BROWN INVESTMENT PROPERTIES HEALTH AND WELFARE PLAN SUMMARY PLAN DESCRIPTION

Introduction

Brown Investment Properties Inc. (the "**Employer**") has established and maintains the Brown Investment Properties Health and Welfare Plan (the "**Plan**") for the exclusive benefit of its eligible employees and their eligible family members. The Plan is a consolidated group health and welfare benefits plan that includes the following Employer-sponsored benefit programs:

- Medical
- Dental
- Vision
- Health FSA
- Basic Term Life
- Long-Term Disability

Each benefit program identified above (including the specific benefits available under the program, the terms and conditions applicable to the receipt of such benefits, and any benefit limitations and program exclusions) is described in (a) one or more insurance policies, certificates of coverage or benefit booklets issued by the insurance company insuring the benefit program, or (b) one or more benefit summaries or benefit booklets furnished by or on behalf of the Employer. Such policies, certificates, booklets and summaries are referred to throughout this document as the "**Related Documents.**" To the extent that any provision in the Related Documents conflicts with the Employer's legal obligations under federal health care reform legislation or other applicable law, such provision shall not apply to the applicable benefit program.

The Plan is intended to qualify under the applicable sections of the Internal Revenue Code of 1986, as amended (the "**Code**"), and will be interpreted in a manner consistent with the applicable requirements of the Code. As such, the Plan is designed so that certain benefit payments and reimbursements may be excludable from the gross income of individuals who participate in the Plan (the "**Participants**"). Nothing in this document shall be construed as requiring compliance with any provisions of the Code that do not otherwise apply.

Purpose of this Document

The Plan and the benefit programs consolidated under the Plan are subject to the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"), a federal body of law that regulates certain employer-sponsored benefit programs. This document, together with the Related Documents (which are incorporated into this document by reference), is intended to serve as the ERISA-required Summary Plan Description ("**SPD**") for the Plan. The Employer is furnishing this SPD in order to provide you with an overview of the Plan and to address certain information that may not have been included in the Related Documents.

This document is designed to identify all of the ERISA-governed health and welfare benefit programs currently sponsored by the Employer. In addition to serving as the SPD for the Plan, this document is intended to satisfy the plan document requirements and other applicable requirements of ERISA by consolidating the various benefit programs into a single health and welfare plan document for ERISA reporting and disclosure purposes. This document is not intended to provide any substantive rights that are not already provided under or pursuant to the Related Documents, and nothing in this document shall be construed as requiring compliance with any provisions of ERISA that do not otherwise apply.

Note: Make sure you have received or have access to the Related Documents applicable to the benefit programs in which you participate. It is important for you to read and refer to the Related Documents in order to gain a complete understanding of your benefits under the Plan. If you do not have the Related Document(s) for each benefit program in which you participate, please contact the Plan Administrator (identified below) to obtain the relevant information.

Administration of the Plan and the Individual Benefit Programs

As noted above, the benefit programs identified in this SPD are consolidated into a single document for ERISA purposes *only*, and not for any other purpose or analysis. Each individual benefit program under the Plan is administered separately. Some benefit programs under the Plan may be self-funded, and other benefit programs under the Plan may be fully insured (as addressed in more detail below). Each benefit program is required to be administered in accordance with the terms and conditions of the applicable Related Documents and in accordance with the applicable provisions of this SPD. If there is a direct conflict between the terms of this SPD and the terms of any Related Document, the terms of the Related Document will control, rather than this SPD, unless otherwise stated in this SPD or required by law.

The Plan Administrator (identified below) is responsible for administering the Plan. However, with respect to any fully insured benefit program under the Plan, the Plan Administrator shares administrative responsibilities with the insurance company providing the insurance policy through which benefits are paid. Under its contractual arrangement with the Employer or the Plan Administrator, each such insurance company (the "**Insurance Claims Administrator**") provides claims administration services and related services in connection with the benefit program it insures. Each Insurance Claims Administrator is a named fiduciary for purposes of ERISA with respect to the particular benefit program it insures. This is the case even if the Related Documents issued by the Insurance Claims Administrator contain language denying such named fiduciary status. In this context, a **"named fiduciary"** is a person or entity with the authority to control and manage the operation and administration of a particular benefit program.

With respect to any self-funded benefit program under the Plan, the Plan Administrator may perform all administrative functions itself, or it may hire a service provider (each, a "**Contract Claims Administrator**") to perform certain administrative functions, including claims processing functions. The Contract Claims Administrator (if any) of a particular benefit program does not insure the benefits provided under the benefit program, and, unless specifically stated in the applicable Related Documents, does not serve as a named fiduciary with respect to such benefit program.

Any Insurance Claims Administrator and any Contract Claims Administrator identified in this SPD may be referred to generally as the "**Claims Administrator**" of a particular benefit program. In connection with the administrative services it provides, each Claims Administrator has the authority to require Participants and eligible individuals to furnish information that the Claims Administrator deems necessary for the proper administration of the applicable benefit program.

For more information relating to the administration of the Plan, please refer to the ***Plan Administration*** provisions set forth below.

Basic Information About the Plan	
Name of the Plan:	Brown Investment Properties Health and Welfare Plan
Name and Address of the Employer/Plan Sponsor:	Brown Investment Properties Inc. 1007 Battleground Ave Suite 401 Greensboro, North Carolina 27408 (336) 541-5511
Plan Administrator and Named Fiduciary:	Brown Investment Properties Inc. 1007 Battleground Ave Suite 401 Greensboro, North Carolina 27408 (336) 541-5511 In this context, the **"Named Fiduciary"** is a person or entity with the authority to control and manage the operation and administration of the Plan.
Agent for Service of Legal Process:	Brown Investment Properties Inc. 1007 Battleground Ave Suite 401 Greensboro, North Carolina 27408 (336) 541-5511 Service of legal process may be made upon the Agent for Service of Process or the Plan Administrator.
Employer's EIN:	56-6029496
ERISA Plan Number:	501
ERISA Plan Year:	The ERISA Plan Year is the 12-month period beginning each October 1 and ending each September 30, during which the Plan is in effect. *Note: The Plan's fiscal records are maintained on an ERISA Plan Year basis. However, one or more benefit programs under the Plan may be maintained or administered on the basis of a different 12-month period that reflects the applicable policy period, deductible tracking period, annual open enrollment period, or other similar period.*

Type of Plan:	The Plan is a consolidated group plan providing health and welfare benefits under the benefit programs identified in the ***Introduction*** provisions above.
Type of Administration:	The type of administration provided by an Insurance Claims Administrator is referred to as "insurer administration." The Insurance Claims Administrators of the fully insured benefit programs included in the Plan are as follows: <u>Dental</u>: Policy # 1142839 Principal PO Box 10357 Des Moines, Iowa 50306 (800) 247-4695 www.principal.com <u>Vision</u>: Policy # 01U3803 United Healthcare PO Box 30978 Salt Lake City, Utah 84130 (800) 357-0978 www.myuhcvision.com <u>Basic Term Life</u>: Policy # 758821 The Standard PO Box 2800 Portland, Oregon 97208 (800) 628-8600 www.standard.com <u>Long-Term Disability</u>: Policy # 758821 The Standard PO Box 2800 Portland, Oregon 97208 (800) 368-2859 www.standard.com The type of administration provided by a Contract Claims Administrator is referred to as "contract administration." The Contract Claims Administrators of the self-funded benefit programs included in the Plan are as follows:

