollment. You may also change your election to add or

increase coverage for a person who is losing eligibility for CHIP. You must request the change within 60 days of losing the other coverage.

E. FMLA PROVISIONS

If you take a leave of absence from work pursuant to the Family and Medical Leave Act of 1993 (FMLA), including the National Defense Authorization Act, an extension of FMLA which provides additional FMLA leave for military families and signed into law on January 28, 2008, unless you otherwise elect to discontinue coverage as indicated on your application for Leave of Absence request form, your group health, dental, prescription, and AD&D coverage, as well as your health care FSA coverage (but not your Dependent Care Reimbursement Plan coverage), will be continued under the same terms and conditions that would have applied had you continued working. This means that you must continue to pay any contributions you were required to pay on the day immediately prior to your FMLA. Generally, if you are on unpaid leave, you must remit contributions on a pay-as-you-go after-tax basis. If your leave is paid FMLA, you continue to pay your contribution in the same manner as applied before the paid leave. If you do not return to active work as an eligible employee after your FMLA leave has expired, or if you give notice of intent not to return to active work before the end of your FMLA leave, your coverage may be continued only under COBRA provisions of the applicable plans (medical, prescription, dental and health care FSA) effective on the earlier of (1) the day following the last day of the month in which your FMLA leave ends or (2) the day following the last day of the month in which you give notice of your intent not to return to work. Among other things, this means that you generally will be responsible for payment of the entire cost of coverage and an administrative fee during the period that benefits are continued under COBRA. FMLA will not count toward the maximum duration of coverage you are permitted under COBRA. Your coverage during FMLA leave may cease if your payment for any required contribution is more than 30 days late and will definitely be terminated if your payment for any required contribution is more than 90 days late. However, before your coverage is terminated, you will receive a written notice that you are delinquent on your contribution and you will have at least 15 days from the date of the notice to make the required payment. If you do not make the required contribution by the date specified in the notice, your coverage may be terminated retroactively.

If your coverage was terminated during your FMLA leave, either because you failed to pay your portion of the contribution or because you elected not to continue coverage, your coverage will be reinstated on the date you return to active employment if you (1) return to active employment immediately upon expiration of your FMLA leave (2) re-enroll for coverage within 30 days of your return to active employment, and (3) make the required contribution. You will not be required to satisfy any eligibility waiting period when you re-enroll.

F. MILITARY LEAVES OF ABSENCE (USERRA PROVISIONS)

Under a federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered under medical, dental, prescription, AD&D or health care FSA and become absent from employment with your Employer due to military service for a period of more than 31 days, you will be deemed to be on an approved unpaid leave of absence while performing military service. You will be entitled to all of the rights and benefits under your applicable Devereux benefit plan that is available to a covered employee on an unpaid leave of absence. If your military service does not exceed 31 days, you will continue to be covered by each plan as a regular, active employee. If your coverage terminates due to the expiration of your leave of

absence while you are still in the military, you and your dependents will be entitled to continue coverage under COBRA for those plans for a period not exceeding 24 months, as defined by the Veterans Benefits Improvement Act (VBIA) of 2004, from the date on which your absence began or, if earlier, the day after the date on which you fail to return to employment.

If you return as an active employee after your military service, coverage for you and your eligible dependents will be immediately reinstated if:

- You and your dependents were covered under your plans on the day before your absence from employment due to military service; and,
- Your total military service while you were absent from employment did not exceed five years.

If you return to active service during the same plan year in which you left, eligible charges you had accumulated towards satisfying deductibles and out-of-pocket maximums will be taken into account in determining your benefits for the plan year.

G. WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under federal law, medical plans must provide certain benefits related to breast reconstruction. If you are receiving mastectomy benefits from a medical plan and elect breast reconstruction in connection with that mastectomy, the plan will cover:

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

Coverage will be provided in a manner determined in consultation between you and your attending physician. This coverage is subject to the same deductibles and coinsurance limitations that apply for other benefits under the plan.

H. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under the Newborns' and Mothers' Health Protection Act, coverage for a hospital stay for both mother and child cannot be limited to less than 48 hours after a normal delivery or 96 hours after a cesarean section (C-section). By law, no pre-authorization is required for maternity stays within those timeframes. If your maternity hospital stay will extend beyond those times, you must obtain authorization for the additional time. You are always free to leave the hospital earlier if you and your doctor agree that it is appropriate.

I. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was designed to improve the availability and portability of health coverage. HIPAA restricts preexisting condition exclusions and limitations in plans by providing credit for past coverage to either reduce or eliminate the limitations of a preexisting condition. The Act also provides rights to individuals to enroll in plans in situations where other coverage is lost and prohibits discrimination due to health status. HIPAA also guarantees the renewability and availability of health plans for small employers.

If there are any questions about HIPAA, contact the plan administrator or your People Operations

office. If there are any questions about an individual's rights under HIPAA, contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

HIPAA Special Enrollment Period

If you decline company-sponsored medical coverage for yourself or your spouse and/or dependents, because you have other medical insurance, you may qualify for a "special enrollment period" if you lose that other coverage during the year. You would need to enroll within **30** days after the date you lost that other coverage or else wait until the next annual enrollment period. If gaining or losing coverage under a state approved CHIP program, you would need to de-enroll or enroll within **60** days after the date you lost that coverage or else wait until the next annual enrollment period. If you have a new dependent as the result of marriage, birth, or adoption (including placement for adoption), you may be able to enroll yourself and your dependents within 30 days of the date of that event. Contact your People Operations office immediately if you have a question about whether an event in your life qualifies you to change your benefit elections.

HIPAA Notice of Privacy Practices

In April 2003, a new federal law went into effect that guarantees the privacy of health information for all clients and employees. HIPAA gives individuals a right to gain access to their records (where deemed appropriate) and to request amendments to their health information. It requires that all health care providers and payers use a standard format for common transactions, such as submitting an insurance claim. Under applicable law, the plans are permitted to make certain types of uses and disclosures of your Protected Health Information (PHI), without your authorization, for treatment, payment and health care operations purposes. For treatment purposes, such use and disclosure may take place in providing, coordinating or managing health care and its related services by one or more of your providers, such as when your primary care physician consults with a specialist regarding your condition. For payment purposes, such use and disclosure may take place to determine responsibility for coverage and benefits, such as when they confer with other health plans to resolve a coordination of benefits issue. They also may use your PHI for other payment-related purposes, such as to assist in making plan eligibility and coverage determinations, or for utilization review activities. For health care operations purposes, such use and disclosure may take place in a number of ways involving plan administration, including for quality assessment and improvement, vendor review, and underwriting activities. Your information could be used, for example, to assist in the evaluation of one or more vendors who support us, or they may contact you to provide reminders or information about treatment alternatives, or other health-related benefits and services available under the plan. They may disclose your PHI to the plan sponsor in connection with these activities. If you are covered under an insured health plan, the insurer also may disclose PHI to the plan sponsor in connection with payment, treatment or health care operations. In addition, the plans may use or disclose your PHI without your authorization under conditions specified in federal regulations, including:

- As required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law
- For public health activities
- Disclosures to an appropriate government authority regarding victims of abuse, neglect or domestic violence
- To a health oversight agency for oversight activities authorized by law

- In connection with judicial and administrative proceedings
- To a law enforcement official for law enforcement purposes
- To a coroner or medical examiner
- To cadaveric organ, eye or tissue donation programs
- For research purposes, as long as certain privacy-related standards are satisfied
- To avert a serious threat to health or safety
- For specialized government functions (e.g., military and veterans activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- For worker's compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

The plans may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to the person's involvement with your care or payment related to your care. In addition, we may use or disclose the PHI to notify a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your health care. Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization in writing at any time.

