

ALASKA PUBLIC BROADCASTING HEALTH TRUST

HEALTH & WELFARE BENEFIT PLAN

AND

SUMMARY PLAN DESCRIPTION

January 1 through December 31

This Plan Document and Summary Plan Description together with the applicable certificates of insurance, insurance booklets, benefit summaries and/or group insurance contracts constitute the written plan document required by ERISA §402 and summary plan description for the component employee benefit plans offered under the Alaska Public Broadcasting Health Trust Health & Welfare Benefit Plan.

For employers required to submit form 5500 reports (usually 100+ participants on any group plan as of the beginning of the plan year), this document is considered a "wrap" plan so the report is done on the wrap plan as a whole, not each individual plan.

This plan is available to the following categories of employees:
Regular eligible employees as defined within this document.

Effective Date: January 01, 2020

Original Date: January 01, 2018

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Alaska Public Broadcasting Health Trust

Health & Welfare Benefit Plan Document

And

Summary Plan Description

SECTION 1: INTRODUCTION

This document contains a summary of your rights and benefits under Alaska Public Broadcasting Health Trust Health & Welfare Benefit Plan (the "Plan"). Complete details can be found in the underlying component benefit program documents which govern the operation of the Plan, and are available with this document or through the Plan Administrator. In the event of any difference or ambiguity between your rights or benefits described in this document and the underlying component benefit program documents, the underlying component benefit program documents will control with regard to the specific benefits provided under the particular plan. For purposes of this document, component benefit programs are those benefit programs specified under Provider Companies found towards the end of this document and contained in the applicable component plan documents. Component benefit program documents include certificates of insurance, group insurance contacts, ERISA plan documents (if self-funded) and governing benefit plan documents for non-insurance benefit programs.

A copy of each certificate, summary or other governing document is included with this document, was previously provided, or can be obtained from the Plan Administrator. Information contained in the underlying component benefit program documents defines and governs specific benefits including your rights and obligations for each plan. If you have any questions about this document or the component plan information, contact your Plan Administrator listed on the next page.

Each benefit option is summarized in component benefit program documents issued by providers, Third Party Administrators, or the Company. When the Plan refers to these documents, it also refers to any attachments to such contracts, as well as documents incorporated by reference into such contract (such as the application, certificate of insurance, ERISA plan documents and any amendments).

SECTION 2: PLAN INFORMATION

The following information concerns the Plan. If you need more information, contact the Plan Administrator.

NAME OF PLAN
Alaska Public Broadcasting Health Trust Health & Welfare Benefit Plan

EMPLOYER
Participating member stations of the Alaska Public Broadcasting Health Trust

PLAN SPONSOR
Alaska Public Broadcasting Health Trust (APBHT), 135 Cordova Street, Anchorage, AK, 99501, (907) 277-6300

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER
81-7104348

TYPE OF PLAN
This Plan provides comprehensive Medical, Dental and Life/AD&D benefits and is considered a "Health & Welfare Benefit Plan" under ERISA.

PLAN YEAR: January 1 - December 31

PLAN NUMBER: 501

PLAN ADMINISTRATOR AND LEGAL PROCESS AGENT
Alaska Public Broadcasting Health Trust, Attn: Kim Pigg, Benefit Administrator, 135 Cordova Street, Anchorage, AK 99501, (907) 230-0835, kim@coastalaska.org.

2.1. ADMINISTRATION & FIDUCIARY

This document and the component plan documents describe the various benefits, whether each benefit is insured or self-funded, and Claims Administration and other services under the group benefit contracts.

- For self-insured benefits under this Plan, the Plan Administrator may elect to use a Third Party Administrator (TPA) to administer these benefits and adjudicate claims. In such case, the TPA may be the Claims Administrator and the Named Fiduciary for purposes of Claims Administrator, but the Plan Administrator will remain your point of contact for questions.
- For fully-insured benefits, the insurance company is the Named Fiduciary and has complete discretion to determine benefit payment amounts and to adjudicate claims. The Plan Sponsor has no fiduciary responsibility in these areas. See providers, policy numbers and their related contact information toward the end of this document.

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to interpret and construe the provisions of the Plan, to decide all questions that arise including any dispute which may arise regarding the rights of participants and beneficiaries under the Plan; provided, however, that if an insurance certificate sets forth a specific claims procedure, such provisions shall apply for the purpose of that component plan. It also is the Plan Administrator's duty to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, allocating fiduciary responsibilities, determining eligibility for and the amount of benefits, employing legal, actuarial, medical, accounting, clerical, and other assistance as it may deem appropriate in carrying out the terms of the Plan, and authorizing benefit payments and gathering information necessary for administering the Plan.

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

Except as provided below, under "Power and Authority of Insurer or Third Party Administrator", the Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurer or Third Party Administrator

The Insurers or Third Party Administrator are responsible for

(1) Determining eligibility for and the amount of any benefits payable under the respective component benefit program, and
(2) Prescribing claims procedures (that comply with ERISA requirements) to be followed and the claims forms to be used by Employees to obtain their respective benefits.

The Insurers, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the Insurers or Third Party Administrators for administering these program benefits.

Exclusive Benefit
All Plan assets shall be used for the exclusive benefit of eligible Employees, their Spouses, their other designated Dependents and their designated beneficiaries, in accordance with the provisions of the Plan, and/or for paying reasonable expenses associated with administering the Plan.