	Medical: Trustmark Benefits 400 Field Dr Lake Forest, Illinois 60045 (800) 223-3943 myTrustmarkBenefits.com Health FSA: isolved Benefit Services PO Box 889 Coldwater, Michigan 49036 (800) 796-7910 www.isolvedbenefitservices.com *Note: The Health FSA is part of a separate Code Section 125 cafeteria plan sponsored by the Employer. The full cafeteria plan is incorporated into this SPD. However, only the Health FSA component of the cafeteria plan is subject to ERISA. The pre-tax premium component and any other components of the cafeteria plan are not subject to ERISA, and their inclusion as part of this SPD is not intended to subject such components to the application of ERISA.*
Funding Arrangement:	Each fully insured benefit program is provided under an insurance policy contract between the Employer and the applicable insurance company. The applicable insurance company (rather than the Employer) is responsible for funding (*i.e.,* paying with its own funds) any claims that are payable under the benefit program it insures. The Plan includes the following fully insured benefit programs: • Dental • Vision • Basic Term Life • Long-Term Disability With respect to any self-funded benefit program, the Employer is responsible for funding any claims that are payable under such benefit program. The Employer pays such claims from its general assets. The Plan includes the following self-funded benefit programs: • Medical • Health FSA Contributions or insurance premiums under the following benefit programs are paid in part by the Employer out of its general assets and in part by employees through pre-tax payroll deductions (to the extent coverage does not exceed specified tax code limits, if applicable):

	• Medical • Dental Contributions or insurance premiums under the following benefit programs are paid solely by employees through pre-tax payroll deductions (to the extent coverage does not exceed specified tax code limits, if applicable): • Health FSA Contributions or insurance premiums under the following benefit programs are paid solely by the Employer out of its general assets and are treated as taxable wages paid to the employee: • Basic Term Life • Long-Term Disability Contributions or insurance premiums under the following benefit programs are paid solely by employees through post-tax payroll deductions: • Vision Each ERISA Plan Year, the Employer will identify the amount of the contribution or insurance premium payable by the employee for coverage under each benefit program. For an outline of the amounts currently required, please contact the Plan Administrator. *Note: Any refund, rebate, dividend, experience adjustment, or other similar payment to the Employer or the Plan pursuant to a group insurance contract (or HMO), pharmacy benefit management agreement, or other similar arrangement will be allocated in a manner that is consistent with applicable fiduciary requirements under ERISA.*
Effective Date of this SPD:	November 29, 2023
Plan Amendments and Termination:	The Employer has established the Plan with the intention of maintaining it for an indefinite period of time. However, the Employer recognizes that future events cannot be anticipated. Therefore, the Employer reserves the right to amend or terminate the Plan at any time, subject to the requirements of applicable law.
Foreign Language Assistance:	**Este documento contiene un resumen en inglés de sus derechos y beneficios bajo el Plan. Si tiene dificultades para comprender alguna parte de este documento, comuníquese con el Administrador del plan**

	durante el horario comercial normal para obtener ayuda. El Empleador se compromete a ayudarlo a comprender las opciones de beneficios disponibles para usted en virtud del Plan.

Eligibility and Participation Requirements

Eligible Employees:

In order to be eligible to participate in the Plan, an employee must be eligible to participate in one or more of the benefit programs identified in the ***Introduction*** provisions above. Generally, in order to be eligible to participate in each benefit program, an employee must be regularly scheduled to work at least 30 hours per week.

Note: Medical benefit programs are required to comply with health care reform legislation. Among the provisions applicable to large employers is a requirement that the program identify a measurement method and measure employees' full-time status on an ongoing basis to determine whether an employee who was previously a part-time, variable-hour, or seasonal employee has become an employee with full-time status under the medical benefit program, and whether an employee who was previously a full-time eligible employee has lost such eligibility status. A large employer refers to an employer with an average of at least 50 full-time employees, including full-time-equivalent employees, during the prior calendar year. Please contact the Plan Administrator for more information regarding the application of these requirements to the medical benefit program(s) offered under the Plan (if any).

Persons Excluded from Coverage: Generally, leased employees, independent contractors, and employees belonging to a collective bargaining unit are excluded from participation in the benefit programs available under the Plan and are, therefore, ineligible individuals. Please refer to the applicable Related Documents for more information regarding eligibility to participate in a particular benefit program and for more information regarding the individuals who are excluded from participation.

Eligible Family Members:

Certain family members of an eligible employee, such as the employee's spouse and dependent children may be eligible to participate in a particular benefit program, as specified in the applicable Related Documents. Please refer to the applicable Related Documents to determine which family members, if any, are eligible to participate in a particular benefit program.

Waiting Period:

Prior to participation in a particular benefit program, an eligible employee may be required to satisfy a specified period of service or "waiting period." The waiting period applicable to each benefit program under the Plan is 60 days.

For Medical Benefit Programs: For purposes of any medical benefit program under the Plan, the "waiting period" is defined as the period of time that must pass, once an employee becomes eligible to participate in the medical benefit program, before coverage under such program will begin.

For Other Benefit Programs: With respect to any other benefit program under the Plan, the waiting period is measured in the manner set forth in the Related Documents. Please refer to the applicable Related Documents for more information regarding the application of the waiting period to a particular benefit program.

Entry Date:

An employee's entry date with respect to a particular benefit program under the Plan is the date on which the employee's coverage under the benefit program becomes effective. An eligible employee who becomes covered under a benefit program is referred to as a "**Participating Employee**" with respect to such benefit program. An eligible family member who becomes covered under a benefit program is referred to as a "**Participating Family Member**" (or a "**Participating Spouse**" or "**Participating Child**," as applicable) with respect to such benefit program.

For Medical Benefit Programs: For purposes of any medical benefit program, a newly-hired eligible employee who satisfies the applicable waiting period (if any) set forth above will become covered under the medical benefit program immediately upon satisfaction of the waiting period, as long as the employee has taken the necessary steps to enroll for such coverage (as described in more detail below). Employees who are not eligible for such coverage when they begin working for the Employer, but later become eligible for such coverage, may become covered under the medical benefit program based on the rules applicable to the measurement method adopted by the Employer (if applicable), as described above.

For Other Benefit Programs: For benefit programs other than the medical benefit program, a newly-hired eligible employee who satisfies the applicable waiting period (if any) set forth above will generally become covered under the program immediately upon satisfaction of the waiting period, as long as the employee has taken the necessary steps to enroll for such coverage (as described in more detail below). In order to participate in the Basic Term Life benefit program, however, a newly-hired eligible employee who satisfies the applicable waiting period (if any) set forth above will generally become covered under the program on the first day of the month following satisfaction of the waiting period. Employees who are not eligible for coverage under a particular benefit program when they begin working for the Employer, but later become eligible for such coverage, may become covered under such benefit program, to the extent permitted under the terms of such benefit program, as set forth in the applicable Related Documents.

Please refer to the applicable Related Documents for more information relating to the date of coverage under a particular benefit program.

Enrollment Process:

Employees who are eligible to participate in a particular benefit program under the Plan may be automatically enrolled in the benefit program. Alternatively, Employees who are eligible to participate in a particular benefit program under the Plan may be required to take certain actions to enroll themselves and any eligible family members for coverage, if they desire to participate in the benefit program (*e.g.,* complete an enrollment or election form). To help the Plan operate more efficiently, the Employer may allow any such forms to be sent by electronic means.

Timing Requirements: For benefit programs requiring enrollment, new employees who are eligible for benefits must generally enroll within a certain time period after being hired, and newly-eligible employees must generally enroll within a certain time period after first becoming eligible, if they desire to participate in the benefit program. Employees who fail to enroll themselves and any eligible family members in a particular benefit program during such time period will generally be required to wait until the next annual open enrollment period applicable to the benefit program (if any) to enroll in the benefit program.

Similarly, eligible employees who fail to take the necessary steps to enroll themselves and/or their eligible family members in a particular benefit program during the benefit program's annual open enrollment period (if any) may be required to wait until a subsequent open enrollment period of the benefit program to do so.

Notwithstanding the timing restrictions described above, certain benefit programs may be required to permit eligible employees and/or their eligible family members to enroll for coverage before the next open enrollment period, based on a special enrollment right (as described in more detail below).

For more information on the enrollment requirements (if any) applicable to each benefit program under the Plan, please refer to the Related Documents.