J. CONTINUATION OF GROUP HEALTH PLAN COVERAGE (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you, your spouse, and your dependent children may elect to temporarily continue coverage under health coverage in certain instances where coverage otherwise would be reduced or terminated. Individuals entitled to COBRA continuation (qualified beneficiaries) are you, your spouse, and your dependent children who are covered at the time of a qualifying event. In addition, a child who is born to you, adopted by, or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary. COBRA does not legally apply to domestic partner coverage. However, Devereux will offer an extension of coverage to domestic partners and their dependents if an employee's applicable benefits terminate due to employment events (change in status or loss of job). Health coverage eligible for continuation under COBRA includes:

- National Medical Plans including Prescription Drug coverage
- HMO Medical Plan (NY only)
- Dental Plan
- Health Care Flexible Spending Account through Employee Benefits Corporation, Devereux's Third Party Administrator, administers COBRA coverage.

Qualifying Events

If your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your health coverage terminates, you, your covered spouse, your domestic partner, and your covered dependent children may continue health coverage for up to 18 months. If you (the employee) should die, become legally separated or divorced, or become entitled to Medicare, your covered dependents whose health coverage would be reduced or terminated may

continue health coverage for up to 36 months. Also, your covered children may continue health coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the plan. Certain events may extend an 18 month COBRA continuation period applicable to your termination of employment or reduction in hours worked:

- **If your dependent(s) experience a second qualifying event** within the original 18 month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
- **If you elected COBRA due to a military leave AND your benefits terminated on or after December 10, 2004**, the COBRA coverage period for you, your covered spouse, your domestic partner or dependent child(ren) is a period that can continue up to 24 months from the initial COBRA effective date, as defined by the Veterans Benefits Improvement Act of 2004.
- **If you (the employee) became entitled to Medicare** while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (e.g., your termination of employment or reduction in hours of work) happens within 18 months, you as the employee may elect COBRA for up to 18 months from the termination or change in part time status while your dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.
- **If you (the employee) became entitled to Medicare** while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (e.g., your termination of employment or reduction in hours of work) happens after 18 months, you as the employee and your dependents may elect COBRA continuation for up to 18 months from the termination or change in part-time status.
- **If you or your dependent is disabled** (as determined by the Social Security Administration) on the date of a termination of employment or reduction in work hours or at any time during the first 60 days of COBRA continuation coverage due to such event, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). To qualify for this disability extension, the plan administrator must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18 month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the plan administrator within 30 days after this determination.

Important Note: If a second qualifying event occurs at any time during this 29 month disability continuation period, then each qualified beneficiary who is a spouse, domestic partner, or dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation upon legal separation, divorce, or loss of child's dependent status under the plan, you or one of your dependents **must** notify the center People Operations department of the legal separation, divorce, or loss of dependent status within 60 days of the later of the date of the event or the date the individual would lose coverage under the plan. Your covered dependents then will be provided with instructions for continuing their health coverage. Individuals

already on COBRA continuation must notify the plan administrator within these deadlines if a legal separation, divorce, Medicare entitlement, determination of disability by the Social Security Administration (SSA), or loss of a child's dependent status occurs that would extend the period of COBRA coverage for your spouse, domestic partner, or dependent children. In addition, the qualified beneficiary must notify the plan administrator of any address changes in order to protect his or her rights. Written notification must be submitted within 60 days from the date of the event and sent via e-mail, fax or mail to Employee Benefits Corporation. For other qualifying events (if your employment ends, including not returning from an approved leave of absence, your hours are reduced, or you become entitled to Medicare), you and your covered dependents will be provided with instructions for continuing your health coverage. In the event of your death, the Company will notify your covered dependents regarding how to continue health coverage.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered dependents must choose to continue coverage under the plan within 60 days after the later of the following dates:

- The date you and/or your covered dependents would lose coverage as a result of the qualifying event, or
- The date the Company notifies you and/or your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

Premium Due Date

If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of the first of each month. If you elect COBRA continuation, but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your coverage will be terminated retroactively to the last day of coverage for which timely payment was made.

Cost

The cost of COBRA coverage is 102% of the full cost of coverage. The cost of coverage for the 19th through 29th months of coverage under the disability extension is:

- 150% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual, and
- 102% for any family members participating in a different coverage option than the disabled individual, except as provided below.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, during the 19th through 29th months), then the rate for the 19th through 36th months of the COBRA continuation period is:

- The 150% rate for all family members participating in the same coverage option as the disabled individual, and
- The 102% rate for any family members in a different coverage option than the disabled individual.