2.2. ELIGIBILITY AND PARTICIPATION

Premium contributions for each of the health and welfare benefit plans provided by Alaska Public Broadcasting Health Trust are either attached to this document, given out separately or may be obtained from the Plan Administrator upon request.

Eligibility
Employee benefits begin the first day of the month following 30 days of eligible employment (unless stated below) provided the employee meets the applicable requirements and satisfies the enrollment requirements established under the Plan.

A. Full-Time Ongoing and New Hire Employees - Eligibility and Participation

Regularly Scheduled employees working an average of 30 hours per week are eligible to participate in Plan benefits on the first day of the month following 30 days of eligible service.

Once an Employee has met the eligibility requirements and an appropriate Enrollment Form has been submitted to the Plan Administrator, the Employee's coverage will commence on the date specified in the eligibility requirements at the beginning of this section and in the applicable component benefits program documents.

B. Eligible Family Members

You may also enroll eligible family members in the Medical and/or Dental plans. Eligible Dependents are generally described below but the governing eligibility rules for Dependents are set forth in the applicable component benefit plan documents.

Eligible family members include:

- Legal Spouse or Domestic Partner
    - Spouse means an individual who is legally married to a participant as determined under Revenue Ruling 2013-17, in accordance with federal and state law and as specified in each benefit plan
    - Domestic Partner can be broadly defined as an unrelated and unmarried person who shares common living quarters with an employee and lives in a

committed, intimate relationship that is not legally defined as marriage by the state in which the partners reside. Domestic Partners do not have the same rights as a spouse in terms of COBRA continuation coverage, see component plan documents for further information.

- Child (ren) up to age 26 or as defined in component plan documents; and/or
- Unmarried child (ren) of any age who depend upon the employee for support because of a mental or physical disability (For specified benefits only as defined in component plan documents).

Refer to underlying component benefit program documents for more information about Dependent eligibility, definitions of Dependents, and overall coverage. Your benefits eligibility may be affected if your status changes to inactive due to a family, medical, or personal leave of absence. Contact your Plan Administrator for additional information.

Certain benefits require that an eligible Employee make an annual election to enroll for coverage. Information regarding enrollment procedures, including when coverage begins and ends for the various benefits under the Benefit options, is set forth in the certificate of insurance, component Summary Plan Descriptions or other governing documents. An eligible Employee may begin participating in any benefit based on his or her election to participate in accordance with the terms and conditions established for each benefit.

C. Qualified Medical Child Support Orders

With respect to component benefit programs that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA Section 609(a)). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

In the event the Plan Administrator receives a qualified medical child support order, the Plan Administrator will notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a QMCSO. Within a reasonable period the Plan Administrator will determine whether the order is a qualified medical child support order and will notify the Participant and alternate recipient of such determination.

2.3. ANNUAL OPEN ENROLLMENT PERIOD

Each year Alaska Public Broadcasting Health Trust has an open enrollment that takes place during December when participants can make plan changes or new participants can enroll. Changes and elections

made during the open enrollment period are generally effective (upon plan renewal) following the open enrollment period.

2.4. ENROLLMENT IN THE PLAN

A. Enrollment Procedures

An Employee who is eligible to participate in this Plan shall commence participation after the eligibility requirements have been satisfied, provided that any enrollment forms are submitted to the Plan Administrator before the date that participation would commence. Such enrollment forms shall identify the Spouse and other Dependents who are eligible for benefits under the elected benefit plan.

B. Mid-Year Enrollment Changes (Only if Qualified Change in Status)

If benefits are paid on a pre-tax basis through a Cafeteria Plan, legal rules require that benefit choices made must remain in effect for the entire Plan Year, January 1 to December 31 (or the balance of the Plan Year for Employees hired and who enroll during the Plan Year), unless the Employee experiences a Qualified Change in Status. While the list of possible events that could allow you to make mid-year election changes is set by the IRS and the Internal Revenue Code, Alaska Public Broadcasting Health Trust and its Insurance Carriers or Third Party Administrator can select a sub-group of these events to allow changes under a particular plan. Under the Code you must enroll within a reasonable time period from your eligibility date. Once you are enrolled, you may only make changes to your benefit elections during Open Enrollment or if you have a Qualifying Change in Status that affects the eligibility of you or your dependents, and the requested election change is consistent with your Qualifying Change in Status.

The following are examples of what might be considered a Qualifying Change in Status, refer to your Cafeteria Plan for an accurate list of qualifying events:

A Qualifying Life Event/Qualifying Change in Status includes:

- A change in your Legal Marital Status such as marriage, death of a spouse, divorce, legal separation or annulment.

- A change in your Number of Dependents such as birth, adoption, placement for adoption, or death of a child.

- A change in Employment Status such as commencement or termination of employment for you, your spouse, or your dependent.

- A change in Work Schedule such as a reduction or increase in hours, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence for you, your spouse, or your dependent.

- If Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents due to factors such as age.

- A change in Residence or Worksite for you, your spouse, or your dependent.

- The receipt of a Qualified Medical Child Support Order or National Medical Support Notice.

- A change in Entitlement to Medicare or Medicaid for you, your spouse, or your dependent.

- A change in Eligibility for COBRA for you, your spouse, or your dependent while you are still an active employee.

- A change in a spouse's coverage such as benefit reduction, cost increase or decision to join or not to join a plan during open enrollment.

- A change where an Employee may qualify for exchange coverage because the employer coverage does not meet the affordability requirements.

