SOUTHEASTERN FREIGHT LINES, INC.
INSURANCE PLAN

Amended and Restated
Effective January 1, 2024

**THIS BOOKLET IS NOT A CONTRACT,
EITHER EXPRESS OR IMPLIED.**

This booklet, which incorporates by reference the applicable insurance policies, certificates of coverage, and component plan benefit booklets, serves as both the official plan document and the Summary Plan Description (SPD) for Southeastern Freight Lines, Inc. Insurance Plan (Plan), which is generally effective as of January 1, 2024.

Southeastern Freight Lines, Inc. (Company) reserves the right to amend, suspend or terminate the Plan or any of the benefits thereunder at any time and for any reason. If any such amendment, modification, or termination results in a material reduction of benefits, the Company will notify you and/or your beneficiary(ies) of the adoption of the amendment, modification, or termination.

Only the Company, the Plan Administrator or the designated claims fiduciary is authorized to interpret the Plan and will do so only in writing. You should not rely on any representation—whether verbal or in writing—that any other individual may make concerning Plan provisions and your entitlement to benefits under the Plan.

Southeastern Freight Lines, Inc.
420 Davega Road
Lexington, SC 29073
(803) 794-7300

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Other required notices, including, but not limited to, the Marketplace Notice, the CHIP Notice, the Medicare Part D Notice of Creditable Coverage, and HIPAA Notice of Privacy Practices are available on our microsite at https://www.benefitsquest.com/sefl/. You should refer to our microsite for that important additional information.

IMPORTANT Information

This booklet, which incorporates by reference the applicable insurance policies, certificates of coverage, and component plan benefit booklets, serves both as the official plan document and as the SPD for the Plan. The Employer intends for this Plan to serve as the single plan through which all of the Employer's welfare benefits that are governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA) are offered. The Employer also intends for this Plan to satisfy the requirements for a cafeteria plan as set forth in Section 125 of the Internal Revenue Code of 1986, as amended (Code). The following component plan benefits are offered under the Plan to eligible employees of Southeastern Freight Lines, Inc.:

Medical Benefits, including Prescription Drug Benefits
Dental Benefits
Vision Benefits
Health Savings Account
Healthcare Flexible Spending Account
Dependent (Daycare) Flexible Spending Account
Long-Term Disability Benefits
Life & Accidental Death & Dismemberment Benefits (Basic)
Supplemental Life Benefits
Supplemental Accidental Death & Dismemberment Benefits
Critical Illness Benefits
Supplemental Short-Term Disability Benefits
Accident Benefits
Hospital Indemnity
Employee Assistance Program (EAP)

Except as otherwise provided herein or in an Appendix hereto, in the event of a conflict between the benefits information in this booklet, if any, and the applicable insurance policies, certificates of coverage or other component plan benefit booklets, such insurance policy, certificate of coverage or other component plan benefit booklet will prevail. Copies of the insurance policies, certificates of coverage and other component plan benefit booklets are available through the Plan Administrator.

This booklet includes information about the administration of the benefits under the Plan and your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA). Except as otherwise provided herein, this booklet and the applicable insurance policies, certificates of coverage or other component plan benefit booklets replace all plan documents and SPDs previously issued with regard to the Plan.

To the extent a component plan benefit is not subject to ERISA (for example, the Health Savings Account benefit or Dependent (Daycare) Flexible Spending Account Plan benefit), its inclusion in this booklet is for informational purposes only and will not serve to subject such benefit to ERISA.

Plan Sponsor

The Plan Sponsor for the Plan is the Company.

The Internal Revenue Service assigns every employer a Company Identification Number (EIN). The Plan Sponsor's EIN is 57-0301199. If you need to write to a government agency about the Plan, use this number along with the Plan name, Plan identification number, and the Plan Sponsor's name.

Plan Administration, Funding, Expenses, Other Provisions

■ Plan Administrator

The Southeastern Freight Lines, Inc. Administrative Steering Committee is the Plan Administrator with respect to the Plan. You can contact the Plan Administrator at the following address: 420 Davega Road, Lexington, SC 29073. The telephone number is (803) 794-7300.

The Company provides indemnification against liability, costs, and expenses incurred by any employee or member of a board of directors or trustees of the Company acting as a Plan fiduciary other than those that may result from the gross negligence, willful misconduct, or deliberate breach of fiduciary duty of that person. This indemnification is in addition to any other rights of the fiduciary. Fidelity bonds cover Plan fiduciaries and other parties having authority to handle Plan funds to the extent required by ERISA Section 412 or other applicable law.

Employees, officers, directors, and agents of the Company shall not be personally liable for any action taken in good faith in reliance on any tables, valuations, certificates, or reports furnished by any duly appointed advisor to the Plan, such as an actuary, accountant, legal counsel, and/or physician.

■ Discretionary Authority of Plan Administrator and Plan Fiduciaries

The Plan Administrator has the full and discretionary authority and power to administer and construe the Plan (and any component plans there under) except to the extent that such powers have been delegated, such as to an administrator for claims determinations. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

- Allocate fiduciary responsibilities and designate one or more persons to carry out those responsibilities
- Designate agents to carry out responsibilities other than fiduciary responsibilities
- Employ legal, actuarial, medical, accounting, clerical, and other assistance as it may deem appropriate in carrying out the terms of the Plan
- Perform or cause to be performed anything necessary, appropriate, or convenient in the administration of the Plan
- Except as otherwise provided below, to interpret and construe the provisions of the Plan, to decide all questions that arise including any dispute which may arise regarding the rights of participants and beneficiaries under the Plan, which determinations shall be final and conclusive on all persons claiming benefits under the Plan; provided, however, that if an insurance certificate or benefits booklet sets forth a specific claims procedure, such provisions shall apply for purposes of that component plan, consistent with the “Claims and Appeals Procedures” section below; and
- To make and enforce such rules and regulations as it may deem necessary or proper for the efficient administration of the Plan.

For component plans provided through insurance, the insurance company, not the Company or the Plan Administrator, is responsible for paying the actual cost of eligible claims you and your dependents incur. The insurance company providing such benefits has the full and final discretionary authority to interpret the component plan terms, determine benefit eligibility and is responsible for ensuring that claims are paid according to the provisions of the component plan. Such determinations shall be final and conclusive on all persons claiming such benefits.

■ Type of Administration

The Plan Administrator has delegated authority under the Plan to the respective insurance company or third party administrator to administer benefit claims under the applicable component plan. The Plan Administrator may designate different administrators from time-to-time, at the Plan Administrator's discretion. The administrator for claims determinations for each benefit is identified in the chart in the Summary Plan Information section below. The Plan Administrator administers the Plan for the exclusive benefit of participants and beneficiaries.

■ Funding of Insured Benefits

The Company pays premiums to the applicable insurance company for the insured component benefits under the Plan. For some insured benefits, you may be required to contribute all or a portion of the cost of these premiums through payroll deductions. The insurance companies, not the Company or the Plan Administrator, are responsible for paying the actual cost of eligible claims you and your dependents incur under the insured component program. The Plan Administrator has delegated to these insurance companies the full authority to administrator and make final determinations concerning all claims for benefits and appeals of denied claims for benefits.

■ Plan Expenses

All fees and reasonable expenses incurred by the Plan, to the extent payable from the assets of the Plan as permitted by ERISA, shall be an expense of the Plan. Notwithstanding the foregoing, the Company reserves the right to either pay the administrative costs directly or allocate and reallocate administrative costs between the Company and participants in the Plan.

■ Clerical Errors

Any clerical or similar error in keeping pertinent records or a delay in making an entry will not invalidate coverage or otherwise validate in force or continue coverage otherwise validly terminated. An equitable adjustment will be made when the error or delay is discovered.

■ Misrepresentation or Fraud

If a Plan participant or a person eligible for coverage under the Plan makes any intentional misrepresentations or uses fraudulent means in applying for coverage, making a change in their existing coverage election, or filing a claim for benefits, his or her coverage may be subject to immediate termination of coverage, recoupment by the Plan of erroneously paid expenses based on the misrepresentation or fraud, and other remedies available to the Plan Administrator at law and in equity, including retroactive rescission of coverage. For purposes of this section, a participant's failure to inform the Plan Administrator of status changes that would affect coverage (such as participant's divorce) will be considered an intentional misrepresentation.

■ Limitations on Actions

Notwithstanding the provisions of any applicable insurance policies, certificates of coverage or other component plan benefit booklets, any claims or action filed in court against or with respect to the Plan, the Plan Administrator, or the Plan Sponsor must be started within the following timeframes:

- Claims for benefits (including eligibility) cannot be started before all internal administrative claims and appeals procedures have been exhausted.