Coverage during the Continuation Period

If coverage under the plan is changed for active employees, the same changes will apply provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods, if a change in status occurs or at other times under the plan to the same extent that active employees may do so.

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any person will **end** when the first of the following occurs:

- The applicable continuation period ends.
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due.
- After the date COBRA is elected, the qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan not offered by the Company that does not contain an exclusion or limitation affecting the person's preexisting condition, or the other plan's preexisting condition limit or exclusion does not apply or is satisfied because of the HIPAA rules.
- The qualified beneficiary first becomes entitled to Medicare after the date COBRA is elected. (This does not apply to other qualified beneficiaries who are not entitled to Medicare).
- If in the case of the extended coverage period due to a disability, there has been a final determination under the Social Security Act that the qualified beneficiary is no longer disabled, then the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.
- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred.
- The Company terminates all group health coverage for all employees.
- At the end of the calendar year, in which you terminated or changed to part-time status, for your health care FSA. (*Note:* A medical FSA cannot be elected under COBRA in a new plan year). Contact the plan administrator for further details.

If your COBRA payment is deemed short by what the COBRA legislation calls "an insignificant amount," you will be notified by mail that your payment was short, and you will be responsible for paying the difference within 30 days thereby making it a whole premium payment. If you do not make your partial premium payment whole within the agreed time frame, do not send any monthly payment, or pay by check without sufficient bank funds, you have not paid your monthly premium. This means your COBRA coverage will be cancelled. The COBRA regulations state that the payment is considered to be made to the plan or COBRA Administrator on the date that it is sent (postmarked date). At the conclusion of the 18, 29, or 36 month period, you may have the option of converting to your own private individual health insurance policy. It is your responsibility to contact the health insurance carrier if you are interested in this option. Dental and prescription insurance conversions are not available.

K. ERISA RIGHTS STATEMENT

As a participant in the welfare benefits plan offered to employees of Devereux, you are entitled to

certain rights and protections as guaranteed under the **Employee Retirement Income Security Act (ERISA)** of 1974. **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 work sites, all documents governing the plan, including insurance contracts, 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 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 copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The plan administrator may make a reasonable charge for 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 (SAR).
- 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 surrounding your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting 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 carrier 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 preexisting condition exclusion for up to 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 benefits plan. The people who operate your plan, called fiduciaries of the plan, have the duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under **ERISA**. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under **ERISA**, there are steps you can take to enforce the above rights. For instance:

- If you request materials from the plan administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is denied or ignored in whole or part, you may file for review 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 medical child support order, you may file suit in federal court.
- If the 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 the 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 (such as if it finds your claim is frivolous).
- If you have any questions about your plan, you should contact your plan administrator or your People Operations professionals. If you have any questions about this statement or about your rights under **ERISA**, you should contact the nearest Office of Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

L. CONTRACT OF EMPLOYMENT

This document is intended to provide you with direction and guidance regarding Devereux's benefits program. This document does not constitute an implied or expressed contract or guarantee of employment. Devereux's employment relationship with you, and yours with Devereux, is at-will. This permits Devereux or you to terminate the employment relationship at any time, for any reason. Devereux does not and will not modify its policy of employment-at-will in any case. Further, no manager, supervisor or other representative of Devereux has the authority to enter into any expressed or implied agreement of employment for any specified period of time or for employment other than at-will.

M. PLAN DOCUMENT

Summary Plan Descriptions as legally required for Devereux's benefit plans consist of two components:

- (1) Insurance carrier and plan administrator documents, handbooks and other forms of plan description.
- (2) This "wrap-around document" that provides overview information on all Devereux benefits and includes legally required information that may not be included in each separate insurance carrier document.