- An Employee may drop coverage if their hours drop below 30 hours/week on average, even if the Employee does not lose eligibility for coverage due to Affordable Care Act rules on eligibility.

All election changes must be requested within 30 days of the event in question unless otherwise required by state or federal laws or healthcare mandates (e.g. loss of coverage under Medicaid or CHIP allows up to 60 days to obtain coverage). *To make an election change, contact your Plan Administrator listed above.*

2.5. PLAN BENEFITS AND COST SHARING PROVISIONS

A. Participant Contributions

Participant premium contributions for coverage are fixed, and the Employer bears the risk of premium and/or administrative cost above that amount.

If the Plan has cost sharing with a Cafeteria Plan, employee contributions for qualifying benefits will be paid through a pre-tax payroll deduction starting the first pay period following enrollment, unless

they are benefits that are not eligible for pre-tax deduction such as life or disability insurance or the Employee requests post-tax deductions. Contributions will be paid Varies by member for all employees. Actual contribution rates will be published each year during the open enrollment period. See summary of coverage for additional deductible, coinsurance, copayments, services, and coverage, and enrollment documents for applicable rates and contribution levels.

B. Employer Contribution Levels

The Employer will make its contributions in an amount that (in the Employer's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by the eligible Employee's contributions. The Employer will pay its contribution and the eligible Employee's contributions to the Trust, which will forward contributions to the Insurer or Third Party Administrator. The eligible Employee's contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

Insurance premiums for Employees and their eligible family members are paid in part by the Employer out of its general assets and in part by employees' pre-tax payroll deductions, where applicable. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable.

C. Ordering of Participant and Employer Contributions

This section applies unless the plan sponsor has adopted specific written procedures or a document that specifies a different ordering for plan contributions or for plan receipts to plan contributions.

- All participant contributions will be applied first to cover premiums or benefit costs, and then Employer contributions will be applied to cover any remaining premiums or benefit costs plus the cost of other plan expenses, including stop-loss premiums if applicable.

- In the event a medical loss ratio (MLR) rebate or other type of rebate is paid to the Plan, the portion of the rebate that does not exceed the Employer's total amount of prior contributions during the relevant period will be attributable to Employer contributions, not to participant contributions.

2.6. COMPONENT BENEFIT PLAN DOCUMENTS

All documents relating to the Alaska Public Broadcasting Health Trust Health & Welfare Benefits Plan, including the Evidence/Certificate of Coverage for each plan, Listing of Network Providers, Contribution Rates, General COBRA Notice, Medicare Creditable Coverage Notice, and any other relevant Plan Documents or Notices, are available to Employees and their dependents by contacting the Plan

Administrator. Plan participants may receive a paper copy of any of the above documents free of charge by contacting the Plan Administrator.

Please refer to the component plan documents for each plan's specific details, including a description of benefits, cost-sharing provisions, requirements for use of network providers, and circumstances by which benefits may be denied.

2.7. POSSIBLE LIMITS ON OR LOSS OF BENEFITS

Summary of Benefits and Coverage
See component plan documents and Summary of Benefits and Coverage (SBC) for details regarding deductibles, co-pays, coverage, claims procedures, resources and provider company information.

A. Coordination of Benefits

For Participants and Dependents who do not maintain coverage under a health and welfare plan sponsored by another unrelated employer's health and welfare plan, the Plan will be the primary payer for all eligible claims and benefits as defined in the underlying component benefit program documents. If participants or dependents are covered by another medical or insurance plan, the two plans will coordinate together eliminating duplication of payments as explained in the component plan documents. The insurer has primary responsibility to coordinate benefits for eligible expenses for other employer plans, government plans, Medicare or other coverage such as motor vehicle insurance.

B. Subrogation of Benefits

The Insurer or third-party administrator shall undertake reasonable steps to identify which Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer or Third-Party Administrator to facilitate enforcement of its rights and interests. Participants must fully cooperate and do their part to ensure the Plan's right of recovery and subrogation are secured. If the Participant fails or refuses to honor the Plan's recovery and subrogation rights, the Plan may recover any cost to enforce its rights. This includes, but is not limited to, attorney fees, litigation court cost and other expenses as covered in the underlying component benefit program documents.

C. Rescission

Benefits for you and/or your enrolled dependent(s) will be terminated retroactively (this is known as *"rescission"*) if the Carrier or Plan Administrator determines that you obtained benefits under the Plan as a result of fraud or intentional misrepresentation of a material fact. You will be given 30 days prior written notice, and coverage will be terminated back to the date of the fraud or intentional misrepresentation. You will be required to reimburse the Plan for any benefits you or your eligible dependent(s) received since the date of the fraud or

material misrepresentation, and such amount will be offset against the premiums you paid before they are refunded to you, to the extent allowed by applicable law.

D. Denial or Loss of Benefits

A Participant's benefits under the Plan will cease when the eligible Employee's participation in the Plan terminates. A Participant's benefits will also cease on termination of the Plan. Other circumstances can result in termination, reduction or denial of benefits. Refer to the component benefit program documents for details regarding when a plan may terminate.

2.8. TERMINATION OF BENEFITS

Benefits under any Component Benefit Program will terminate for all participants if that Component Benefit Program is terminated, and will terminate for a particular participant if his or her participation is ended due to loss of eligibility or termination of employment or other reason.