Contribution Requirements: As part of the enrollment process described above, employees who are eligible to participate in a particular benefit program under the Plan may also be required (in addition to completing and submitting enrollment or election forms) to pay for the cost of such coverage (or a portion of such cost), if they desire to participate in the benefit program. In such cases, the employee will be required to enter into a salary reduction agreement with the Employer, allowing the Employer to withhold the amount of the applicable employee contribution (on either a pre-tax or post-tax basis, as specified above) from the employee's periodic paychecks. The amount of the applicable employee contribution (if any) shall be determined from time to time by the Employer. Participation in the following benefit programs is conditioned upon the eligible employee's payment of employee contributions:

- Medical
- Dental
- Vision
- Health FSA

Special Enrollment Rights:

Certain group health plans (such as medical benefit programs) are required to include special enrollment provisions. Special enrollment rights provide eligible employees and their eligible family members with an opportunity to enroll for coverage, upon the occurrence of a specified event, during a period that is outside of both the benefit program's annual open enrollment period and the eligible employee's initial enrollment period.

Loss of Coverage: A special enrollment right is available when an eligible employee (or his or her eligible family member):

- Did not elect coverage under the benefit program when he or she was first eligible to do so, because the eligible employee (or his or her eligible family member) was covered under another

group health plan or had other insurance at the time coverage under the applicable Employer-sponsored benefit program was previously offered; and

- Loses such other coverage (or loses eligibility for such other coverage) due to termination of employment in a class eligible for such coverage; reduction in hours of employment; death of the employee; divorce or legal separation; exhaustion of COBRA Continuation Coverage; termination of employer contributions toward the coverage; the individual's ceasing to be a dependent (such as by attaining the maximum age to be eligible as a dependent child); termination of a benefit package option; no longer living or working in the HMO's service area (and there is no other coverage available); or the benefit program's ceasing to offer coverage to a class of similarly situated individuals that includes the eligible employee (or his or her eligible family member); and
- Requests special enrollment (into the Employer-sponsored benefit program) within 30 days of the date of the loss of coverage for one of the reasons stated above (in which case, coverage will become effective no later than the first day of the first month following the benefit program's receipt of the completed enrollment form requesting special enrollment).

New Family Member: A special enrollment right is available when an eligible employee acquires an eligible family member:

- Through marriage and requests special enrollment (into the Employer-sponsored benefit program) within 30 days of the date of the marriage (in which case, coverage will become effective no later than the first day of the first calendar month following the benefit program's receipt of a completed enrollment form requesting special enrollment);
- Through birth and requests special enrollment (into the Employer-sponsored benefit program) within 30 days of the date of the birth (in which case, coverage will become effective no later than the date of birth); or
- Through adoption or placement for adoption and requests special enrollment (into the Employer-sponsored benefit program) within 30 days of the date of such adoption or placement for adoption (in which case, coverage will become effective no later than the date of adoption or placement for adoption).

Gaining or Losing Medicaid or CHIP Eligibility: A special enrollment right is available when an eligible employee or eligible family member who is not participating in the particular Employer-sponsored benefit program:

- Either loses eligibility and coverage under a Medicaid plan or the state children's health insurance program ("**CHIP**") or becomes eligible for group health plan premium assistance under Medicaid or CHIP; and
- Requests special enrollment into the Employer-sponsored benefit program) within 60 days after the termination of Medicaid or CHIP coverage, or within 60 days after the date of the Medicaid or CHIP eligibility determination for premium assistance, as applicable (in which case, coverage will become effective no later than the first day of the first month following the benefit program's receipt of a completed enrollment form requesting special enrollment).

Please refer to the applicable Related Documents for more information relating to special enrollment rights. If you believe you are entitled to special enrollment under a particular benefit program, please contact the Plan Administrator to request an election form as soon as possible.

QMCSO Enrollment:

The group health plan components of the Plan (including any medical benefit program, dental benefit program and vision benefit program) are required to comply with a properly issued qualified medical child support order ("**QMCSO**"). A QMCSO is a court or administrative order requiring one or more group health plan components of the Plan to provide coverage to an eligible child of an eligible employee.

Procedures: Upon receiving a medical child support order, the Plan Administrator will determine, based on the Plan's written procedures for determining the qualified status of a medical child support order, whether such order is a QMCSO. Participants and beneficiaries may obtain, upon request, a copy of the Plan's procedures for determining the qualified status of a medical child support order.

Enrollment and Coverage: If the Plan Administrator determines that the order is a QMCSO, the Plan Administrator shall enroll, for immediate coverage under the applicable benefit program(s), any eligible child who is the subject of the QMCSO. Such coverage will take effect regardless of (a) whether the eligible employee has legal custody of the child, (b) whether the child is dependent on the eligible employee for support, and (c) any enrollment restrictions that may otherwise exist for coverage of an eligible family member.

If the eligible employee fails to enroll the child as required, the custodial parent or applicable state agency may do so. Furthermore, the Employer may be permitted to withhold from the eligible employee's paycheck any employee contributions required for such coverage.

Coverage During FMLA Leave:

The Family and Medical Leave Act of 1993 ("**FMLA**") provides certain employees with the right to take an unpaid, job-protected leave of absence for certain family and medical reasons. The FMLA generally applies to (a) private employers with 50 or more employees (within a 75-mile radius) in the current or prior calendar year; and (b) all public agencies (federal, state, and local governments) and local educational agencies (including public school boards, and public as well as private elementary and secondary schools), regardless of the number of employees.

Group Health Plan Coverage: If the Employer is subject to the FMLA, a Participating Employee who takes a leave of absence that qualifies as FMLA leave has the right to continue participating in the group health plan components of the Plan (including any medical benefit program, dental benefit program and vision benefit program) during such FMLA leave on the same basis as if the Participating Employee were actively at work.

Maintenance Obligations: If the Participating Employee chooses to continue participating in one or more group health plan components of the Plan during FMLA leave, the Employer must maintain the employee's coverage (*i.e.,* pay the Employer's share of the cost of such coverage) on the same basis as if the Participating Employee were actively at work. Similarly, the Participating Employee will be required to pay the employee's portion of the cost of any such coverage (*i.e.,* make employee contributions). Payments by the Participating Employee must be made in the time and manner specified in the Employer's FMLA policy.

Cessation and Reinstatement of Coverage: If the Participating Employee chooses not to participate in one or more group health plan components of the Plan during FMLA leave, or the Participating Employee fails to make a required employee contribution as specified by the Employer's FMLA policy, the Participating Employee's coverage under such group health plan components may cease. However,

the Employer must reinstate the Participating Employee's coverage (and the coverage of Participating Family Members) immediately upon the Participating Employee's return from FMLA leave (as long as he or she returns to a class of employees eligible to participate in the applicable group health plan components of the Plan).

Failure to Return: If the Participating Employee does not return to work at the end of the FMLA leave period, or the Participating Employee informs the Employer of an intent not to return from FMLA leave, the Participating Employee will generally be entitled to elect COBRA Continuation Coverage (as described in more detail below), even if he or she was not covered under the applicable group health plan component during FMLA leave.

Other Benefit Coverage: During FMLA leave, a Participating Employee will also have the right to continue participating in other (non-group health plan) benefit programs under the Plan on the same basis as other Participating Employees who are taking other types of unpaid leave.

Coverage During Other Leaves of Absence:

If a Participating Employee takes a leave of absence that does not qualify as FMLA leave (as described in more detail above), Military Leave (as described in more detail below), or other leave protected under federal or state law, his or her coverage (and the coverage of any Participating Family Members) under a particular benefit program may remain in place for a limited period of time if the Employer's leave of absence policies or the appliable Related Documents provide for such ongoing coverage.

If coverage under any group health plan component of the Plan is lost due to the leave of absence (*i.e.,* the Participating Employee loses eligibility due to a reduction in hours of employment), COBRA Continuation Coverage rights may be triggered (as described in more detail below).

Please refer to the applicable Related Documents for more information regarding coverage under a particular benefit program during a leave of absence. Please contact the Employer for more information relating to the Employer's leave of absence policies.

Termination of Coverage

Timing of Coverage Termination:

Your coverage under the Plan will remain in effect as long as you are covered under at least one of the benefit programs identified in the ***Introduction*** provisions above.