- A participant, beneficiary or alternate payee (collectively referred to as "Claimant" in this section) seeking judicial review of an adverse benefit determination under the Plan, whether in whole or in part, must file any suit or legal action (including, without limitation, a civil action under Section 502(a) of ERISA) within 12 months of the date the final adverse benefit determination is issued. Notwithstanding the foregoing, any Claimant that fails to engage in or exhaust the claims and review procedures must file any suit or legal action within 12 months of the date of the alleged facts or conduct giving rise to the claim (including,

without limitation, the date the Claimant alleges he or she became entitled to the Plan benefits requested in the suit or legal action). Nothing in this Plan should be construed to relieve a Claimant of the obligation to exhaust all claims and review procedures under the Plan before filing suit in state or federal court. A claimant who fails to file such suit or legal action within the 12 month limitations period will lose any rights to bring any such suit or legal action thereafter.

- All other claims with respect to any fully insured benefit must be filed within the same time period specified by the insurance company in the applicable insurance policies, certificates of coverage or other component plan benefit booklets.

Any claim or action not started within the above timeframes will be void and forfeited.

■ Acceptance and Cooperation

Any individuals seeking or accepting benefits under the Plan are considered to have accepted its terms. All individuals claiming any interest in or benefits from the Plan agree to perform any act and to execute any documents that may be necessary or desirable to carry out the Plan or any of its provisions.

■ Governing Law

The Plan is to be interpreted under federal law, including ERISA, and under the laws of the State of South Carolina, to the extent state law is not preempted.

■ Third Party Beneficiaries; Assignment

The Plan is not intended to benefit any person other than covered individuals. Other than direct payment to health care providers, and except as may otherwise be required in applicable insurance policies, certificates of coverage or other component plan benefit booklets or documents (but only to the extent permitted by applicable law), a covered individual cannot assign or alienate (voluntarily or involuntarily) the covered individual's rights under or interest in the Plan. Any such attempt to assign or alienate these rights or interests is void. In no event shall any assignment of benefits be construed to confer status as a participant or a beneficiary, or to confer standing to sue whether in a direct or representative capacity.

■ Coordination of Benefits (COB)

Subject to the terms of the insurance policies, certificates of coverage or other component plan benefit booklets, if you or an eligible child are covered by any other group plan (for example, if your child has coverage through this plan and your spouse's employer's plan), benefits from this Plan and the other plan will be "coordinated." That means the benefits you receive from this plan, when combined with benefits from all other group plans, will not add up to more than 100% of the eligible expense for the covered service.

Plan Limitations

Nothing contained in the benefit documents or this booklet creates any employment contract or in any way alters the Company's policy and practice of employment at will contained in the Company's employment application, handbook and/or policy manuals.

Plan Continuance and Amendment or Termination

The Plan Sponsor reserves the right at its discretion to amend or terminate the Plan, or any provision, benefit coverage or contribution under any component plan, at any time, for any reason, prospectively or retroactively. Contributions, premium rates, deductibles, out-of-pocket maximums, benefit levels, covered benefits, and other plan features may be affected. Such changes may affect any or all participants, including active and inactive retired

employees. Notwithstanding the foregoing, no verbal statement made by anyone involved in administering this plan, or any other employee of the Company or a Plan vendor, can waive any of the terms or conditions of this Plan or prevent the Company enforcing any provision of this Plan. Waivers are valid only if they are contained in a written instrument signed by an authorized individual on behalf of the Company. Any such written waiver will be valid only as to the specific plan, term or condition set forth in the written instrument. Unless specifically stated otherwise, a written waiver will be valid only for the specific claim involved at the time and will not be a continuing waiver of the term or condition in the future.

If the Plan is terminated for any reason, you will be notified. You will receive information about converting your health care and group insurance benefits to individual policies wherever conversion privileges apply.

Without limiting any other Plan provisions for the discontinuance of coverage, including but not limited to the provisions of any component plan as provided in the applicable insurance policy, certificate of coverage or other component plan benefit booklet, your coverage will terminate when the Plan Sponsor terminates the Plan, or when you are no longer eligible to receive benefits under the Plan, whichever occurs first. Neither you, your dependents, your beneficiaries, nor any other person have or will have a vested or non-forfeitable right to receive benefits under the Plan.

Plan Records

The records of the Plan are kept on the basis of a "plan year." The Plan Year shall mean the twelve-month period which begins on January 1 and ends on December 31. The Plan Administrator keeps records on all of its proceedings and determines which records are necessary or advisable for Plan administration. The Plan Administrator may also use records of the Company.

Reimbursement, Subrogation and Recovery of Overpayment

As a condition for receiving benefits under the Plan, you, your spouse or any dependent child (each, a "covered person") agree to and grant the Plan the rights of reimbursement, subrogation and recovery of overpayment. To the extent that a benefit booklet or insurance certificate also contains provisions regarding reimbursement, subrogation and/or recovery of overpayment, this section and the applicable provisions of such booklet or certificate both apply so as to grant the Plan the greatest possible rights.

With respect to the right of reimbursement, if a covered person becomes injured or ill because of the actions or inactions of a third party, the Plan shall have the right to recover related Plan expenses out of any payments made by (or on behalf of) the third party (whether by lawsuit, settlement, or otherwise) to a covered person (or his or her assignee). The Plan's right of recovery applies to the extent the Plan has paid expenses related to the injury or illness, regardless of whether any related settlement or other third-party payment states that the payment (all or part of it) is for health care expenses. By accepting Plan benefits to pay for treatments, devices or other products or services related to such injury or illness, a covered person agrees to place such third-party payments in the covered person's separate identifiable account (in an amount equal to related expenses paid by the Plan or, if less, the full third-party payment amount) and that the Plan has an equitable lien on such funds, without regard to whether the covered person has been made whole or fully compensated for the injury or illness. The covered person also agrees to serve as a constructive trustee over the funds until the time they are paid to the Plan. The covered person further agrees to cooperate with the Plan's recovery efforts and do nothing to prejudice the Plan's recovery rights. The Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) incurred in obtaining the funds.

Should it be necessary for the Plan to institute proceedings against the covered person for failure to reimburse the Plan or to otherwise honor the Plan's equitable interest in obtaining amounts described in this Section, the covered person shall be liable for the costs of collection relating to such failure, including reasonable attorney's fees. The Plan shall have the right to offset future benefits to which a claimant (or a covered person through whom the

claimant derives his or her claim) may be entitled, until the amount otherwise due the Plan under this Section, plus interest, has been received by the Plan.

The Plan's rights under this Section shall be enforceable regardless of whether the third party admits liability for the injury or illness to a covered person and shall remain enforceable against the heirs and estate of any covered person.

If for some reason a benefit is paid that is larger than the amount allowed under the plan, the Plan Administrator has the right to recover the excess amount from the person or agency that received it. A person receiving benefits must complete any papers requested by the Plan Administrator that are needed to ensure this right of recovery.

If an overpayment is made to a covered person, the Plan Administrator may withhold future benefit payments from the plan until the overpayment has been collected or, instead, the covered person may be required to reimburse the plan in full for the overpayment.

Unclaimed Benefits

In the event that any self-insured benefit payment under the plan remains unclaimed for one year, or if any check issued to you, your spouse or dependent, or a provider remains uncashed for one year, then such benefit or other entitlement will be forfeited. If the claimant subsequently files a valid claim for the forfeited benefit payment or other entitlement, then such amount will be paid to the claimant, without interest.

Agent of Service for Legal Process

Any legal process against the Plan in the event of an unresolved dispute over benefit plan provisions should be served on the Plan Administrator.

Claims and Appeals Procedures

Claims for Benefits.

If you feel an error has occurred in your records or in processing your claim for benefits, you should know that claims and appeals procedures are available to every participant and beneficiary in the applicable insurance policy, certificate of coverage, booklet or other component benefit plan document. **Your claim(s) for benefits will be processed according to the procedures set out in the applicable insurance policy, certificate of coverage, benefit booklet or other component plan document. In the event no such claims and appeals procedures are included in the applicable insurance policy, certificate of coverage, booklet or other component benefit plan document, or such claims and appeals procedures do not comply with applicable law, the below procedures will apply.**

The Plan Administrator has delegated to the insurance companies of the applicable component benefit plans the full authority, in each case as claims administrator, to administer and make final determinations concerning all claims for benefits and appeals of denied claims for benefits. With respect to any component plan that is a group health care plan subject to the Patient Protection and Affordable Care Act (Affordable Care Act), you also have the right under the Plan to request an external review in accordance with the provisions of the component plan booklet, insurance policy or certificate of coverage.