This wrap-around document serves as both the Summary Plan Description and as the official plan document for Devereux's benefit plans. While every effort has been made to provide correct information and to answer most of your questions, this summary does not provide all the details of every plan. Specific details can be found in each individual plan's description. If there are any differences between this wrap-around document and the plan descriptions provided by each insurance carrier and plan administrator, the terms of the carrier and plan administrator documents will prevail. Any differences in this document or other benefit resource information do not create eligibility for a benefit that Devereux did not intend as part of the formal plan. Devereux reserves the right to authorize benefits or payment not explicitly identified in this document or in carrier or plan administrator plan descriptions when doing so is deemed to be in the best interest of Devereux and the employee. You can obtain a copy of the plan document and insurance contracts from your plan administrator. There may be a minimal charge for copying costs.

N. LIMITATION ON ASSIGNMENT

Your rights and benefits under these plans cannot be assigned, sold, transferred or pledged by you or reached by your creditors or anyone else except under limited circumstances.

O. RIGHT TO AMEND OR TERMINATE PLAN(S)

Devereux reserves the right to change or terminate any benefit plan at any time, with or without notice. Although it is our intent to continue benefits, business conditions and other factors require that we reserve this right to amend, modify, revoke or terminate the benefits in whole or part at any time. In general, if a plan is ended, you will not be vested in any plan benefits or have any rights (other than payment of claims incurred before the plan ended), subject to applicable law. The amount and form of any final benefit you may receive will depend on plan assets, any contract or insurance provisions affecting the plan, and decisions made by Devereux. A change in carrier does not constitute termination and participants must remain in the equivalent plan selected by Devereux.

SECTION 5: Claim Procedures

Under federal law, each Devereux welfare benefit plan covered by the Employee Retirement Income Security Act (ERISA) is subject to claim procedures and appeal rules in effect since 2002-2003. Each program's plan description includes specific language on claim procedures and appeals applicable to that plan. You should refer to these materials for a complete description of each plan's obligations and your rights. The sections that follow provide an overview of the general rules applicable to each type of welfare benefit plan. In all cases, each plan's description takes precedence over the information provided in this section.

A. HEALTH PLANS

Time Frame for Initial Claim Determination

For urgent care claims and pre-service claims (claims that require approval of the benefit before receiving medical care), the plan administrator will notify you of its benefit determination (whether adverse or not) within the following period:

- 72 hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification).
- 15 days after receipt of a pre-service claim.

For post-service claims (claims that are submitted for payment after receiving medical care), the plan administrator will notify you of an adverse benefit determination within 30 days of receipt of the claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For urgent care claims, if you fail to provide the plan administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the plan administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

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

For pre and post-service claims, a 15-day extension may be allowed to make a determination, if the plan administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the plan administrator must notify you before the end of the first 15 or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim. If an extension is necessary for pre and post-service claims due to your failure to submit necessary information, the plan’s time frame for making a benefit determination is stopped from the date the plan administrator sends you an extension notification until the date you respond to the request for additional information. In addition, if you or your authorized representative fails to follow the plan’s procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and,
- Is a communication that names you, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

Urgent Care Claims

Urgent care claims are those which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient’s life, health or ability to regain maximum function; or,
- In the opinion of a physician with knowledge of the patient’s medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the plan, applying the judgment of a prudent layperson that has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient’s medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a plan amendment or plan termination.

If You Receive an Adverse Benefit Determination

The plan administrator will provide you with a notification of any adverse benefit determination, which will set forth:

1. The specific reason(s) for the adverse benefit determination;
2. References to the specific plan provisions on which the benefit determination is based;
3. A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
4. A description of the plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination;
Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
5. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and,
6. If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits.
2. Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as relevant to your claim if it:
 - i) Was relied upon in making the benefit determination;

- ii) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
 - iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination; or,
 - iv) Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
3. A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
 4. A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate.
 5. A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental).
 6. The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.
 7. In the case of a claim for urgent care, an expedited review process in which:
 - i) You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination; and,
 - ii) All necessary information, including the plan's benefit determination on review, will be transmitted between the plan and you by telephone, facsimile, or other available similarly prompt method.