Your coverage under each benefit program ends on the last day of the month in which you terminate employment or otherwise lose eligibility for coverage under the benefit program.

Note: As stated above, medical benefit programs are required to comply with health care reform legislation. Among the provisions applicable to large employers (employers with an average of at least 50 full-time employees, including full-time-equivalent employees, during the prior calendar year) is a requirement that the program identify a measurement method and measure employees' full-time status on an ongoing basis. As such, in order to confirm the accuracy of the date identified above (with respect to an employee's termination of coverage under a medical benefit program), please refer to the applicable Related Documents or contact the Plan Administrator for more information regarding the application of the selected measurement method.

Earlier Termination: Your coverage under a particular benefit program may terminate earlier than the date identified above if you fail to make a required contribution or premium payment, if you submit a false claim, if the Plan or the particular benefit program is terminated by the Employer, or for any other reason identified in the applicable Related Documents.

Loss by Family Members: Participating Family Members will generally lose coverage under a benefit program at the same time your coverage under the benefit program ends. A family member's coverage may terminate earlier if that family member becomes ineligible for coverage under the particular benefit program (for example, a Participating Spouse may become ineligible due to a divorce, or a Participating Child may lose eligibility upon reaching a certain age) or for any other reason identified in the applicable Related Documents.

Please refer to the applicable Related Documents for more information regarding the termination of coverage under a particular benefit program.

Note: When coverage under certain benefit programs ends, you and/or your Participating Family Members may be permitted to extend your coverage beyond the applicable termination date identified above. Rights to continuation coverage are described in more detail below.

Participation Upon Rehire:

If an eligible employee or a Participating Employee terminates employment with the Employer and is rehired as an eligible employee by the Employer 30 or more days later, certain benefit programs under the Plan may treat such employee as a new hire and require the employee to satisfy (once again) the benefit program's waiting period and enrollment requirements (if any) prior to participation in the benefit program. However, as a result of health care reform legislation, large employers (employers with an average of at least 50 full-time employees, including full-time-equivalent employees, during the prior calendar year) generally may not treat a rehired employee as a new hire, for purposes of any medical benefit program, until the period between employment termination and rehire is longer than 13 weeks (or 26 weeks for large employers that are educational institutions).

Please refer to the applicable Related Documents or contact the Plan Administrator for more information relating to a rehired employee's Plan participation.

COBRA Continuation Coverage and Other Coverage Continuation Rights

COBRA Continuation Coverage:

Generally, any employer that employed 20 or more employees on a typical business day during the prior calendar year is required to operate its group health plans in compliance with the continuation of coverage provisions set forth in the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (**"COBRA"**).

COBRA is a federal law that provides individuals with the right to extend or "continue" their group health plan coverage (*e.g.*, medical, dental, vision, etc.) for a certain period of time after it would otherwise end as a result of certain events. Each such event is referred to as a "**Qualifying Event**" and is outlined in more detail below. The ongoing coverage available under COBRA is referred to as "**COBRA Continuation Coverage.**" Each person entitled to COBRA Continuation Coverage is referred to as a

"**Qualified Beneficiary.**" Unless a broader definition is set forth in the applicable Related Documents, Qualified Beneficiary status is limited to the following individuals who, on the day before the Qualifying Event, were covered under a group health plan component of the Plan:

- The Participating Employee;
- The Participating Spouse of the employee; and
- Any Participating Child of the employee.*

*A child born to, or placed for adoption with, a Participating Employee during a period of COBRA Continuation Coverage will be considered a Participating Child (and a Qualified Beneficiary) entitled to COBRA Continuation Coverage.

Benefit Programs Subject to COBRA: If the Employer is subject to COBRA, COBRA Continuation Coverage rights apply to the following benefit programs, which qualify as group health plans under the Plan:

- Medical
- Dental
- Vision
- Health FSA

Qualifying Events for Participating Employees: COBRA provides a Participating Employee with the right to continue group health plan coverage if such coverage would otherwise end due to:

- A reduction in hours of employment; or
- Termination of employment (for reasons other than gross misconduct).

Qualifying Events for Participating Spouses: COBRA provides a Participating Spouse with the right to continue group health plan coverage if coverage would otherwise end due to the Participating Employee's:

- Death;
- Termination of employment (for reasons other than gross misconduct);
- Reduction in hours of employment;
- Divorce or legal separation; or
- Medicare entitlement (but only in limited situations).

Qualifying Events for Participating Children: COBRA provides a Participating Child with the right to continue group health plan coverage if coverage would otherwise end due to:

- The Participating Child's loss of dependent status (*e.g.*, reaching a certain age); or
- The Participating Employee's death;
- The Participating Employee's termination of employment (for reasons other than gross misconduct);
- The Participating Employee's reduction in hours of employment;
- The Participating Employee's divorce or legal separation; or
- The Participating Employee's Medicare entitlement (but only in limited situations).

Bankruptcy as Qualifying Event: With respect to any retiree group health plan coverage, a Chapter 11 bankruptcy filing by the Employer will be a Qualifying Event if the bankruptcy results in any retiree's (and any Participating Spouse's or Participating Child's) loss of coverage.

Note: The loss of coverage contemplated in connection with a Qualifying Event need not occur immediately after the Qualifying Event, as long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage period (as described in more detail below) that would apply.

Note: Loss of coverage includes any increase in the premium or contribution that must be paid by the Participant for coverage under a group health plan component of the Plan, which increase results from the occurrence of one of the Qualifying Events identified above.

Nature of Coverage: Those who elect COBRA Continuation Coverage are entitled to the same level of coverage that was in effect under the applicable benefit program immediately before the Qualifying Event. If coverage under the benefit program is modified for similarly situated active Participating Employees during a Qualified Beneficiary's period of COBRA Continuation Coverage, then it will be modified for the Qualified Beneficiary. Qualified Beneficiaries will be permitted to make a change in their coverage upon the occurrence of any event that permits a similarly situated active Participating Employee to make a benefit change.

Notice Obligations: If a Qualified Beneficiary loses or will lose coverage under a group health plan component of the Plan as a result of a divorce, legal separation or ceasing to be an eligible dependent child, the Participating Employee (or the Qualified Beneficiary) must notify the Plan Administrator within 60 days of the divorce, legal separation or loss of eligible dependent child status. Failure to provide timely notice will result in a termination of the Qualified Beneficiary's right to COBRA Continuation Coverage. If the Plan Administrator is timely notified that one of these events has occurred, the Plan Administrator will notify the applicable Qualified Beneficiaries of the right to elect COBRA Continuation Coverage. Notice to a Participating Employee's spouse is treated as notice to any Participating Child residing with the spouse.

During the period of COBRA Continuation Coverage, a Qualified Beneficiary must notify the Plan Administrator if he or she becomes covered under another group health plan or Medicare.

Election: In order to elect COBRA Continuation Coverage, a Qualified Beneficiary must complete the COBRA election form(s) provided by the Plan Administrator. Each Qualified Beneficiary is entitled to make a separate election for COBRA Continuation Coverage under the applicable benefit program. A Qualified Beneficiary has 60 days from the later of the following dates to elect to continue coverage:

- The date of the notice outlining the Qualified Beneficiary's right to elect COBRA Continuation Coverage; or
- The date coverage under the benefit program would otherwise end due to the Qualifying Event.

A Qualified Beneficiary who fails to return the election form within the 60-day period described above will lose the right to elect COBRA Continuation Coverage.

Payment Obligation: A Qualified Beneficiary who elects COBRA Continuation Coverage will be required to pay the entire cost of such coverage (the Employer's contribution plus the employee's contribution). The cost of COBRA Continuation Coverage will not be more than 102% of the cost of such coverage (100% of the underwriting cost plus a 2% administrative fee) for the period of COBRA Continuation Coverage. However, if a Qualified Beneficiary extends the COBRA Continuation Coverage period due

to a disability (as described in more detail below), the Qualified Beneficiary may be required to pay up to 150% of the cost of coverage.