To the extent that a component plan provides for voluntary levels of appeal, the Plan agrees (i) to waive the right to assert that you failed to exhaust your administrative remedies by not submitting the dispute to the voluntary level of appeal; (ii) that the statute of limitation will be tolled during the time that such voluntary level of appeal is pending;

and (iii) that you may elect to submit the benefit dispute to the voluntary level of appeal only after you have exhausted the appeals permitted under Department of Labor regulations.

If the Plan Administrator learns of conflicting benefit claims made by two or more claimants, the benefit may be withheld until the conflict is resolved by one of the following: (a) agreement between the claimants; (b) a final judicial determination of entitlement to benefits; or (c) any other procedure reasonably calculated to protect the Plan from paying the same benefit more than once. If there is both a conflict between claimants and a dispute between one of those claimants and the Plan regarding benefit payment, the Plan Administrator may allow the processing of the request for benefits under normal appeal procedures before resolving the conflict between claimants.

Claims Regarding Plan Eligibility.

Claims for eligibility will normally be approved or denied by the Plan Administrator within 90 days after they are received. If your claim is denied, the written notice you receive will tell you why it was denied and will refer to the Plan provisions upon which the decision was based. The notice will also tell you about any additional information which may be necessary for your claim to be approved.

You may appeal the denial of your claim by writing the Plan Administrator and stating that you wish to appeal. The Plan Administrator will consider your written appeal provided it is received no more than 30 days after you have received notice of the denial of your claim. You may submit written comments, documents, records, and other information relating to your claim.

If you appeal, the Plan Administrator will review your appeal and any additional information you furnish. Normally the Plan Administrator will decide your appeal within 60 days after it is received. In unusual circumstances, it may be necessary to delay the final decision of your appeal for an extra 60 days. You will be notified of any delay within 60 days after your appeal is received. After your appeal is decided, the Plan Administrator will tell you both how it was decided and what Plan provisions the Plan Administrator relied upon.

Medical Claims.

Medical Benefit claims shall be processed according to the procedures set out in the applicable Medical Benefit booklet or other component plan document.

Disability Claims

Disability claims shall be processed according to the procedures set out in the applicable insurance policy, certificate of coverage, benefit booklet or other component plan document.

All Other Claims

These procedures are intended to meet ERISA requirements set forth in DOL Regulation §2560.503-1 and will be interpreted in accordance with such regulations. The procedures are designed to ensure that claimants are not unduly inhibited from making claims; that claimants may appoint an authorized representative in accordance with Plan rules; determinations will be made in accordance with the Plan documents; and that Plan provisions are applied consistently.

The Plan may offer additional voluntary appeal and/or mandatory arbitration procedures other than those described here. If applicable, the Plan will not assert that a claimant has failed to exhaust administrative remedies for failure to use the voluntary procedures, any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending; and the voluntary process is available only after exhaustion of the appeals process described in this section. If mandatory arbitration is offered by the Plan, the arbitration must be conducted instead of the appeal process described in this section, and the claimant is not precluded from challenging the decision under ERISA §501(a) or other applicable law.

The “claimant” refers to you, your authorized representative, or anyone else entitled to benefits under the Plan (such as a beneficiary).

For purposes of these procedures, a document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

How do I submit a claim for Plan benefits?

You may file a claim for benefits by submitting a written request for benefits to the Plan Administrator. You should contact the Plan Administrator to see if there is an applicable distribution form that must be used. If no specific form is required or available, then your written request for a distribution or a written assertion that your benefits under the Plan have been determined incorrectly, will be considered a claim for benefits.

Decisions on the claim will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days. If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

Initial Claims

A claim must be resolved, at the initial level, within 90 days of receipt by the Plan. A Plan may, however, extend this decision-making period for an additional 90 days for reasons beyond the control of the Plan. The Plan will notify the claimant of the extension prior to the end of the initial 90-day period, explaining the circumstances requiring the extension and the date the Plan Administrator expects to render a decision to the claimant. It will explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues.

In the case of claims for benefits under the Healthcare FSA, a claim must be resolved, at the initial level, within 30 days of receipt by the Plan. A Plan may, however, extend this decision-making period for an additional 15 days for reasons beyond the control of the Plan. The Plan will notify the claimant of the extension prior to the end of the initial 30-day period, explaining the circumstances requiring the extension and the date the Plan Administrator expects to render a decision to the claimant. It will explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues.

The claimant will have 45 days from the date of receipt of the Plan Administrator’s notice to provide the information required.

What if my benefits are denied?

If the Plan Administrator determines that all or part of the claim should be denied (an "adverse benefit determination"), it will provide a notice of its decision in written or electronic form explaining the claimant's appeal rights. An "adverse benefit determination" also includes a rescission, which is a retroactive cancellation or termination of entitlement to disability benefits. The notice will be provided in a culturally and linguistically appropriate manner and will state:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination was based.

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

(e) In the case of a claim for reimbursement of medical expenses under the Healthcare FSA, if the denial is based on an internal rule, guideline, protocol or other similar criterion, a statement that such rule, guideline, protocol or criterion was relied upon in making the denial and that a copy of it will be provided free of charge to you upon request.

(f) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Review of Adverse Benefit Determinations

When a claimant receives a notice of an adverse benefit determination, the claimant may request a review of the decision. The request must be in writing and must be filed within 180 days following receipt of the notice. In the case of an adverse benefit determination regarding a rescission of coverage, the claimant must request a review within 90 days of the notice. The claimant or his authorized representative may submit written comments, documents, records, and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be considered by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the initial adverse benefit determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was neither involved in or subordinate to the person who made the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Plan considers, relies upon or creates any new or additonal evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to the claimant, free of charge, as soon as

possible and sufficiently in advance of the time within which a determination on review is required to allow the claimant time to respond.

Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, the claimant must be provided a copy of the rationale at no cost to the claimant. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the claimant time to respond.

The claimant will be notified of the determination on review of the claim no later than 45 days after the Plan's receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, the claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify the claimant of the determination on review no later than 90 days after receipt of the request for review.

Notice of Adverse Benefit Determination on Review

The Plan Administrator shall provide written or electronic notification to the claimant or his authorized representative in a culturally and linguistically appropriate manner. If the initial adverse benefit determination is upheld on review, the notice will include:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination was based.

(c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

(d) A statement of claimant's right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to claimant's right to bring such an action, a statement to that effect which includes the calendar date on which such limitation expires on the claim.

If the Plan offers voluntary appeal procedures, a description of those procedures and the claimant's right to obtain sufficient information about those procedures upon request to enable the claimant to make an informed decision about whether to submit to such voluntary appeal. These procedures will include a description of the claimant's right to representation, the process for selecting the decision maker and the circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on the claimant as part of the voluntary appeal. A claimant's decision whether to use the voluntary appeal process will have no effect on the claimant's rights to any other Plan benefits.

(e) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

- the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or

- a disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.

(f) If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination,

applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(g) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

Your Rights Under ERISA

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

■ Your Right to Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

■ Your Right to Continue Group Health Plan Coverage

Under ERISA, you are entitled to:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Appendix entitled “COBRA Continuation Coverage” and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

■ Your Right to Prudent Actions by Plan Fiduciaries

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

■ How to Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and

pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits, which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

■ Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-275-7922 or go to www.dol.gov/ebsa.

Summary Plan Information

Official Plan Name:	**Southeastern Freight Lines, Inc. Insurance Plan**
Plan Sponsor	Southeastern Freight Lines, Inc. 420 Davega Road Lexington, SC 29073 (803) 794-7300 EIN: 57-0301199
Plan Administrator	Administrative Steering Committee Southeastern Freight Lines, Inc. 420 Davega Road Lexington, SC 29073 (803) 794-7300 EIN: 57-0301199
Agent for Service of Legal Process	Southeastern Freight Lines, Inc. Attn: Vice President of Legal Services 420 Davega Road Lexington, SC 29073 (803) 794-7300
Plan Number:	**511**
Type of Plan:	Welfare benefit plan, with the following component plan benefits: Medical Benefits, including Prescription Drug Benefits Dental Benefits Vision Benefits Health Savings Account Healthcare Flexible Spending Account Dependent (Daycare) Flexible Spending Account Long-Term Disability Benefits Life & Accidental Death & Dismemberment Benefits (Basic) Supplemental Life Benefits Supplemental Accidental Death & Dismemberment Benefits Critical Illness Benefits Supplemental Short-Term Disability Benefits Accident Benefits Employee Assistance Program ***To the extent a component plan benefit is not subject to ERISA (for example, the Health Savings Account benefit, or Dependent (Daycare) Flexible Spending Account Plan benefit), its inclusion in this booklet is for informational purposes only and will not serve to subject such benefit to ERISA.***