Medical and Dental benefits terminate the last day of the month in which eligibility ends. Life/AD&D benefits terminate the last day of employment. Plans may or may not have conversion options (check with Plan Administrator). See continuation options available for such benefits as medical, dental, vision and health flexible spending accounts, if applicable, under COBRA (Consolidated Omnibus Budget Reconciliation Act) as explained below. Check with the Plan Administrator for possible conversion options or questions on possible continuation rights. See each component benefit program documents for termination provisions.

An eligible Employee's participation and the participation of his or her eligible Dependents in the Plan will terminate on the date specified in the component benefit program documents. Other circumstances can result in the termination of benefits as described in the component benefit program documents.

Participation in the Plan may be terminated due to disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, etc. Refer to the corresponding component benefit program documents for detailed information. Alaska Public Broadcasting Health Trust reserves the right to change, cancel, or alter all or any portion of the Employee Welfare Benefit Plan as it deems necessary.

The Company has the right to terminate the Plan in its entirety, or any portion thereof at any time. In the event that the Plan is terminated, a written notice shall be given 60 days in advance.

An officer, as designated by the Company, may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

Other circumstances can result in the termination of benefits. The insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the applicable Attachments, previously sent documents or available through the Plan Administrator, provide additional information.

2.9. PLAN AMENDMENT AND TERMINATION

Amendment of the Plan

The Company reserves the right to amend, modify, or discontinue the Plan in any respect, including but not limited to, implementing a change in the amount or percentage of premiums or cost that must be paid by the Participant. No Participant shall have any vested right to any benefits under the Plan, subject to any duty to bargain that may exist. The Company shall have the right to amend the Plan at any time and to any extent deemed necessary or advisable; provided, however, that no amendments shall:

1. Have the effect of discriminatorily depriving, on a retroactive basis, any eligible Employee, dependent or beneficiary of any beneficial interest that has become payable prior to the date such amendment is effective; or

2. Have the result of diverting the assets of the Plan to any purpose other than those set forth in this Plan.

An officer, as designated by the Company, may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

In the event that the Plan is terminated, a written notice shall be given to participants 60 days in advance. If the Plan is amended, the Plan Administrator will promptly provide notice to participants as required under applicable law and shall execute any instruments necessary in connection therewith.

The Company shall promptly notify the Plan Administrator and all interested parties of any amendment adopted pursuant to this Section.

2.10. CLAIMS PROCEDURES

A. Overview of Claims Procedures

Details regarding the Plan's claim procedures are furnished automatically, without charge, as a separate document, copies of which are included with this document, were previously provided, or can be obtained from the Plan Administrator. These will comply with applicable ERISA requirements.

Generally, to obtain benefits from the Insurer or Third Party Administrator (TPA) of a provided component benefit program, you must follow the claims procedures under the applicable component benefit program documents, which may require you to complete, sign, and submit a written claim on the Insurer's or Third Party Administrator's form. In that case, the form is available from the Plan Administrator.

Summary of the ERISA claims and appeals process, for any type of ERISA benefits:

1) Claim is filed – by the plan participant or his/her authorized representative.
2) Claim is either paid in full or denied in whole or in part – by the Claims Administrator. If the claim is denied in whole or in part, this is called an "Adverse Benefit Determination."
3) Appeal of Adverse Benefit Determination – by the plan participant or his/her authorized representative.
4) Final decision on the appeal – by the Claims Fiduciary (not the same individual who made the initial claims denial, nor a subordinate of that person).

If your appeal is denied, or if the claims fiduciary does not comply with the ERISA timeframes specified below, you can file a civil action (lawsuit) in Federal court, under ERISA section 502(1).

B. Standard Claims Procedures for Medical Benefit

1) Fully-Insured Medical Benefits
   For purposes of determining the amount of, and entitlement to benefits under a component medical program whose benefits are paid under an insurance policy, the Insurance Company is the Named Fiduciary and shall have the full power to make factual determinations and to interpret and apply the terms of the policy as they relate to the benefits provided through the insured arrangement, unless the Plan Administrator has explicitly and in writing retained the right to make a final determination. The Insurance Company is also the Claims Administrator for purposes of claims determinations.

C. Claims Procedure for Benefits Based on a Determination of Disability

ERISA claims procedures apply specifically to claims made on or after April 1, 2018, under the Plan for benefits based on a determination of disability. However, if the Plan Administrator has delegated and named an insurer or third party administrator as the claims fiduciary, then such entity shall have full discretion and authority to determine eligibility for such benefits, and the insurer's or third party administrator's claims procedures shall apply as long as such other claims procedures comply with current Department of Labor Regulations. For additional information, please contact the disability insurer.

Additionally, if a disability determination is made outside the plan for reasons other than determining eligibility for plan benefits, the new ERISA disability claims procedures shall not apply. Examples of when the ERISA disability claims provisions do not apply are where the disability determination is based solely

on whether the claimant is entitled to disability benefits under either the Social Security Act or the employer's long term disability plan.

Below is a short summary of the disability claims procedures effective for claims filed on or after April 1, 2018, if: a) the Plan Administrator makes the disability determination, or b) the Plan Administrator has designated a separate claims fiduciary but that entity's claims procedures are not compliant with applicable DOL regulations.

1) If the claims administrator denies your claim, it must notify you of its decision within 45 days of receipt of your completed claim, except that it may extend the time by not more than two additional 30-day periods if it first notifies you in writing and if certain other requirements are met.