Ordinarily, a decision regarding your appeal will be reached within:

- 72 hours after receipt of your request for review of an urgent care claim
- 30 days after receipt of your request for review of a pre-service claim
- 60 days after receipt of your request for review of a post-service claim

The plan administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

1. The specific reason(s) for the adverse benefit determination.
2. References to the specific plan provisions on which the benefit determination is based.
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
4. A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.
5. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request; and,

6. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

B. DISABILITY PLANS

Time Frame for Claim Determinations

If you receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the plan administrator will notify you of the adverse determination within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if the plan administrator both determines the extension is necessary due to matters beyond the control of the plan, and notifies you, before the initial 45-day period expires, of the reason(s) requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the plan administrator again determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days. In such case, the plan administrator must notify you, before the first 30 day extension period expires, of the reason(s) requiring the extension of time and the date by which the plan expects to render a decision.

All extension notices you receive regarding your disability benefits must specifically explain:

- The standards on which entitlement to a benefit is based;
- The unresolved issues that prevent a decision on the claim; and,
- The additional information needed to resolve those issues.

You have 45 days to provide the specified additional information. In the event that an extension is necessary due to your failure to submit necessary information, the plan's time frame for making a benefit determination is tolled (i.e., stopped) from the date the plan administrator sends you the extension notification until the date you respond to the request for additional information.

If You Receive an Adverse Benefit Determination

The plan administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination;
- Reference to the specific plan provisions on which the benefit determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why that material or information is necessary;
- A description of the plan's appeal procedures and time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA after an adverse determination on appeal;
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination will be provided free of charge to you upon request; and,
- If the adverse benefit determination was based on a medical necessity or experimental

treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Procedure for Appealing an Adverse Benefit Determination

You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits;
- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as relevant to your claim if it:
 - Was relied upon in making the benefit determination;
 - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
 - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or
 - Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- A review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination;
- A review that does not defer to the initial adverse benefit determination and that is conducted by a named fiduciary of the plan that is neither the individual who made the adverse determination nor that person's subordinate;
- If the appeal involves an adverse benefit determination based in whole or in part on a medical judgment, require the named fiduciary to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination nor the subordinate of any such individual; and,
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the decision.

The plan administrator must notify you of the plan's benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of your request for review by the plan, unless the plan administrator determines that special circumstances require an extension of time. If an extension of time is required, a written notice of the extension must be sent to you before the end of the initial 45-day period. The notice of the extension must indicate the special circumstances and the date by which the plan administrator expects to render the determination on review. In the event an extension is necessary due to your failure to submit necessary information, the plan's time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the plan administrator sends you the extension notification until the date you respond to the

request for additional information. The plan administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination;
- Reference to the specific plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or notice that a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination will be provided free of charge upon request; and,
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

C. OTHER PLANS

Time Frame for Claim Determinations

If you receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the plan administrator will notify you of the adverse determination within a reasonable period of time, but no later than 90 days after receiving the claim. This 90-day period may be extended for up to an additional 90 days, if the plan administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 90-day period expires, of the special circumstances requiring the extension of time and the date by which the plan expects to render a determination. In the event an extension is necessary due to your failure to submit necessary information, the plan's time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the plan administrator sends you the extension notification until the date you respond to the request for additional information.

If You Receive an Adverse Benefit Determination

The plan administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination;
- Reference to the specific plan provisions on which the benefit determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why that material or information is necessary;
- A description of the plan's appeal procedures and time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA after an adverse

determination on appeal.

Procedures for Appealing an Adverse Benefit Determination

You, or your authorized representative, have 60 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits;
- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as relevant to your claim if it:
 - Was relied upon in making the benefit determination;
 - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
 - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or,
 - A review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The plan administrator will notify you of the plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt of your request for review by the plan. This 60-day period may be extended for up to an additional 60 days, if the plan administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 60-day period expires, of the special circumstances requiring the extension of time and the date by which the plan expects to render a determination on review. In the event an extension is necessary due to your failure to submit necessary information, the plan's time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the plan administrator sends you the extension notification until the date you respond to the request for additional information. The plan administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination;
- Reference to the specific plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and,
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

Note: The preceding information is provided as general information for your convenience only. In all cases, each plan's description takes precedence over the information provided in this section.