Component Benefit	***Type of Financing and Administrators for Claims Determinations***
Medical Benefits, including Prescription Drug Benefits	*Self Insured Medical Benefits:* Administrator for claims determinations*: Quantum Health 855-576-9984 www.myseflbenefits.com *Self Insured Prescription drug benefits:* Administrator for claims determinations: Optum 855-576-9984 www.myseflbenefits.com
Dental Benefits	Self Insured *Administrator for claims determinations*: Delta Dental of Missouri 1-800-392-1167 www.deltadentalmo.com
Vision Benefits	Fully Insured *Administrator for claims determinations*: EyeMed 1-855-264-9912 www.eyemed.com
Health Savings Account	*Administrator for claims determinations*: HSA Bank 1-800-357-6246 www.hsabank.com
Healthcare Flexible Spending Account	*Administrator for claims determinations*: Flores and Associates 1-800-532-3327 www.flores247.com
Dependent (Daycare) Flexible Spending Account	*Administrator for claims determinations*: Flores and Associates 1-800-532-3327 www.flores247.com
Long-Term Disability Benefits	Fully Insured *Administrator for claims determinations*: Metropolitan Life Insurance Company 1-800-438-6388 www.metlife.com/sefl

Component Benefit	***Type of Financing and Administrators for Claims Determinations***
Life and Accidental Death & Dismemberment Benefits (Basic)	Fully Insured *Administrator for claims determinations*: Securian 1-866-293-6047 www.lifebenefits.com
Supplemental Life Benefits	Fully Insured *Administrator for claims determinations*: Securian 1-866-293-6047 www.lifebenefits.com
Supplemental Accidental Death & Dismemberment Benefits	Fully Insured *Administrator for claims determinations*: Securian 1-866-293-6047 www.lifebenefits.com
Critical Illness Benefits	Fully Insured *Administrator for claims determinations*: Voya 1-855-663-8692 https://presents.voya.com/EBRC/SEFL
Supplemental Short-Term Disability Benefits	Fully Insured *Administrator for claims determinations*: Metropolitan Life Insurance Company 1-800-438-6388 www.metlife.com/sefl
Accident Benefits	Fully Insured *Administrator for claims determinations*: Voya 1-855-663-8692 https://presents.voya.com/EBRC/SEFL
Hospital Indemnity	Fully Insured *Administrator for claims determinations*: Voya 1-855-663-8692 https://presents.voya.com/EBRC/SEFL

Component Benefit	*Type of Financing and Administrators for Claims Determinations*
Employee Assistance Program (EAP)	Fully Insured *Administrator for claims determinations*: LifeWorks 1-888-319-7819 www.metlifeeap.lifeworks.com user name = metlifeeap password = eap

Participants should review the applicable insurance policies, certificates of coverage or other component plan benefit booklets for additional contact and other information.

**** Special Note About Medical Benefits Claims Processing: Your medical providers also need to communicate with the Plan. The Plan has partnered with Quantum Health to work together with BlueCross BlueShield of South Carolina (BCBSSC) in administering claims under the Plan. Quantum Health will confirm your Medical Benefits for providers and also preauthorize the payment for medical expenses, including mental health and substance abuse claims. Quantum Health will communicate these decisions and exchange information with the Medical Benefits claims administrator so that your Medical Benefits claims can be paid. By enrolling in coverage, you acknowledge that you understand when you consent to a providers' sharing medical information with the Plan for payment purposes, you are providing that access to all of the Plan's partners who are involved in the administration of claims, including Quantum and BCBSSC.***

APPENDIX – Eligibility for Coverage, Commencement and Termination of Coverage

■ Employee Eligibility

Subject to any limitations included in the insurance policies, certificates of coverage or benefit booklets, you are eligible to participate in the Plan if you meet the eligibility conditions for one or more component plans. Very generally, participation is limited to "full-time" employees residing in the United States, who are not ineligible as described below. The definition of "full-time" varies for the component plans.

- **General Eligibility Rule.** Except as provided below, only those employees who are expected to work at least 40 hours a week or who are designated or treated as "full-time" under the Employer's normal practices are eligible to participate in the component plans and thereby the Plan.

- **Special Eligibility Rule For Medical, Dental, and Vision Benefits (collectively, the "Health Benefit" for purposes of this Appendix).** Only for purposes of the Health Benefit component plans, "full-time" employees who are eligible to participate also includes those variable hour employees who the Plan Administrator has determined in accordance with rules and procedures adopted in conformity with regulations issued under the Affordable Care Act has averaged 30 or more hours per week during the Employer's previous measurement period. Notwithstanding the foregoing, if you are considered a "full time" employee for purposes of the Affordable Care Act based on the Company's determination in its sole discretion, you will be eligible to participate in the Health Benefit component plans for as long as you are considered a full-time employee under the Affordable Care Act, even if your expected hours per week are fewer than 30.

- **Special Eligibility Rule for Health Savings Account and Flexible Benefit Account Benefits. HSA-Eligible Individuals.** An employee who satisfies the eligibility conditions for participation in the Medical Benefit component plan also is eligible to elect the Heath Savings Account (HSA) benefit, but only if the associate is an HSA-Eligible Individual. Only HSA-Eligible Individuals are eligible to elect the HSA benefit. You are an "HSA-Eligible Individual" if you are eligible to contribute to an HSA under the tax laws, elect coverage under the Employer's high deductible health plan option (which the Employer refers to as "HSA Plan"), and do not elect any disqualifying coverage (such as the Employer's Healthcare FSA benefit).

  Also, in spite of the above rules, persons who are 2% shareholders (as defined in the Internal Revenue Code) are not eligible to participate in the Flexible Benefits Plan or the available Flexible Spending Accounts (FSA). Those employees who have elected to participate in the HSA Plan are not eligible to participate in the Healthcare FSA. Associates who have elected an HSA may not also elect to participate in the Healthcare FSA. Associates who are considered to be "highly compensated participants" are not eligible to participate in the Dependent (Daycare) FSA.

■ Waiting Period

In general, there is a waiting period of 30 days following your date of hire (or promotion into a full-time position) to participate in the Plan.

■ Ineligible Employees

In addition to the ineligible employees described above who do not satisfy the eligibility conditions for participation, the following employees are not eligible to participate in the component plans described in this booklet:

- **Part-Time, Temporary, or Seasonal Employees.** Employees who are designated or treated as "seasonal" under the Employer's normal practices, as well as employees designated or treated as "part-time," or "temporary" unless these part-time or temporary employees are eligible under the Special Eligibility Rule for the Health Benefit described above.

- **Puerto Rico Employees.** Persons whose normal work site is located in Puerto Rico, except as otherwise provided in the applicable insurance policy, certificate of coverage, benefit booklet or component benefit plan.

- **Union Employees.** Persons who are subject to a collective bargaining agreement.

- **Related Employer Employees.** Persons employed by any employer who is related to the Employer pursuant to Sections 414(b), 414(c), 414(m) or 414(o) of the Code.

- **Leased, Payroll Service or Agency.** A leased, payroll service or agency employee means an individual (a) for whom the direct payor of compensation with respect to the performance of services for the Company or an affiliated employer is any outside entity, including but not limited to a payroll service or temporary employment agency, rather than by the Company's internal payroll system; or (b) who is paid directly by the Company, but not through an internal corporate payroll system (e.g., through purchase order accounts); or (c) designated by the Company as an independent contractor, either through the terms of an agreement with such individual or otherwise. The determination whether an individual is a "payroll service or agency employee" shall be made by the Company, in its sole discretion, based solely upon these criteria, without regard to whether the individual is considered a common law employee of the Company or an affiliated employer for any other purpose. Any independent contractor or any other ineligible individual who is reclassified by a court, administrative agency or other party as an eligible employee will not be considered an eligible employee for periods before the Company implements the reclassification decision, even if the decision applies retroactively for other purposes.

■ Enrollment

In order to participate in any of the component plans under the Plan, you must timely complete and submit the applicable enrollment materials (either electronically or in paper, as required by the Plan Administrator in accordance with applicable law) and satisfy any other enrollment requirements for the component benefit.

- Associates must enroll for the Health Benefit within 30 days of the date the Associate first satisfies the eligibility conditions (i.e. becoming a Full-Time Associate). All supporting documentation (e.g., marriage license, birth certificate, etc.) must be provided within 60 days of the date the Associate first satisfies the eligibility conditions. The Employer uses

Workday, an online benefits portal located at www.myworkday.com/sefl/, both for enrollments and the provision of supporting documentation. Information as to how to reach the online benefits portal is provided to Associates at their work location and may also be requested by contacting the Employer's Benefits Department.