Timing of Payment: Once a Qualified Beneficiary elects COBRA Continuation Coverage, the first premium payment is due 45 days after the date of election. Subsequent premiums must be paid within a 30-day grace period following the payment due date identified by the Plan Administrator (which is typically the first day of each month). Failure to pay premiums within the required time period will result in an automatic termination of COBRA Continuation Coverage. If a Qualified Beneficiary makes a premium payment that is insufficient by an insignificant amount (the lesser of $50 or 10% of the premium), he or she will be given additional time to pay the remaining amount owed.

If the Qualified Beneficiary incurs a covered medical expense during any period for which the COBRA premium payment has not yet been paid, payment or reimbursement of the claim for such services may be postponed until the applicable COBRA premium payment is received by the benefit program.

If a Qualified Beneficiary timely elects COBRA Continuation Coverage and timely pays the applicable COBRA premium, COBRA Continuation Coverage will relate back to the first day on which regular coverage would have been lost.

Length of COBRA Continuation Coverage: The maximum period of COBRA Continuation Coverage shall be as follows and depends on the specific Qualifying Event that caused the loss of group health plan coverage:

- If a Participating Employee (and/or his or her Participating Spouse or Participating Child) loses coverage as a result of the Participating Employee's termination of employment or reduction in hours of employment, COBRA Continuation Coverage will be available to each Qualified Beneficiary for a period of 18 months beginning on the date of the Qualifying Event (or on the date coverage is lost, if so specified in the applicable Related Documents).
- If a Participating Spouse or Participating Child loses coverage as a result of a Qualifying Event other than the Participating Employee's termination of employment or reduction in hours of employment, COBRA Continuation Coverage will be available to each such Qualified Beneficiary for a period of 36 months beginning on the date of the Qualifying Event (or on the date coverage is lost, if so specified in the applicable Related Documents).

Potential Disability Extension: The COBRA Continuation Coverage period identified above may be extended if any Qualified Beneficiary (*i.e.,* the Participating Employee or his or her Participating Spouse or Participating Child):

- Lost group health plan coverage as a result of the Participating Employee's termination of employment or reduction in hours of employment;
- Elects COBRA Continuation Coverage; and
- Was either disabled (as determined by the Social Security Administration under Title II or Title XVI of the Social Security Act) at the time of the Qualifying Event or becomes disabled within the first 60 days of COBRA Continuation Coverage.

Disability Notice Requirements: In a disability case meeting the requirements above, the 18-month COBRA Continuation Coverage period otherwise applicable to each Qualified Beneficiary who elected COBRA Continuation Coverage may be extended for up to an additional 11 months, for a maximum period of up to 29 months from the date of the Qualifying Event (or from the date coverage is lost, if so specified in the applicable Related Documents). However, in order to receive a disability extension,

a Qualified Beneficiary must inform the Plan Administrator of the determination of disability within 60 days after the latest of:

- The date of the Social Security disability determination;
- The date of the Qualifying Event (*i.e.*, the Participating Employee's termination of employment or reduction in hours);
- The date on which the group health plan coverage would otherwise be lost as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed (through the furnishing of this SPD or the initial/general COBRA notice) of both (a) the responsibility to provide notice of the disability determination, and (b) the procedures for providing such notice to the Plan Administrator.

In no event, however, may notice of the disability determination be provided to the Plan Administrator after the initial 18-month period of COBRA Continuation Coverage has expired.

If the Social Security Administration subsequently determines that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan Administrator within 30 days of the determination.

Potential Extension for Second Qualifying Event: If a second Qualifying Event occurs while a Qualified Beneficiary's 18-month (or 29-month) COBRA Continuation Coverage period is in effect, the Qualified Beneficiary may be permitted to extend his or her COBRA Continuation Coverage period, for a maximum period of 36 months from the date of the original Qualifying Event (or from the date coverage is lost, if so specified in the applicable Related Documents). The second Qualifying Event may be the death of the Participating Employee, the Participating Employee's divorce or legal separation, the Participating Employee's entitlement to Medicare (but only in limited situations), or a Participating Child's loss of dependent status.

In addition, if a Participating Employee becomes entitled to Medicare and then loses group health plan coverage as a result of a termination of employment or reduction in hours of employment within 18 months of becoming entitled to Medicare, the Participating Spouse and any Participating Child (but not the Participating Employee) will be entitled to extend their COBRA Continuation Coverage period, for a maximum period of 36 months from the date the Participating Employee became entitled to Medicare.

Potential Reduction of COBRA Continuation Coverage Period: The COBRA Continuation Coverage period may be reduced in the following circumstances and end on the following dates:

- The last day of the month for which the last COBRA premium was timely paid;
- The date, after electing COBRA Continuation Coverage, that the Qualified Beneficiary becomes covered under another group health plan;
- The date, after electing COBRA Continuation Coverage, that the Qualified Beneficiary becomes entitled to Medicare;
- The date the Employer no longer provides group health coverage to any of its employees; or
- The first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled.

Please refer to the applicable Related Documents or contact the Plan Administrator for more information regarding COBRA.

COBRA Alternatives: In addition to COBRA rights, a Qualified Beneficiary may have coverage options (and special enrollment rights, as described in more detail above) under the Health Insurance Exchange/Marketplace, Medicare, Medicaid, CHIP, or another group health plan (such as a spouse's plan) following the loss of coverage under any group health plan component of the Plan. Some of these options may cost less than COBRA Continuation Coverage. Please visit *www.healthcare.gov* for more information regarding the coverage options that may be available.

Questions Regarding COBRA Continuation Coverage: If you have questions about your COBRA Continuation Coverage, you may contact the Plan Administrator or the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("**EBSA**"). Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website at *www.dol.gov/ebsa*. You may also contact the nearest Regional or District EBSA Office if you have questions about your rights under ERISA or health care reform legislation or other laws affecting the Plan. For more information about the Health Insurance Exchange/Marketplace, you may visit *www.healthcare.gov*.

State Mini-COBRA Laws:

Small employers that are not subject to COBRA (*i.e.,* employers with fewer than 20 employees on a typical business day during the prior calendar year) may be subject to state "mini-COBRA" laws that provide for the continuation of certain benefit coverage that would otherwise be lost as a result of a specified event. Please refer to the applicable Related Documents or contact the Plan Administrator for more information regarding the application of any mini-COBRA provisions to the benefit programs under the Plan.

Continuation Rights Under Other Benefit Programs:

With respect to any benefit program to which COBRA does not apply, please refer to the applicable Related Documents for information relating to any conversion rights or portability options that may be available.

USERRA Continuation Coverage:

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("**USERRA**") is a federal law that requires all employers (regardless of size) to offer Participating Employees an opportunity to extend or "continue" group health plan coverage (*e.g.*, medical, dental, vision, etc.) that would otherwise be lost, when they are absent from work due to uniformed service that lasts 31 days or longer ("**Military Leave**"). Participating Family Members do not have an independent right to elect continuation coverage under USERRA. However, the Participating Employee may make an election on their behalf.

Application: Continuation coverage rights under USERRA apply to the following benefit programs, which qualify as group health plans under the Plan:

- Medical
- Dental
- Vision
- Health FSA

Nature of Coverage: Participating Employees who elect continuation coverage under USERRA are entitled to the same level of coverage that was in effect under the applicable benefit program immediately before the Military Leave. If coverage under the benefit program is modified for similarly situated active Participating Employees during the period of continuation coverage, then it will be modified for a Participating Employee on Military Leave as well. Participating Employees on Military Leave will be permitted to make a change in their coverage upon the occurrence of any event that permits a similarly situated active Participating Employee to make a benefit change.

Notice: Generally, any Participating Employee who expects to take Military Leave must provide advance notice of the leave to the Employer, as early as is reasonable under the circumstances. However, advance notice of Military Leave is not required if such notice would be impossible or unreasonable under the circumstances.

Election: If the Plan Administrator has adopted procedures relating to continuation coverage elections under USERRA, such procedures may specify a time period during which elections must be made. A Participating Employee who fails to make an election (or fails to have an election made on his or her behalf) in accordance with such procedures, if any, may lose the right to elect continuation coverage under USERRA. Please contact the Plan Administrator for more information regarding the USERRA procedures applicable to the Plan.