2) Any adverse benefits determination will include the specific information specified in the DOL final regulations.

3) You have 180 days to appeal an adverse benefit determination. You may request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. You may submit information and opinions from experts who were not involved in the initial claim.

4) Within 45 days after the Claims Administrator receives your appeal request, it will notify you of its decision on your appeal, except that this period may be extended for an additional 45-day period if special circumstances (such as the need to hold a hearing) require an extension of time. In such case, you will be notified in writing of the need for the extension. The individual reviewing your appeal shall not be the same individual who made the initial benefit decision, shall give no deference to the initial benefit decision and shall not be a subordinate of the initial decision maker. If your appeal is granted, the decision will contain information sufficient to reasonably inform you of that decision. If the reviewing fiduciary anticipates denying your appeal, whether in whole or in part, the fiduciary must provide you certain information (free of charge) as soon as possible and sufficiently in advance of the date the final decision must be rendered, to provide you a reasonable opportunity to review the information and submit a response. If your appeal is denied, you will be sent written notice which includes the information specified in the final regulations.

2.11. AFFORDABLE CARE ACT COMPLIANCE

The Plan complies with all applicable Patient Protection and Affordable Care Act (PPACA) provisions, as detailed in component plan documents. PPACA applies only to health benefits. It does not apply to other benefits under the Plan, such as dental, vision, life, disability, "excepted" benefits (as defined by law and regulations) or other categories of benefits.

Exceptions: Plans are not required to comply with certain PPACA requirements if they are “grandfathered” as defined under PPACA or “grandmothered” (certain non-ACA-compliant small insured plans that were allowed to renew for a limited period of time, under PPACA and certain states’ laws). See component plan document to clarify if your plan is "grandfathered" or "grandmothered".

PPACA compliance (for plans that are not grandfathered or grandmothered) includes, but is not limited to:

- Coverage of dependents up to age 26
- No annual or lifetime dollar limits on “Essential Health Benefits” as defined in PPACA and regulations
- No pre-existing conditions exclusions
- Prohibition on rescissions
- Patient protections – coverage and payment for emergency services, primary care provider designation, designation of pediatric physician as primary care provider, no prior authorization for access to obstetrical or gynecological care.
- Preventive care – specified preventive care services are covered on a first-dollar basis, not subject to co-payments, co-insurance, deductibles or other cost-sharing requirements.
- Nondiscrimination testing – this Plan is intended to comply with current nondiscrimination rules.

2.12. ERISA NOTICES

With respect to offered group Health Plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as COBRA, HIPAA, HITECH, MHPA, NMHPA, USERRA, GINA, MHPAEA, WHCRA, HCERA and PPACA.

Notice of Rights Under the Newborns & Mothers Health Protection Act
Group Health Plans and Health Insurance Issuers or Third Party Administrators generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and Issuers may not, under federal law, require that a provider obtain authorization from the Plan or the Issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Women's Health & Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable component benefit. Refer to the insurance certificate or benefit booklet for information on the deductibles and coinsurance that apply.
If you would like more information on WHCRA benefits, contact the plan administrator.

HIPAA Portability Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we notify you about a very important provision in the Plan. It is your right to enroll in the Plan under its "special enrollment provision" if you marry, acquire a new dependent, or if you decline coverage under the Plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event or as required by state or federal law (60 days if enrollment in or eligibility for, or loss of eligibility for Medicaid or CHIP).

Family Medical Leave

To the extent the Plan is subject to the Family Medical Leave Act of 1993 (FMLA), the Plan Administrator will permit a Participant taking unpaid leave under the FMLA to continue group health benefits under such applicable law. Non-medical benefits will continue according to the established Employer policy. Participants continuing participation pursuant to the foregoing will pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying applicable regulations. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave.

Mental Health Parity & Addiction Equity Act (MHPAEA)
The MHPAEA applies only to employers with more than 50 employees. If applicable to this Plan, the MHPAEA applies to class health benefits provided under this Plan that provide both medical and surgical benefits as well as mental health or substance use disorder benefits. The MHPAEA requires that:

- The financial requirements that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant financial requirements that apply to substantially all medical and surgical benefits under the Plan, and no separate cost-sharing requirements can be applied only to mental health or substance use disorder benefits.

- The treatment limitations that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant treatment limitations that apply to substantially all medical and surgical benefits under the Plan, and no separate treatment limitations can be applied only to mental health or substance use disorder benefits.

The component plan determines what mental health condition and/or substance use disorder coverage is provided.

USERRA
The Plan Administrator will also permit you to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and will provide such reinstatement rights as required by such law. The Plan Administrator will also permit you to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

Special Enrollment Notice
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or ***your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage)***. However, you must request enrollment within the allowable period outlined in the component plan documents, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within allowable period outlined in the component plan documents, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator.

Genetic Information Nondiscrimination Act of 2008 ("GINA")
The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any of the benefits under provided benefit plans.

GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;

- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;

- Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and

- Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

Michelle's Law

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Plan Administrator.

If your Employer has fifteen (15) or more Employees and you believe that The Employer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance. A grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Participant's Responsibilities

Each Participant shall be responsible for providing the Employer, Plan Administrator, Claims Administrator, if applicable, and the Company and, if required by an Insurance Company or Third Party Administrator, with respect to a fully-insured benefit, the Insurance Company with his or her current address. If required by the Insurance Company, with respect to a fully-insured benefit, each Employee who

is a Participant shall be responsible for providing the Insurance Company with the address of each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Insurance Companies, the Plan Administrator and the Company shall have no obligation or duty to locate a Participant.