- The Plan Administrator or its designee, or an administrator of claims has the right to request information needed to determine or confirm an individual's eligibility for benefits under this Plan.

- You may re-enroll in the next regular election period. For each Plan Year, the regular election period will be the period preceding each January 1st that is designated by the Plan Administrator. If you experience a change in status event or other event that the Plan treats as allowing an election change, or you qualify for special enrollment under HIPAA, you will have a special election period beginning on the date of the change in status, other event, or HIPAA special enrollment event, and ending 60 days later.

- If you do not complete the re-enrollment process, your pre-tax insurance premium benefit election will remain in effect. However, you will not be enrolled in the Healthcare FSA, the Dependent (Daycare) FSA, or the HSA.

■ Commencement of Coverage

- If you have completed enrollment within 30 days from the date you first satisfy the eligibility conditions, coverage generally will be effective on the first day of the payroll period coincident with or next following the completion of the waiting period, except as otherwise provided in the applicable insurance policy, certificate of coverage, benefit booklet or component benefit plan. Except as provided immediately below, if you are not in "active service" on the day the Health Benefit is to begin, you will not be covered until the day you return to work doing the regular duties of your job.

- For purposes of this paragraph, you will be considered engaged in "active service":

    - On any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.

    - On a day which is not one of your Employer's scheduled work days if you were in "active service" on the preceding scheduled work day.

    - On any of your Employer's scheduled workdays if you are absent from work due to any health factor.

■ Changes in Status and Coverage Reinstatements.

- If you change your employment status from ineligible to eligible, your participation in the Plan will be effective on the first day of the payroll period after you both satisfy the waiting period and complete the enrollment process. Enrollment must be completed within 30 days of the date of your status change.

- If you do not complete enrollment within 30 days from the date you first satisfy the eligibility conditions, you will have to wait until the next open enrollment period to join the Plan or you experience a status change event.

- If you change your employment status from eligible to ineligible, with respect to any component benefit under the Plan, other than the Health Benefit component plans, and regardless of the eligibility descriptions contained herein, if you experience a change in position from full-time to part-time that would result in your being reasonably expected to average fewer than the minimum required hours per week in service in the new position, you will be considered to be ineligible for coverage under any such component benefits as of the first day of the payroll period following the date of the change in position, except as otherwise provided under the applicable certificates of coverage or benefit booklets.

- If your coverage under a component plan ceases due to your failure to make any required contribution, you will not be permitted to elect any coverage until the next open enrollment period. However, if you are not in active service due to a qualified leave of absence under the Family Medical Leave Act of 1993 at the time you fail to make a required contribution, your Health Benefits will be reinstated when you return to active service, regardless of any eligibility requirements or waiting periods for electing Health Benefits, provided you make the required contribution.

- If your coverage is terminated by reason of your taking a military leave of absence, and you subsequently are reemployed in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA") following the military leave, your Health Benefit will be reinstated when you return to active service, regardless of any eligibility requirements or waiting periods for electing coverage. However, sicknesses or injuries incurred or aggravated during military service will not be covered by the Health Benefit component plan.

- Upon rehire by the Employer, you generally will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. However, if you are rehired in an eligible class while you are receiving continuation coverage under COBRA or USERRA, you may immediately rejoin the Health Benefits component plan without regard to the eligibility waiting period.

■ Individuals with an Employment-Related Common Bond

Notwithstanding the foregoing, as specifically authorized by the Treasury Regulations applicable to the Plan, the Health Benefit also is available to certain individuals having an employment-related common bond with covered employees, as determined in the sole discretion of the Plan Administrator ("Employment-Related Individuals") and their Eligible Dependents. The terms and conditions for such coverage shall be the same as that provided to eligible employees, as applicable, except that Employment-Related Individuals are required to pay the COBRA continuation coverage premium rate for such coverage with after-tax dollars and any employment or service-based eligibility criteria (e.g. working an average of 30 hours per week), does not apply. In no event shall independent contractors of the Company be considered Employment-Related Individuals.

■ Dependent Eligibility

The insurance policies, certificates of coverage or other component plan benefit booklets describe the classes of dependents eligible to participate, as well as the requirements for enrollment, waiting periods, if any, and when coverage commences.

In order to participate in such plan(s), dependents must be timely enrolled. The Plan Administrator or its designee, or an administrator of claims has the right to request information needed to determine or confirm an individual's eligibility for coverage and/or benefits under this Plan at enrollment or any time thereafter.

■ Eligible Dependents for Purposes of Health Benefits

An eligible employee who enrolls in a Health Benefit component plan also may enroll one or more Eligible Dependents, but only if they reside in the United States and submit a valid social security number to the Employer's Benefits Department or such other documentation deemed acceptable from time to time by the Plan Administrator.

- **Eligible Dependent(s):** An individual is an Eligible Dependent if he or she is an eligible, covered employee's Spouse, Child, or Incapacitated Dependent.

  Your Eligible Dependents do not include: other individuals living in the covered Associate's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Associate; any person who is on active duty in any military service of any country; or anyone who is not residing in the United States.

  No one may be considered as an Eligible Dependent of more than one employee. If an individual is eligible for coverage by more than one employee, only one employee may cover that Eligible Dependent.

- **Child:** An individual is a Child, up to the limiting age of 26 years old, if he or she is:

  - an eligible employee's natural child, adopted child, step-child or foster child;
  - effective May 1, 2021, a child for which you have legal custody or legal guardianship as determined by a court of law. You may only cover a grandchild if you have been granted legal custody or legal guardianship. Proof of custody or guardianship is required; and
  - a child who, under a Qualified Medical Child Support Order, has a right to enroll under the Employer's Health Benefits component plan.

  A Child does not include the spouse of an eligible Child. If a Child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

- **Incapacitated Dependent:** An individual is an Incapacitated Dependent if he or she is a child of the eligible employee, whether a natural child, adopted child, or step-child, who is all of the following:

  1) Covered by the component plan on the child's 26th birthday;
  2) Continuously covered under the component plan following the child's 26th birthday;

3) Unmarried;
4) Incapable of financial self-sufficiency by reason of the child's becoming mentally or physically disabled prior to attaining the age of twenty-six (26); and,
5) Dependent upon the employee for at least fifty-one (51) percent of his or her support and maintenance.

A Child must meet all of these requirements to qualify as an Incapacitated Dependent. The Associate will update these items each year or upon the Plan Administrator's request. A Child who is not incapacitated by the age of 26 will not be covered.

- **Spouse:** A person who has entered into a ceremonially solemnized legal marriage with the covered employee and is recognized as the spouse under the Internal Revenue Code. "Spouse" shall also include a person treated as a Spouse of a covered employee under the terms of the Southeastern Freight Lines, Inc. Health Insurance Plan in effect on December 31, 2003. The Plan Administrator may require documentation proving a legal marital relationship.

■ Changes to Eligible Dependent Status

It is the responsibility of the employee or the employee's covered dependents to notify the Plan Administrator in the event that an individual who is covered as an Eligible Dependent no longer meets the eligibility requirements of the component plan (for example, a spouse being legally separated or divorced from the Associate). This notification must take place within sixty (60) days from the date the dependent no longer meets the eligibility requirements of the component plan.

■ Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order ("QMCSO") is issued for a Child, that Child will be eligible for coverage as required by the QMCSO.

You are required to send your Employer's Benefits Department a copy of the court order for medical child support, which the Benefits Department will review in accordance with the Plan of Benefits' QMCSO procedures included in an Appendix to this Plan to determine whether the medical child support order satisfies the qualification requirements of ERISA. The Benefits Department will notify the proper parties upon the receipt of a medical child support order.

■ Termination of Coverage

In general, the insurance policies, certificates of coverage or other component plan benefit booklets describe when coverage terminates under the respective component benefit plan. Subject to the terms of the insurance policies, certificates of coverage or other component plan benefit booklets, coverage for you and your eligible dependents will end automatically on the first to occur of the following:

- The last day of the period for which the last contribution was made, if a required contribution is not made by the employee when due.

- The last day of the payroll period in which the Employee's employment with the Company terminates or the employee or dependent ceases to be in eligible for the applicable component benefit plan.

- The last day of the payroll period during which you have been absent for more than 26 weeks due to a paid or unpaid leave of absence.

- The date that the Plan or a component benefit under the Plan is terminated by the Company or an insurance company.

- The date you cease to have a valid election in effect.

If earlier, Health Benefits for your eligible dependents will terminate:

- The date dependent coverage is terminated under the component plan;

- The date our election change to terminate coverage is effective; or

- The last day of the payroll period during which you fail to submit acceptable supporting documentation demonstrating that the individual qualifies as an eligible dependent.