Payment Obligation: A Participating Employee may be required to pay up to 102% of the entire cost of coverage (determined in the same manner as the cost of COBRA Continuation Coverage).

Length of Continuation Coverage: USERRA continuation coverage is available for a period of up to 24 months beginning on the first day the Participating Employee is absent for Military Leave.

Potential Reduction: USERRA continuation coverage may be terminated before the 24-month period has expired if the Participating Employee fails to make timely premium payments. In addition, if the Participating Employee does not return to work in accordance with the rules and regulations under USERRA after completing a Military Leave that is shorter than 24 months, the right to USERRA continuation coverage will end when the time period for reporting back to work expires.

Re-employment and Reinstatement: Subject to certain exceptions, USERRA provides employees with certain guaranteed re-employment rights upon return from Military Leave. Furthermore, if group health plan coverage was terminated as a result of the Participating Employee's Military Leave, such coverage must be reinstated immediately upon the Participating Employee's re-employment.

Other Group Health Plan Mandates

Coverage of Adopted Children:

Any group health plan component of the Plan (including any medical benefit program, dental benefit program and vision benefit program) that covers dependent children is required to provide coverage to children placed for adoption with a Participant under the same terms and conditions as those that apply to dependent children who are natural children of the Participant, even if the adoption has not yet become final.

HIPAA Nondiscrimination:

The Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**") prohibits group health plan components of the Plan (including any medical benefit program, dental benefit program and vision benefit program) from discriminating with regard to eligibility and benefits (such as enrollment, entry dates, waiting period, covered benefits, contribution amounts, etc.) based on any of the following health status-related factors: (a) health status; (b) medical condition (mental or physical); (c) genetic information; (d) claims experience; (e) receipt of health care; (f) medical history; (g) disability; or (h) evidence of insurability (including conditions arising out of acts of domestic violence and participation in dangerous activities, such as motorcycling, horseback riding, skiing, etc.).

The group health plan components of the Plan may impose benefit restrictions that apply to all similarly situated individuals. For example, a benefit program may limit or exclude benefits for specific conditions or diseases, for certain types of treatments or drugs, etc. However, any limitations or exclusions may not be directed at individual participants based on health status-related factors.

Mental Health Parity:

If a group health plan component of the Plan (including any medical benefit program) provides medical/surgical benefits and also provides either mental health benefits or substance use disorder benefits, it must comply with the "mental health parity" requirements of the Mental Health Parity Act and the Mental Health Parity and Addiction Equity Act of 2008. Specifically, when mental health and substance abuse benefits are covered under a group health plan component of the Plan, the financial limitations and treatment limitations for these benefits must not be more restrictive than the financial limitations and treatment limitations applied to substantially all of the medical and surgical benefits provided under such group health plan component.

Other parity-related requirements apply to "nonquantitative" treatment limitations. Specifically, any processes, strategies, evidentiary standards, or other factors used to apply the nonquantitative treatment limitation to mental health or substance use disorder benefits must be comparable to (and applied no more strictly than) the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits. Furthermore, separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits are prohibited.

Michelle's Law:

Each group health plan component of the Plan (including any medical benefit program, dental benefit program and vision benefit program) is required to continue providing benefit coverage to any Participating Child during a medically necessary leave of absence from college. Such coverage must continue for a period of up to one year beginning on the first day of the leave of absence.

GINA:

The Genetic Information Nondiscrimination Act of 2008 ("**GINA**") prohibits the group health plan components of the Plan (including any medical benefit program, dental benefit program and vision benefit program) from (a) adjusting group premium or contribution amounts on the basis of genetic information; (b) requesting or requiring an individual or an individual's family members to undergo genetic testing; or (c) requesting, requiring, or purchasing genetic information for underwriting purposes.

Patient Protections:

Consistent with the requirements of health care reform legislation, each medical benefit program under the Plan (if any) generally allows for the designation of a primary care provider. Participants have the right to designate any primary care provider who participates in the medical benefit program's network and who is available to accept the Participant. A pediatrician may be designated as the primary care provider of a Participating Child. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact the Claims Administrator for the applicable medical benefit program at the number on the back of your ID card.

A Participant does not need prior authorization from the Plan Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the medical benefit program's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please contact the Claims Administrator for the applicable medical benefit program at the number on the back of your ID card.

Claims and Appeals Procedures

Submission of Benefit Claims:

In order to obtain benefits under a particular benefit program, you must follow the claims procedures for that benefit program, as set forth in the applicable Related Documents. The procedures may require you to complete and submit a claim form to the applicable Claims Administrator identified above. You may also be required to provide other information that the Claims Administrator deems necessary or appropriate for determining the validity of your claim.

Unless a particular benefit program specifically provides for a different time period (or applicable law specifically requires a different time period), a claim for benefits under the Plan must be made within one year after the date the expense (to which the claim relates) was incurred. It is the responsibility of the Participant, or his or her representative, to make sure this requirement is met.

To obtain the appropriate claim form or more information on filing a claim, you may contact the applicable Claims Administrator for the particular benefit program, or you may contact the Plan Administrator.

Claims Processing and Benefit Determinations:

Your claim for benefits under the Plan will be governed by the terms and conditions of the applicable benefit program, as described in the applicable Related Documents. The Claims Administrator for a particular benefit program will review and process your claim based on such terms and conditions and based on the reasonable claims procedures established for that benefit program, as required by ERISA and other applicable law. The Claims Administrator has the right to obtain independent medical advice, if applicable, and to require such other evidence as it deems necessary in order to process your claim.

If the Claims Administrator determines that you have submitted a valid claim and that benefits are payable under the applicable benefit program, then benefits will be paid to your health care provider (if applicable) or to you (or your beneficiary) or a Participating Family Member (or his or her

beneficiary), as required by the terms of the applicable benefit program. If your claim is denied, in whole or in part, you will receive a written notification of the denial and the reason(s) for the denial.

Insured Benefits: For purposes of determining the amount of, and entitlement to, benefits under any fully insured benefit program, the applicable Insurance Claims Administrator (as the named fiduciary for benefit determinations) will have the full power and authority to interpret and apply the terms of the applicable insurance policy (and the terms of any coverage contract between the Employer and the insurance carrier) as such terms relate to the benefits provided under the benefit program. The Insurance Claims Administrator will also be responsible for making all determinations as to the rights of any Participant (or any beneficiary of a Participant) to receive benefits under the benefit program, to the extent such rights are not already specified in the applicable Related Documents.

Self-funded Benefits: For purposes of determining the amount of, and entitlement to, benefits under any self-funded benefit program, the Plan Administrator is the named fiduciary, with the full power and authority to make factual determinations and to interpret and apply the terms of the applicable Related Documents as they relate to the benefits provided under the benefit program. The Plan Administrator will also be responsible for making all determinations as to the rights of any Participant (or any beneficiary of a Participant) to receive benefits under the benefit program, to the extent such rights are not already specified in the applicable Related Documents. In the event the Plan Administrator has delegated any claims processing and/or determination functions to a Contract Claims Administrator, communications relating to claims and appeals for a particular benefit program may be handled by the Contract Claims Administrator for such benefit program.

For more information relating to a particular benefit program's claims procedures, please refer to the applicable Related Documents or contact the Plan Administrator or the applicable Claims Administrator.

Right to Appeal a Denied Claim:

If your claim under a benefit program is denied, you may seek a review of your denied claim by making an appeal to:

- The applicable Insurance Claims Administrator (in the case of an insured benefit program); or
- The Plan Administrator or the applicable Contract Claims Administrator (in the case of a self-funded benefit program).

The Insurance Claims Administrator, the Plan Administrator, or the Contract Claims Administrator, as applicable, will decide your appeal in accordance with its reasonable claim procedures, as required by ERISA.