Documenting Eligibility for Enrollment and Benefits Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully-insured benefit, the Insurance Company or Third Party Administrator with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan. Refer to details in the component benefit program documents.

The Plan Administrator, Claims Administrator, if applicable, (and, with respect to a fully-insured benefit, the Insurance Company) shall have the right and opportunity to have a Participant examined when benefits are claimed, and when and as often as it may be required during the pendency of any claim under the Plan.

2.13. HIPAA PRIVACY AND SECURITY COMPLIANCE

Application
The Privacy and Security Rules in the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) apply only to those Component Benefit Programs that constitute group health plans that are subject to HIPAA, and that are self-funded or for which the plan sponsor uses or discloses “protected health information” (PHI). Such group health plans are "Covered Programs" under HIPAA.

Privacy and Security Policy
The Covered Programs will adopt HIPAA privacy and security policies, as appropriate.

Business Associate Agreement
The Covered Programs will enter into a business associate agreement with any persons or entities as may be required by applicable law, as determined by the Plan Administrator.

Notice of Privacy Practices
The Covered Programs will provide each Participant with a notice of privacy practices to the extent required by applicable law.

DISCLOSURE TO THE COMPANY

In General

This Subsection permits the Covered Programs to disclose PHI to the Company to the extent that such PHI is necessary for the Company to carry out its administrative functions related to the Covered Programs.

If part of their job responsibilities include administration or management of the group health plan, there may be times that the following departments have access to an employees PHI: Accounting, IT, Legal, HR, Benefits. Examples of how their job responsibilities may require access to PHI or ePHI include (but are not limited to): payment of claims; review of amounts paid for medical services; legal review of claims or appeals or benefits issues; or access to ePHI that is at rest on (or in transit using) the Company's server, network, Intranet or Internet.

If you have any questions as to the person/persons that have access to this information, please see your Plan Administrator.

Permitted Disclosure

1) Permitted Disclosure of Enrollment/Disenrollment Information. The Covered Programs may disclose to the Company information on whether an individual is participating in the Covered Programs. Enrollment and disenrollment functions performed by the Employer are performed on behalf of Participant and beneficiaries of the Covered Programs, and are not plan administration functions. Enrollment and disenrollment information held by the Employer is held in its capacity as an employer and is not PHI.

2) Permitted Uses and Disclosure of Summary Health Information (SHI). The Covered Programs may disclose Summary Health Information, as defined in the HIPAA privacy rules, to the Company, provided that the Company requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Covered Programs; or (ii) modifying, amending, or terminating the Covered Programs.

3) Information Disclosed Pursuant to a Signed Authorization. Information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR 164.508 is not subject to any restrictions, except as specified on the signed authorization.

4) Permitted and Required Uses and Disclosure of Protected Health Information (PHI) for Plan Administration Purposes. If the component health plans have not already been amended to include this information, this Wrap document amends them to incorporate the following provisions, which allow the Covered Programs to disclose PHI to the Plan Sponsor for "plan administration purposes" as defined in HIPAA regulations. This includes quality assurance, claims processing, auditing, and monitoring. The Plan Sponsor shall only use such PHI for purposes of plan administration and not

for any employment-related actions or decisions. This section also serves as Certification from the Plan Sponsor that its component Health Programs have been amended to include the following limitations/restrictions:

- *Use and Further Disclosure:* The Company will not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to the HIPAA privacy rules. When using or disclosing PHI or when requesting PHI from the Covered Programs, the Company will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.
- *Agents and Subcontractors:* The Company will require any agents, including subcontractors, to whom it provides PHI received from the Covered Programs to sign Business Associate Agreements and to agree to the same restrictions and conditions that apply to the Employer, Company or Plan Sponsor with respect to such information.

  Questions regarding use of PHI should be directed to the Insurer or Third Party Administrator in question. The Insurer or Third Party Administrator will advise a Plan Participant who wants to exercise any of his/her rights concerning PHI, of the procedures to be followed.
- *Employment-Related Actions:* Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, the Company will not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Company.
- *Reporting of Improper Use or Disclosure:* In accordance with (16 CFR Part 318), Health Breach Notification Rule, where applicable, agrees to notify both the participants, the Federal Trade Commission and Covered Programs of any use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, or which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.
- *Adequate Separation. The Company will ensure that adequate protection of PHI and separation between the Covered Programs and the Company (i.e., a "firewall") is established and maintained.*
- *Comply with Individual's Privacy Rights:* The Company will make available PHI to comply with an individual's right to access PHI, or to amend PHI (and the Company will make any appropriate amendments); the Company will make available the information required to provide an accounting of disclosures when requested by an individual.
- *Information to HHS:* The Company will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with HIPAA's privacy requirements.

- *Return or Destroy PHI:* If feasible, the Company will return or destroy all PHI received from the Health Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, it will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

2.14. COBRA

COBRA NOTICE

The Plan Administrator of any group health plan that is a Component Benefit Program under this Plan will provide (or have provided) to group health plan participants appropriate COBRA notices, if applicable, both upon initial enrollment and if a Qualifying Event occurs. Plan participants can request a copy of these COBRA notices from the Human Resources Department at any time.