Where applicable, however, you may be eligible to continue your coverage under COBRA, FMLA, or USERRA, or to convert to individual coverage.

In addition to the provisions above, your covered dependent's benefits terminate on the date that person no longer meets the definition of dependent, or such later date provided under the applicable insurance policies, certificates of coverage or other component plan benefit booklets. The dependent may be eligible for continuation of coverage under COBRA or other continuation or conversion coverage, as applicable.

If you or your dependent(s) engage in fraudulent conduct or intentionally furnish the Company, a Claims Administrator or other service provider with fraudulent or misleading material information relating to claims or application for benefits, your coverage and that of your dependents may be adversely affected, up to and including termination of your benefits, effective on the date you engaged in fraudulent conduct or intentionally furnished fraudulent or misleading material information, whichever is applicable. You shall be responsible to pay the Company or the applicable carrier, and the Company and applicable carrier may seek to recoup for the cost of previously received services, less any copayments made or fees paid for such services.

If you permit the use of your or any other person's identification card by any other person; use another person's card; or use an invalid card to obtain services, your coverage shall terminate immediately. Any person or dependent involved in the misuse of an identification card will be liable to and must reimburse the Company or the applicable carrier for the cost of services received through such misuse.

APPENDIX – Change in Status

While you are a member of the Plan, you usually will only be allowed to make changes to your elections during the annual Open Enrollment Period, unless you have a "Change in Status." A Change in Status may allow you to enroll, disenroll, or change your benefit elections. However, the change in your election must be consistent with the Change in Status. That is, the change must be on account of and correspond with a Change in Status that affects eligibility for coverage under this Plan, or another employer's plan.

If an eligible employee is terminated from the Company and is rehired by the Company within 30 days of his termination date, the benefit elections in place at the time of his termination will remain in effect until the end of the applicable Plan Year, unless an election change is permissible hereunder. If the rehire date is more than 30 days from the termination date, the eligible employee is treated as a new employee for purposes of making benefit election.

■ Change in Status Events.

Currently, federal law considers you to have a "change in status event" if:

- You get married, divorced, legally separated, or you have your marriage annulled.
- Your covered spouse or child dies.
- You have a child, adopt a child, or have a child placed for adoption.
- Any of the following events change your employment status or that of your spouse or your dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of a cafeteria plan or other employee benefit plan of the employer of you, your spouse, or your dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment status.
- Your dependent satisfies or ceases to satisfy the requirements of an unmarried dependent.
- You, your spouse, or your dependent has a change in place of residence.

Other events may be designated as changes in status events by the Internal Revenue Service in its regulations. You should direct any questions about change in status events to the Plan Administrator. Any change in your election must be consistent with the change in status event and must be made within 60 days of the event.

■ Other Election Change Events

- Change in Cost or Coverage of Benefits other than Healthcare FSA Benefits. You may change an existing election, or make a new election, for the remainder of the Plan Year with respect to your coverage under the pre-tax insurance premium benefit and

Dependent (Daycare) FSA benefit (but not the Healthcare FSA benefit) in the following circumstances:

- If the cost you are charged for a benefit significantly increases or significantly decreases during the Plan Year, you may make a corresponding change in election under the Plan. Changes that may be made include commencing participation in the Plan for a benefit with a decrease in cost, or in the case of an increase in cost, revoking an election for that coverage and either receiving similar coverage on a prospective basis or dropping coverage if similar coverage is not available. In the case of benefits under the Dependent (Daycare) FSA program, the cost change must be made by a dependent care provider who is not your relative.

- If you, your spouse, or dependent have a significant curtailment of coverage under a plan during a period of coverage that is not a loss of coverage, you may revoke your election for that coverage and elect to receive similar coverage on a prospective basis. If you, your spouse, or dependent have a significant curtailment of coverage that is a loss of coverage, you may revoke your election and elect either to receive similar coverage on a prospective basis or drop coverage if no similar option is available.

- If a new benefit option or other coverage option is added to the Plan, or if coverage under an existing benefit or coverage option is significantly improved during the Plan Year, you (whether you previously made an election under the Plan) may revoke your election and elect coverage under the new or improved benefit option on a prospective basis.

- You may make a prospective election change that corresponds with a change made under another employer plan if the other plan permits participants to make mid-year election changes or participants may elect a period of coverage under the other plan that is different from the period of coverage under the Plan.

- You may make a prospective election to add coverage for yourself, your spouse, or dependent if you, your spouse, or dependent lose coverage under any governmental or educational group health plan.

You must change your election within 60 days of the date the Plan Administrator issues written notice of the significant change in cost, curtailment, or coverage of the benefit originally elected or the addition or improvement of a benefit option, or within 60 days of the date of a written notice by a plan administrator of a change in coverage under another employer plan or loss of coverage under a governmental or educational group health plan.

- Judgment, Decree or Order. If you receive a judgment, decree or order resulting from a divorce, legal separation, or change in legal custody, including a Qualified Medical Child Support Order ("QMCSO"), that requires accident or health coverage for your dependent(s), you may be allowed to change your election to comply with the order. You may terminate coverage for a child only if the order requires your spouse, former spouse or other individual to provide coverage for the child and that coverage is, in fact, provided. You must make a new benefit election within 60 days of the date of the judgment, order or decree. Plan participants and beneficiaries can obtain, without charge, a copy of the QMCSO procedures from the group health plan administrator(s).

- Family and Medical Leave Act. If you take leave under the Family and Medical Leave Act ("FMLA"), you may be allowed to change your election of health plan coverage as provided under the FMLA.

- Entitlement to Medicaid or Medicare. If you, your spouse, or your dependent become entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), you may be allowed to cancel or reduce coverage of such person under a health plan. Also, if you, your spouse, or dependent loses eligibility for such coverage, you may be allowed to commence or increase coverage of such person under a health plan.

- Special Enrollment Periods under HIPAA. You can change your elections during HIPAA Special Enrollment Periods. For more information, refer to **APPENDIX – Required Notices.**

■ Company Approval and Determination of the Change in Status

It is important to remember that having a Change in Status does not automatically mean that you may change your election. The IRS has strict guidelines about when mid-year election changes may be made. The Company, in its sole discretion, will determine if you have had a Change in Status and if a requested election change is "consistent" with the Change in Status and consistent with IRS rules, regulations and guidelines. The Company reserves the right to deny any change request that the Company, in its sole discretion, determines is not permitted or appropriate under IRS rules and regulations.

If the Company determines that you have had a Change in Status, but the election change you have requested is not "consistent" with the Change in Status, you will not be allowed to change your before-tax election until the next annual Open Enrollment Period, or special enrollment event, even though you have had a Change in Status.

If you anticipate that for some reason you may want to adjust your contribution amount or cancel your membership in the Plan during the next Plan Year, you should contact the Plan Administrator before making your election to determine if your situation will qualify as a Change in Status.

Again, you may only change your election to make adjustments to your membership that are on account of and consistent with a Change in Status.

■ How to Make the Change Effective

Once a Change in Status occurs, you will have an opportunity to change your before-tax election to make adjustments to your membership that are "consistent" with the Change in Status.

You must make the change by completing a Change in Status Event within 60 days from the Change in Status.

Remember, the change to your election must be completed and returned within 60 days of your Change in Status. If the change to your election is not completed and returned within 60 days of

your Change in Status, you will not be allowed to make the change until your next annual Open Enrollment Period.

■ When the Change is Effective

Election changes are effective as of the date of the election change event. Your payroll deductions will be adjusted as soon as administratively practicable after your election change is processed to reflect the cost of your new Benefit Elections. In the case of Change in Status elections that require Evidence of Insurability (EOI), the change is effective as of the date of the EOI approval.

APPENDIX – Leaves of Absence

Except as provided in the underlying insurance and benefit booklets, this section describes how your coverage will be continued during certain leaves of absence. ***Thus, to know whether you will be eligible to continue coverage during a leave of absence, you must review the terms of the applicable insurance policies, certificates of coverage or component plan benefit booklets.*** If you have any questions, contact the Plan Administrator.

■ Employer-Certified Disability Leave of Absence

In addition to other options that may be available, if you are not actively working for the Employer because you are "disabled" within the meaning of the Employer's short-term disability program, are on an administrative safety leave, or had an injury that is compensable under applicable worker's compensation law take an approved paid leave of absence, and coverage under one or more component benefits is continued, such as under the Family and Medical Leave Act (FMLA), your scheduled payroll deductions will automatically continue during your leave**.** If your paycheck does not cover the amount of any regularly scheduled contribution during your leave, you may make an after-tax payment to make up the difference.