Important Appeal Deadlines:

If you do not appeal a denied claim within the required time period identified in the applicable Related Documents, you will lose your right to obtain further review of your claim, and you may lose your right to file a lawsuit in state or federal court regarding your claim, because you will have failed to exhaust your internal administrative appeal rights. Such exhaustion is generally required in order to bring a lawsuit in state or federal court.

Note: Under certain benefit programs, you may also have the right to obtain an external review of your claim by an independent third party.

Please review the applicable Related Documents for more information on filing a claim and the applicable claims and appeals procedures, including the applicable deadlines for taking action.

Limitation of Actions:

If you wish to file a lawsuit in connection with the benefits provided under a particular benefit program under the Plan, you must do so within three years of the date you are notified of the Plan's final decision on your appeal, unless the benefit program specifically provides for a different time period for such an action.

HIPAA Privacy and Security

HIPAA's privacy and security rules apply to the group health plan components of the Plan (including any medical benefit program, dental benefit program and vision benefit program). The rules recognize the confidentiality and sensitivity of your health information and are designed to protect such information from inappropriate uses and disclosures. Specifically, the rules restrict the use and disclosure of your Protected Health Information, including uses by, and disclosures to, the Employer.

"**Protected Health Information**" or "**PHI**" is Individually Identifiable Health Information (as defined below) that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium, including oral or written information. The HIPAA privacy rule applies to PHI, and the HIPAA security rule applies to electronic PHI. "**Individually Identifiable Health Information**" is health information, including demographic information, collected from an individual and created or received by a health care provider, a health plan, an employer, or a health care clearinghouse, that identifies the individual involved or can reasonably be used to identify the individual involved.

Note: PHI excludes certain Individually Identifiable Health Information contained in certain education records and employment records held by the Employer in its role as an employer.

Privacy Notice: As required by HIPAA, each group health plan component of the Plan (if any) has adopted certain privacy policies and procedures, as set forth in its notice of privacy practices (the "Privacy Notice"), which outlines how and when the applicable benefit program may use or disclose your PHI, as well as your rights and protections under the law. If you are a Participant under a benefit program that is subject to HIPAA, you should have received a copy of the benefit program's Privacy Notice. If there are material changes made to the benefit program's practices and procedures regarding the use and protection of your PHI, you will receive a revised Privacy Notice. In addition, you may receive a copy of the Privacy Notice at any time by contacting the benefit program's Claims Administrator or the Privacy Officer identified by the applicable benefit program.

Disclosure of Summary Health Information: A group health plan component of the Plan (and any insurance company insuring such component) may disclose Summary Health Information (as defined below) to the Employer, if the Employer requests such information for the purpose of (a) obtaining premium bids in order to provide health insurance coverage under the Plan, or (b) modifying, amending or terminating a group health plan component of the Plan, including analyzing the costs of the group health plan component and the effectiveness of its administration. A group health plan component of the Plan (and any insurance company insuring such component) may also disclose Summary Health Information to the Employer for such other purposes as may be permitted under HIPAA and the disclosure provisions outlined below. In the case of any disclosure of Summary Health Information,

however, the disclosing party must not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

"**Summary Health Information**" refers to information that summarizes the claims history, claims expenses, or types of claims experienced by Participants covered under a group health plan component of the Plan, and from which the following identifiers have been removed:

- Names;
- Geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for, in some cases, the initial three digits of a zip code;
- All elements of dates (except year) directly relating to the Participants involved (*e.g.*, birth date) or their medical treatment (*e.g.*, admission or discharge date), and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
- Other identifying numbers, such as Social Security numbers, telephone numbers, fax numbers, account numbers or medical record numbers, health plan beneficiary numbers, certificate or license numbers, vehicle identifiers and serial numbers; and device identifiers and serial numbers;
- E-mail addresses, Internet Protocol (IP) addresses, and Web Universal Resource Locators (URLs);
- Full face photographic images and any comparable images or biometric identifiers (*e.g.*, finger prints); and
- Any other unique identifying number, characteristic, or code.

Disclosure of Enrollment and Disenrollment Information: A group health plan component of the Plan (and any insurance company insuring such component) may disclose enrollment and disenrollment information to the Employer, provided such information is used by the Employer to perform administrative functions for the applicable group health plan component of the Plan. Plan administrative functions do not include functions performed by the Employer in connection with any other benefit or benefit program of the Employer (such as a long-term disability or life insurance benefit) or any employment-related actions or decisions.

Employer Certification and Responsibility: The following provisions are incorporated into each group health plan component of the Plan (if any) to enable it to disclose PHI to the Employer. Each such group health plan component (if any) acknowledges receipt of a written certification from the Employer that the applicable benefit program has been amended to comply with the certification requirements set forth in the HIPAA regulations. By amending the applicable benefit program, the Employer has agreed:

- To use or disclose PHI only to the extent provided under the applicable benefit program and as otherwise required by law;
- To ensure that any and all of its agents or subcontractors to whom the Employer provides PHI that it received from a group health plan component of the Plan (or any insurance company insuring such component) agree to the same restrictions and conditions as are imposed upon the Employer, including implementing reasonable and appropriate security measures to protect electronic PHI;
- Not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan or program of the Employer;

- To report to the applicable benefit program any use or disclosure of PHI of which it becomes aware that is inconsistent with the permitted uses and disclosures;
- To make PHI available to the applicable individual in accordance with the requirements of the HIPAA regulations outlining the rights of an individual to access, inspect and obtain a copy of his or her PHI);
- To make PHI available for the individual's amendment and incorporate any amendments into the individual's record, in accordance with the requirements of the HIPAA regulations outlining the rights of an individual to have a health care provider, group health plan or health care clearinghouse amend his or her PHI;
- To make the information available that will provide individuals with an accounting of disclosures in accordance with the HIPAA regulations outlining the rights of an individual to receive an accounting of certain disclosures of PHI made by the health care provider, group health plan or health care clearinghouse;
- To make its internal practices, books and records relating to the use and disclosure of PHI received from a group health plan component of the Plan (or any insurance company insuring such component) available to the Secretary of the U.S. Department of Health and Human Services, upon request, for purposes of determining compliance with HIPAA;
- If feasible, to return or destroy all PHI received from a group health plan component of the Plan (or any insurance company insuring such component) that the Employer maintains in any form and retain no copies of such information when such PHI is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer, as applicable, will limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible;
- To ensure that adequate separation between the applicable benefit program and the Employer (*i.e.,* a firewall) is established and maintained and is supported by reasonable and appropriate security measures, as required by the HIPAA regulations and as set forth below;
- To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the applicable benefit program; and
- To report any security incident (as defined under the HIPAA regulations) of which it becomes aware.

Employees and Agents with Access to PHI: A group health plan component of the Plan (and any insurance company insuring such component) may disclose PHI to the employees or classes of employees (or other persons under the control of the Employer) described or identified in the applicable benefit program's Privacy Notice ("**Designated Staff Members**").

Limitations on Access to and Use of PHI: Designated Staff Members' access to and use of PHI are restricted to (a) the uses identified in the *Employer Certification and Responsibility* provisions above, and/or (b) those administrative functions that the Employer performs for the applicable benefit program. Such administrative functions may include quality assurance reviews, claims processing, auditing, monitoring, and benefit program management (including financial and administrative oversight and HIPAA compliance). Furthermore, such access or use is permitted only to the extent necessary for Designated Staff Members to perform their respective duties for the applicable benefit program. All Designated Staff Members must comply with the provisions outlined in this paragraph,

and any non-compliance shall subject the non-compliant Designated Staff Member to disciplinary action or termination of employment, pursuant to the disciplinary policy of the Employer.

Unauthorized Access, Use or Disclosure: The applicable group health plan component of the Plan (or the insurance company insuring such component) will notify you if there is any unauthorized use of, access to or disclosure of your PHI. If the applicable group health plan component of the Plan (or the insurance company insuring such component) discovers a breach in its privacy and security protocols, it will provide notice by first class mail, within 60 days of such discovery, to each individual whose PHI has been (or is reasonably believed to have been) breached.

Plan Administration

Plan Administrator: The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator 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.