2.15. STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) provides that all Plan participants shall be entitled to the rights discussed below. Note that Cafeteria Plans, including any Dependent Care Flexible Spending Arrangement offered under the Cafeteria Plan, is not subject to ERISA.

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and if the group has 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series, if 100 or more participants) and updated Summary Plan Description. Receive a summary of the Plan's annual financial report. If a pension plan is provided, obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months.

Foreign Language

This document contains a summary in English of your plan rights and benefits under the group health plan. If you have difficulty understanding any part of this document, contact the Plan Administrator indicated above.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a pension/welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration (EBSA) US Department of Labor, listed in your telephone directory or (866) 444-3272. You may also obtain EBSA contact information at: https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. You may further obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

SECTION 3: GENERAL PROVISIONS

3.1. NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan will be construed as a contract of employment between the Employer and you, or as a right of any Employee to continue in the employment of the Employer, or as a limitation of the right of the Company to discharge any of its employees, with or without cause "at will".

3.2. GOVERNING LAW

The Plan will be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by federal law. The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

3.3. TAX EFFECT – NOTICE ABOUT PRE-TAX PAYMENTS AND POSSIBLE EFFECT ON FUTURE SOCIAL SECURITY BENEFITS

The Employer may provide benefits under the Plan on a pre-tax basis in accordance with federal tax law. Some benefits may be obtained on an after tax basis. The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

If this Plan allows you to pay for benefits on a pre-tax basis, you will not pay Social Security taxes on the pre-tax dollars you use to pay for coverage. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan normally will be greater than any eventual reduction in Social Security benefits.

3.4. REFUND OF PREMIUM CONTRIBUTIONS

For fully-insured component benefit programs, the Plan will comply with Department of Labor (DOL) guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates (MLR) of insurance premiums). To the extent that the Company receives rebates determined to be plan assets to the extent amounts are attributable to insurance premiums paid by Participants, the rebates will (a) be distributed within 90 days of receipt to the Employers participating in the policy to which the rebate relates under a reasonable, fair, and objective allocation method or (b) if distributing the rebates would not be cost-effective because the amounts are small or would give rise to tax consequences to the Participants, the rebates may be used to pay future Participant premiums or for benefit enhancements which benefit the Participants covered by the policy to which the rebate relates. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the cost to the Plan and the competing interest of participants. Any rebates attributable to insurance premiums paid by the Employer may be retained by the Employer.

3.5. FACILITY OF PAYMENT

When, in the Company or its designated representative's opinion, any Participant under the Plan is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the Company or its representative may direct that payments be made to such Participant's legal representative or withhold payment pending an adjudication of the Participant's legal capacity and the appointment of a legal representative. The Company or its designated representative may also direct that payment be applied for the benefit of the Participant any way the Company considers advisable. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan, the Company or the Employer to the extent of such payment. Any payment requirement shall include payments to a Participant's beneficiary in the case of death benefits paid under the Plan.

3.6. DATA

Participants who may receive benefits under the Plan must furnish the Company, or its designated representatives such documents, evidence, information, releases or authorizations, as it considers necessary or desirable for the purpose of administering the Plan, or to protect the Company. It shall be a condition of the Plan that each such person must furnish such information promptly and sign such documents as the Company may require before any benefits become payable under the Plan.

3.7. ELECTRONIC COMMUNICATIONS

Whenever an Employee, Participant, Spouse, other Dependent or beneficiary is required to provide information or perform a written process, the Plan Administrator may, in its discretion, permit or require that electronic means be used. In addition, meetings with the Plan Administrator may be held in person or through electronic or telephonic means or a combination thereof and written actions of the Plan Administrator may be taken using electronic or conventional means. In the use of electronic communication, the Plan Administrator shall follow all guidelines published by the Department of Labor and the Internal Revenue Service.

3.8. NON-ASSIGNABILITY AND SPENDTHRIFT CLAUSE

To the extent permitted by law, the benefits or payments under the Plan will not be subject to alienation, sale, assignment, pledge, attachment, garnishment, execution, encumbrance or other transfer, nor will they be subject to any claim by any creditor of any Participant under the Plan other than a physician or treatment facility so authorized by the Participant or to legal process by an creditor of any Participant (except in the case of death or obligations owed to the Company). Any attempt to circumvent these provisions shall be considered null and void.

3.9. SEVERABILITY OF PROVISIONS

If any provision of the Plan is held invalid or unenforceable, such invalidity or unenforceability will not affect any other provisions hereof, and the Plan will be construed and enforced as if such provisions had not been included.

3.10. EFFECT OF MISTAKES

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator will, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan.

3.11. COMPLIANCE WITH STATE AND FEDERAL MANDATES

With respect to all Component Programs, the Plan will comply, to the extent applicable, with the requirements of all applicable laws, such as USERRA, COBRA, FMLA, HIPAA, WHCRA, the Health Information Technology for Economic and Clinical Health Act, the Newborns' and Mothers' Health Protection Act of 1996, as amended, the Mental Health Parity Act, the Mental Health Parity Addiction Equity Act, and the Genetic Information Nondiscrimination Act of 2008 ("GINA").