If the full amount of any regularly scheduled contribution is not made within thirty days after it was due, your coverage under the applicable component benefit options under the Plan will be terminated for the remaining period of your leave of absence, retroactive to the last day for which a required contribution was made.

Unless otherwise provided in a component plan document or under applicable law, your coverage under the Plan will generally cease (subject to any COBRA continuation rights or similar) as a result of a leave of absence, whether paid or unpaid, that extends for more than 26 weeks.

■ Other Approved Leaves of Absence

If you are on a temporary lay-off or take an approved leave of absence for reasons other than those described above, your coverage will continue, provided that any required premium payment is paid when due.

In the case of unpaid leave under the FMLA or another job-protected leave, you may elect either to terminate your coverage and to stop making required contributions during your leave, or to continue your coverage if permitted under the terms of the applicable component benefit.

If the full amount of any regularly scheduled contribution is not made within thirty days after it was due, your coverage under the applicable component benefit options under the Plan will be terminated for the remaining period of your leave of absence, retroactive to the last day for which a required contribution was made, and you will not be eligible for reimbursement of any claims incurred while your coverage was terminated.

Unless otherwise provided in a component plan document or under applicable law, your coverage under the Plan will generally cease (subject to any COBRA continuation rights or similar) as a result of a leave of absence, whether paid or unpaid, that extends for more than 26 weeks.

■ Family and Medical Leave Act

Notwithstanding any other provision of this Plan, if you take an approved leave of absence under the FMLA, coverage under the group health plans under this Plan will continue to be made available during such leave period to you and your covered dependents under the same terms and conditions that coverage was made available immediately prior to the commencement of the leave. If you do not wish to continue some or all of these benefits during the FMLA leave, you must inform the Company before the start of the leave. Continuation of coverage also may be available for other component benefits under the Plan. Contact the Plan Administrator for more information.

If you elect to continue your coverage during such a leave period, you must continue to pay any required employee-portion of the cost of the level of coverage elected. Upon returning from an approved FMLA leave, coverage under the Plan will immediately resume regardless of whether you elected to continue coverage during the FMLA leave.

Company Contributions. While you are on an FMLA leave, the Company will continue to make the same contributions toward the cost of coverage continued under the Plan that it would have made had you not taken such leave of absence. The Company will continue to do so until the earlier of the date that (a) you fail to return to work on the expiration of the FMLA leave, or (b) you voluntarily give notice of your intent to terminate employment. For these purposes, you are considered to "terminate employment" when you give oral or written notice of your intent not to return to work due to reasons within your control.

If you voluntarily terminate your employment due to reasons within your control at or before the end of the FMLA leave, the Company shall have the right to be reimbursed by you for any and all contributions the Company has made on behalf of you and your covered dependents during the leave. In this regard, the Company shall have the right to obtain reimbursement from any funds that the Company might otherwise owe you following your voluntary termination, including (but not limited to) (a) any regular or overtime wages, commissions, salary, or bonuses; (b) accrued vacation pay or sick leave pay; or (c) other sources. In addition, the Company shall have the right to pursue reimbursement in a court of law. Regardless of whether or not you return from an FMLA leave, the Company shall be entitled to recover from you any required employee contributions the Company has made on behalf of you and your covered dependents during the unpaid leave to ensure continuity of coverage.

The Company may not recover any of its regular contributions made on behalf of you and your covered dependents for the time you had been on an FMLA leave if your failure to return to employment at the expiration or exhaustion of such leave is due to (a) the continuation, recurrence, or onset of a serious health condition that would entitle you to the FMLA leave; or (b) other circumstances beyond your control (as set forth in the Company's policies and procedures).

Covered Employee. If you choose ongoing coverage during FMLA leave, you must continue to make the same premium payments or contributions that you were making immediately before the leave took effect, as described above.

The obligation to provide ongoing coverage under this Plan for you and your covered dependents on an FMLA leave, if any, ceases if you are more than thirty (30) days late on making a required premium payment; provided, however, that the Company may—at its option—cover your missed payments so that coverage will be uninterrupted. In this event,

the Company's advances may be recovered in the event you voluntarily terminate your employment under circumstances within your control.

■ Military Leave

We will grant a leave of absence to any employee due to military service in the Armed Forces of the United States in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA), and applicable state law. In general, during such a leave of absence under USERRA, you may be eligible to elect to continue group health plan coverage for yourself and your enrolled dependents (if any) for up to 24 months.

More specifically, if you are absent from work for more than 31 days in order to fulfill a period of duty covered by USERRA, you will be treated as having experienced a "qualifying event," as that term is defined under the Plan's COBRA continuation coverage provisions, see below, as of the first day of your absence for such duty. This means that in addition to having the option to elect to continue coverage under COBRA, you will become eligible to elect continuation coverage under USERRA using procedures similar to those required by COBRA. The Plan Administrator or its designee will furnish you with a notice of the right to elect continuation coverage, which will include information about the premiums you will have to pay for such coverage. This notice will allow you the opportunity to elect such coverage for up to 24 months (so long as you continue to be on a leave of absence under USERRA) beginning on the date your USERRA leave commenced. Nothing in the Plan limits your right to continue your coverage under COBRA instead of under this section.

If qualified to continue coverage pursuant to USERRA, you may elect to continue coverage under the Plan by notifying the Plan Administrator and providing payment of any required contribution for the health coverage. The election procedures are same as for COBRA; refer to the COBRA section below for more information. However, only the covered employee who is called to serve in the uniformed services may make an election under USERRA to continue coverage. The employee's spouse and dependent children do not have independent election rights under USERRA. This means that if the employee does not elect continuation coverage under USERRA, his spouse, for example, still may elect continuation coverage under COBRA, but not USERRA. If you do not make your election within 60 days of being provided with the notice mentioned above, you will no longer be eligible to continue coverage under the Plan, except as required by USERRA.

The required contribution will include the amount we normally pay on your behalf if the period of continuation coverage is fewer than 31 days. If not, the required premium will be 102% of the full premium for the level of coverage elected. Premium payments must be made in the same time and manner as those required under COBRA.

If you elect to continue coverage under USERRA, the period of extended group health plan coverage shall run concurrently with the maximum continuation coverage period that may be available under COBRA. Continuation coverage under USERRA will end, however, upon the first to occur of the following: (i) the last day of the 24 month coverage continuation period, (ii) the last day of the period for which timely premium payment is made, (iii) you fail to return to work within the time frame required under USERRA following the completion of your service, or (iv) you lose your rights under USERRA as a result of dishonorable discharge or other conduct under USERRA.

Regardless of whether you continue your health coverage, if you return to your position of employment in the time and manner required under USERRA, your health coverage for you and your enrolled dependents (if any) will be reinstated under the Plan as required under USERRA. No exclusions or waiting period may be imposed on you or your enrolled dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Contact the Plan Administrator for more information regarding your rights under USERRA to continue coverage, as well as reemployment and other rights you may have under USERRA.

APPENDIX – Flexible Benefits Plan (Section 125 Plan) and Flexible Spending Accounts

The Southeastern Freight Lines Flexible Benefits Plan, the Southeastern Freight Lines Dependent Care Flexible Spending Account Plan, and the Southeastern Freight Lines Healthcare Flexible Spending Account Plan (collectively, the Flexible Benefits Plan) was amended and restated herein and expressly made a part of this Plan effective as of January 1, 2021. The Flexible Benefits Plan is intended to satisfy Section 125 of the Internal Revenue Code (Code) and, accordingly, shall be administered in accordance with Code Section 125 and applicable Treasury regulations thereunder. The Flexible Benefits Plan acts as an "umbrella" over several pretax benefit options. Certain benefits such as insurance can be bought with before-tax dollars, providing you with a substantial reduction in cost.

Under the Plan, you will be able to choose benefits that best fit your needs and those of your family. You may purchase benefits or be reimbursed for benefit expenses with a portion of your income before federal income or social security taxes are withheld. The money you set aside is also exempt from most state income taxes and, in some cases, local income taxes. Because your taxable income is reduced, you pay less in taxes--and that can mean more money for you to spend or save.

Elections

Before the beginning of each Plan Year, the Plan Administrator will announce an election period. During the election period, you must complete an election by which you elect to set aside part of your pay to cover your estimated out-of-pocket costs for the benefits offered through the Flexible Benefits Plan for the coming year. Your Employer will set aside the amount you designate before federal and state income taxes and Social Security taxes are calculated. You may choose to forego participation in the Plan in which case your cash compensation will not be affected.