General Fiduciary Responsibilities: The Plan Administrator, the Employer and any other fiduciary under ERISA shall discharge their duties with respect to the Plan solely in the interest of the Participants and their beneficiaries and:

- For the exclusive purpose of providing Benefits to Participants and their beneficiaries;
- With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a similar character and with similar aims; and
- In accordance with the documents and instruments governing the Plan, to the extent that such documents and instruments are consistent with ERISA.

Specific Responsibilities and Authority of the Plan Administrator: Except to the extent that a responsibility has been otherwise assigned or delegated under the terms of the applicable Related Documents, and except as otherwise stated in this SPD, the Plan Administrator shall have such duties and powers as may be necessary to administer the Plan, including, but not limited to, the following:

- To construe and interpret the Plan and decide all questions of eligibility;
- To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;
- To prepare and distribute information explaining the Plan to Participants;
- To receive from Participants such information as necessary for the proper administration of the Plan;
- To furnish Participants such annual reports with respect to the administration of the Plan as are reasonable and appropriate, or as may be required by law;
- To appoint individuals to assist in the administration of the Plan and to engage any other agents it deems advisable, including legal counsel and employee benefits consultants;
- To purchase any insurance deemed necessary for providing benefits under the Plan;
- To implement election and claim procedures to be used by Participants;
- To prepare and file any reports or returns with respect to the Plan, as required by the Code, ERISA or other applicable law;

- To recommend to the Employer such amendments to the Plan as it deems necessary or appropriate in order to enable the Plan to comply with ERISA and any other applicable legal requirements; and
- To take all actions necessary (but not expressly listed in this SPD) for the effective administration of the Plan.

The Plan Administrator and any other fiduciary with respect to the Plan (to the extent that such individual or entity is acting in its fiduciary capacity) shall have the duty and full discretionary authority to interpret the terms of the Plan, to make factual determinations, and to determine all questions arising in connection with the administration, interpretation, and application of the Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefit claims. Using their authority, the Plan's fiduciaries may correct any defects and omissions and reconcile any inconsistency or ambiguity in the Plan. No decision by the Plan's fiduciaries shall be set aside by a court, unless the party contesting the decision proves by clear and convincing evidence that the decision was arbitrary and capricious.

Delegation of Authority: The Plan Administrator has the discretion to delegate to any other person or persons (including, but not limited to, the applicable Claims Administrator) authority to act on behalf of the Plan Administrator, including, but not limited to, the authority to make any benefits determination, or to sign checks or other instruments incidental to the operation of the Plan, for which the Plan Administrator would otherwise be responsible.

Rules and Decisions: The Plan Administrator may adopt such rules and procedures, as it deems necessary, desirable, or appropriate. All such rules and decisions shall be uniformly and consistently applied to all Participants in similar circumstances. When making any decision or determination, the Plan Administrator shall be entitled to reply upon such information as may be furnished to it by a Participant, legal counsel, or the applicable Claims Administrator under the Plan.

Indemnification: The Employer agrees to indemnify and to defend to the fullest extent permitted by law any director, officer, or employee of the Employer against all liabilities, damages, costs and expenses, including attorneys' fees and amounts paid in settlement of any claims approved by the Employer ("**Losses**") caused by or arising from any act or failure to act that is, or is alleged to be, a breach of such person's responsibilities in connection with the Plan (under ERISA or any other law), unless such Losses are determined to be due to such person's negligence or willful misconduct.

Reliance on Other Information: In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by, or in accordance with the instructions of, the applicable Claims Administrator, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

Nondiscriminatory Exercise of Authority: Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

Standard of Review: The Plan Administrator shall perform its duties as the Plan Administrator, and in its sole and exclusive discretion shall determine appropriate courses of action in light of the reason and purpose for which the Plan is established and maintained. In particular, except as otherwise stated in this SPD, and except as otherwise provided in the applicable Related Documents, the Plan

Administrator shall interpret all Plan provisions, and make all determinations as to whether any particular Participant or beneficiary is entitled to receive any benefit under the terms of the Plan, which interpretation shall be made by the Plan Administrator in its sole and exclusive discretion.

If, due to an error in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive discretion, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a manner consistent with its intent, as determined by the Plan Administrator in its sole discretion in accordance with the *Specific Responsibilities and Authority of the Plan Administrator* provisions above. The Plan shall be amended retroactively to cure any such ambiguity. Neither the *Specific Responsibilities and Authority of the Plan Administrator* provisions above, nor any other provision of this SPD, may be invoked by any person to require the Plan to be interpreted in a manner that is inconsistent with its interpretation by the Plan Administrator. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review and shall be entitled to the maximum deference permitted by law.

Miscellaneous Terms

No Employment Rights: Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any employee, nor a guarantee of any employee to be continued in the employment of the Employer, nor as a limitation on the right of the Employer to discharge any of its employees with or without cause.

No Guarantee of Tax Consequences: Notwithstanding any other provision in this SPD, the Employer neither ensures nor makes any commitment or guarantee that any amounts paid to a Participant pursuant to the Plan or any amounts by which a Participant's wages are reduced to pay for benefits under the Plan will be excludable from the Participant's gross income or wages for federal, state or local tax purposes.

Exclusive Benefit: The Plan shall be maintained for the exclusive benefit of the Participants and their beneficiaries. No individual shall have a right to any benefits under the Plan except as specified in this SPD and the applicable Related Documents, and in no event shall a right to benefits under the Plan be or become vested.

Clerical Error: A clerical error by the Employer or Plan Administrator shall not invalidate coverage otherwise validly in force, nor continue coverage otherwise validly terminated.

Right to Offset Future Payments: In the event a payment by the Plan or the amount of a payment by the Plan is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous payment. This right to offset shall not limit the right of the Plan or the benefit program to recover an erroneous payment in any other manner permitted by law.

Right to Recover Payments: In the event a payment is made by the Plan with respect to covered items or services, in an amount in excess of the amount necessary to satisfy the Plan's obligation, the Plan shall have the right to recover the excess amount directly from the person to or for whom the payment was made. This right of recovery does not limit the Plan's right to recover an erroneous payment in any other lawful manner.

Misrepresentation or Fraud: A person who receives a Benefit under the Plan as a result of false information or a misleading or fraudulent representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees. Further, the Employer retains the right to suspend and/or cancel future participation in the Plan and/or impose additional disciplinary action, as deemed appropriate by the Employer.

Statement of ERISA Rights

As a Participating Employee in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participating Employees (and participating former employees) shall be entitled to:

- Receive Information About Your Plan and Benefits:
  - Examine without charge, at the Employer's principal office or other locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
  - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may impose a reasonable charge for the copies.
  - Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator is required by law to furnish each Participating Employee (or participating former employee) with a copy of the summary annual report.

- Continue Group Health Plan Coverage:
  - Continue, to the extent COBRA applies, health care coverage for yourself, your Participating Spouse and/or your Participating Children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Participating Spouse and/or your Participating Children may be required to pay for such coverage. Review this SPD and the applicable Related Documents for additional details about the rules governing your COBRA Continuation Coverage rights, if applicable.
- Prudent Actions by Plan Fiduciaries:
  - In addition to creating rights for Participants in the Plan, ERISA imposes duties on those who are responsible for the operation of the Plan. The people who operate the Plan, called Plan "fiduciaries," have a duty to act prudently and in the interests of you and other Participants and beneficiaries of the Plan. No one, including the Employer or any other person, may fire

you or discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

- Enforce Your Rights:
  - If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
  - Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of the Plan document or the latest annual report (Form 5500), if any, from the Plan and do not receive the requested documentation within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay a penalty to you (of up to $110 for each day beyond 30 days) until you receive the materials, unless the materials were not sent because of a reason outside the control of the Plan Administrator.
  - If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Pan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.
  - If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or entity 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 to be frivolous.
- Assistance with Your Questions:
  - If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you may contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Employer has executed this Summary Plan Description as of the effective date set forth above.

BROWN INVESTMENT PROPERTIES INC.

By: _____

Printed Name: Jon Dyer

Title: HR Manager