3.12. COMPONENT BENEFIT PROGRAM - PROVIDER COMPANIES

Type: Medical Insurance
Name of Provider: Premera Blue Cross Blue Shield of Alaska
Type or Plan Name: Heritage Plus Aggregate 2000 HSA
Plan Funding: Fully-Insured, Group Medical Insurance
Policy Number: 4003399
Administration: Shared between Alaska Public Broadcasting Health Trust & Premera Blue Cross Blue Shield of Alaska
Provider Address:3800 Centerpoint Dr., Suite 940, Anchorage, AK 99503
Provider Phone: (800) 508-4722
Provider URL: www.premera.com

Type: Dental Insurance
Name of Provider: Premera Blue Cross Blue Shield of Alaska
Plan Funding: Fully-Insured, Group Dental Insurance
Policy Number: 4003399
Administration: Shared between Alaska Public Broadcasting Health Trust & Premera Blue Cross Blue Shield of Alaska
Provider Address: 3800 Centerpoint Dr., Suite 940, Anchorage, AK 99503
Provider Phone: (800) 508-4722
Provider URL: www.premera.com

Type: Life/AD&D
Name of Provider: Symetra Life Insurance Company
Policy Number: 01-016756-00
Administration: Shared between Alaska Public Broadcasting Health Trust & Symetra Life Insurance Company
Provider Address: P.O. Box 34690, Seattle, WA 98124
Provider Phone: (800) 796-3872
Provider URL: www.symetra.com

Health Savings Account (HSA)
Participants in the medical insurance may be eligible to participate in a Health Savings Account (HSA) allowing them to make contributions to the HSA which can be used towards eligible uncovered medical expenses (e.g. copays and deductibles).

Contributions to this HSA are voluntary. Please check with your Employer for more information.

SECTION 4: DEFINITIONS

The following words and phrases used herein shall have the following meanings, unless a different meaning is plainly required by the context. Masculine pronouns used in this Plan shall include masculine and feminine gender unless the context indicates otherwise, and words in the singular also include the plural. These are general definitions and the presence of any definition in this section is not, in and of itself, an indication of the existence of a benefit.

"**Cafeteria Plan**" means a cafeteria plan under Code Section 125 sponsored by the Company.

"**Claims Administrator**" means the entity or provider responsible for reviewing and approving insurance claims.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Company**" means the entity or entities or any successor to it by merger, purchase or otherwise and any predecessor which has maintained this Plan or any corporation, sole proprietor, partnership or association that assumes the obligations of this Plan.

"**Component Benefit Programs**" are those benefit programs specified under Provider Companies and contained in previously provided documents, included with this document or available through the Plan Administrator.

"**Component benefit program or plan documents**" include certificates of insurance, group insurance contacts, ERISA plan documents (if self-funded) and governing benefit plan documents for non-insurance benefit programs.

"**Dependent**" means an Employee's Spouse or other dependents that satisfies the dependent eligibility requirements of the applicable insurance plans.

"**Employee**" means any current or former employee of the Employer who satisfies the eligibility provisions as specified in the applicable benefit plans. The determination of whether an individual is an Employee, an independent contractor or any other classification of worker or service provider and the determination of whether an individual is classified as a member of any particular classification of employees shall be made solely in accordance with the classifications used by the Employer and shall not be dependent on, or change due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.

"**Employer**" means Participating member stations of the Alaska Public Broadcasting Health Trust

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Form 5500" The Form 5500 Series is an important compliance, research, and disclosure tool for the Department of Labor, a disclosure document for plan participants and beneficiaries, and a source of information and data for use by other Federal agencies, Congress, and the private sector in assessing employee benefit, tax, and economic trends and policies. For employers required to submit form 5500 reports (usually 100+ participants on any group plan as of the beginning of the plan year), this document is considered a "wrap" plan so the report is done on the wrap plan as a whole, not each individual plan.

"**FMLA**" means the Family Medical Leave Act of 1993, as amended. FMLA only applies to covered organizations with 50 or more employees within a 75 mile radius.

"**GINA**" means the Genetic Information Nondiscrimination Act of 2008.

"**HCERA**" means the Health Care and Education Reconciliation Act of 2010.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**HITECH**" means the Health Information Technology for Economic and Clinical Health Act.

"Hour of service" means (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and (2) each hour for which an employee is paid, or entitled to payment, by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Hours of service for all employees are credited using actual hours of service from records of hours worked and hours for which payment is made or due.

"**Insurer**" means any insurance company, health maintenance organization, preferred provider organization or any similar organization with whom the Company has contracted for an insured or contractually-established benefit.

"**MHPA**" means the Mental Health Parity Act of 1996.

"**MHPAEA**" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.

"New hire employee" means an employee who has been employed for less than one complete standard measurement period.

"**Named Fiduciary**" means the individual(s) or entity or entities responsible for either administering benefit plans or the insurance company providing coverage.

"**NMHPA**" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Ongoing employee" means an employee who has been employed for at least one complete standard measurement period.

"**Participant**" means an eligible enrolled Employee and/or eligible covered Dependents.

"**Plan**" means this employee benefit plan, which includes all benefits described in this document.

"**Plan Administrator**" means the person, the committee or the entity specified in this document to be the Administrator, as defined in ERISA Section 3(16)(A).

"**Plan Year**" means a twelve (12) month period specified in this document. The Plan Year also is the accounting period for the Plan.

"**Protected Health Information**" ("PHI") is individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in 45 CFR § 150.103.

"**PPACA**" means the Patient Protection and Affordable Care Act.
"**Spouse**" means an individual who is legally married to a Participant as determined under Revenue Ruling 2013-17 or otherwise defined in component plan documents.

"**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"**WHCRA**" means the Women's Health and Cancer Rights Act of 1998, as amended.