Benefits You May Choose

Employees who are eligible to participate in one or more of the following component plans (the "Flexible Benefits"), excluding persons who are 2% shareholders (as defined in the Internal Revenue Code), shall be eligible to participate in the Plan and may choose to receive your entire salary in cash, or to have your Employer apply a portion of your pretax pay to one or more of the following Flexible Benefits:

- Healthcare FSA.
- Dependent (Daycare) FSA.
- Pretax payment of premiums for the health, dental and vision plans sponsored by your Employer.
- Pretax contributions to your health savings account ("HSA") offered by your Employer.

Your Employer will provide you with information about what other insurance premiums, if any, may be paid under this Plan. You should refer to the Plan's Open Enrollment materials for more information about the normal cost of the available benefits, as well as any applicable discounts or surcharges.

How Your Contributions are Reimbursed

As you incur Qualified Medical Expenses or Qualified Dependent (Daycare) Expenses during the year, you pay for them as they become due. (See the "Qualified Expenses" section of this Summary Plan Description for a description of the requirements of "Qualified Medical Expenses" and "Qualified Dependent (Daycare) Expenses.") Once your claim for reimbursement has been properly filed and approved by the Plan Administrator, you will be reimbursed from the before-tax pay you set aside in your yearly election. Due to the relatively predictable nature of dependent daycare costs, you cannot be reimbursed for those costs unless you have had sufficient before-tax dollars withheld from your pay at the time you submit your claim for reimbursement.

How Your Required Plan Contributions/Insurance Plan Costs are Paid

The amount you designate for pre-tax payment of required plan contributions or insurance premiums is withheld from your before-tax pay and is used to pay your share of the cost of coverage under the group medical plan insurance premiums and other group insurance plans in which you are enrolled. "Cost of coverage" means the amount of your required contributions for the share of the cost you are required to pay for self-insured benefits or the cost of insurance premiums for fully insured benefits.

Advantages of Participation in the Plan

Below is an example of how the Flexible Benefits Plan helps you get the most from your paycheck:

How Your Flexible Benefits Plan Works

Employee's Annual Income: $36,000

	Before Plan	After Plan
Biweekly income	$1,385	$1,385
Minus qualified expenses*	0	300
Taxable income	$1,385	$1,085
Minus withholding taxes**	-295	-205
Net take-home pay	$ 1,090	$ 880
Plus tax-free reimbursements	0	300
Net spendable income	$ 1,090	$1,180
Tax savings		**$ 90**

* Estimated biweekly expenses:	
Dependent day care	$ 125
Medical expenses not covered by another plan	35
Insurance plan premiums	140
Total	$ 300

** Withholding status assumed to be married with one allowance; Social Security and federal withholding.

When may I join the Plan?

If you are an eligible employee, you may join the Flexible Benefits Plan for purposes of the pretax payment of premiums and the HSA benefit on the date you satisfy the eligibility requirements for your group medical or other insurance plan. If you are an eligible employee (as described above), you may join the Healthcare FSA and Dependent (Daycare) FSA components of the Plan on the first Monday coincident with or next following the completion of 30 days of continuous service with the Employer. If you do not join during your initial election period, you must wait until the next regular election period to join, unless you experience a "change in status event" or other qualifying event before the next regular election period or you qualify under the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Except as provided below with respect to the HSA benefits, you may revoke or change an election for Covered Benefit as provided in **APPENDIX – Change in Status.**

When are the election periods for our Plan?

You are required by federal law to choose, during an "election period," whether or not to participate in the Plan. Your *initial election period* will be the 30-day period prior to the date you meet the Plan's eligibility requirements. You may re-enroll in the next regular election period. For each Plan Year, the *regular election period* will be the period preceding each January 1st that is designated by the Plan Administrator. If you experience a change in status event or other event that the Plan treats as allowing an election change, or you qualify for special enrollment under HIPAA, you will have a *special election period* beginning on the date of the change in status, other event, or HIPAA special enrollment event, and ending 60 days later.

What is the enrollment procedure?

During each election period, you should consider what your Qualified Medical Expenses and Qualified Dependent (Daycare) Expenses are likely to be for the coming year. Consider any changes that may occur during the year that may cause your expenses to increase or decrease. Next, decide how much of your salary or wages you want to set aside. Remember, the total amount you determine will be deducted automatically from each paycheck, in equal amounts throughout the year, and set aside for your reimbursement account or applied directly to insurance costs.

To enroll, you must follow the enrollment procedures established by and communicated to you by the Benefits Department. *Enrollment must be completed before the beginning of each Plan Year.* Note that if you decide to participate in the Dependent (Daycare) FSA, you will be required to

provide the name, address, and taxpayer identification number or Social Security number of the dependent care provider.

For more information, refer to **APPENDIX – Eligibility for Coverage, Commencement and Termination of Coverage.**

What happens if my employment ends during a Plan Year?

Subject to applicable COBRA continuation requirements, if you terminate employment, you will be ineligible to participate for the remainder of the Plan Year. Your election will terminate on the last day of the payroll period in which you terminate employment. If you are rehired, you may rejoin the plan when you again satisfy the eligibility requirements. However, if you are rehired within the same Plan Year, you generally may not make a new election until the next regular election period.

You may submit claims for qualified expenses incurred during the year of termination and prior to your termination date to the extent of the balance of amounts withheld prior to your date of termination, less the amount of any benefits previously paid from your reimbursement account(s) during the Plan Year. Claims must be submitted within 90 days of the end of the Plan Year. The Plan Year ends on December 31. Any amounts remaining in your account(s) after the 90th day after the end of the Plan Year will be forfeited.

What happens if I change from full-time status to part-time status during a Plan Year?

Subject to applicable COBRA continuation requirements, if you change from full-time status to part-time status, you will be ineligible to participate in the Healthcare FSA and the Dependent (Daycare) FSA for the remainder of the Plan Year. Your FSA election(s) will terminate on the last day of the payroll period in which you change status.

You may submit claims for qualified expenses incurred during the year of your change of status and prior to your change of status date to the extent of the balance of amounts withheld prior to your date of change of status, less the amount of any benefits previously paid from your FSA(s) during the Plan Year. Claims must be submitted within 90 days of the end of the Plan Year. Any amounts remaining in your account(s) after the 90th day after the end of the Plan Year will be forfeited.

What happens if I go on a leave of absence?

You may continue your participation for up to 26 weeks, provided you make any required contributions when they are due.

If your leave of absence is a paid leave of absence, your pre-tax contributions will continue while you are on your leave of absence. If your leave of absence is an unpaid leave of absence, you must pay any required contributions by pre-payment before going on leave, by after-tax funds while on leave, or by catch-up contributions after returning from leave, as determined by the Plan Administrator and subject to the requirements of applicable law, including the Family and Medical Leave Act of 1993, as amended. For more information, refer to **APPENDIX – Leaves of Absence.**

How are Healthcare FSA and Dependent (Daycare) FSA contributions made?

During each election period, you decide how much of your salary to place in your Healthcare FSA and Dependent (Daycare) FSA or health savings account for the next Plan Year. The money you designate for reimbursement of dependent daycare or medical expenses will be subtracted from your pay (before taxes are calculated) and set aside in a reimbursement account(s). As you incur qualified dependent daycare and medical expenses throughout the Plan Year, you pay them out of your own pocket. Then you may file claims and your Employer will reimburse you with tax-free dollars from the appropriate reimbursement account.

Because you are lowering your taxable income, you save on income taxes and Social Security taxes. Your future Social Security benefits may be reduced at retirement because Social Security taxes are not withheld on your contributions to the Plan. For most people, however, the current tax savings offset any future lower Social Security benefits.

How much may I elect to contribute to the Plan?

During each election period, you should consider what your qualified expenses are likely to be for the coming year. It may be helpful to review your health care and dependent daycare costs for recent years. Also consider any changes that may occur during the coming year that may affect your expenses. Follow these easy steps to calculate your Plan contribution:

Step 1: Select a level of coverage under the designated insurance benefits that best fits your family's needs.

Step 2: Decide how much of your salary you want to set aside for Healthcare FSA and/or Dependent (Daycare) FSA benefits. Remember, the amount you elect will be deducted from your pay in equal installments during the year.

The Flexible Benefits Plan and federal law limit the amount you may set aside for each of the benefits offered under the Plan. These amounts are set forth in the Open Enrollment materials for the Plan.

If your spouse has no earned income because he or she is a full-time student or is incapable of caring for himself or herself, the limitation shall be $250 per month, or if there is more than one qualifying individual for the calendar year, the amount shall be $500 per month (but no more than the annual limits described above). It is important to plan carefully. If your qualified expenses during the Plan Year are less than the amount you allocate to your reimbursement accounts, the balance of your accounts will be forfeited. Once you enroll in the Plan, you are committed to those benefit elections for the entire Plan Year, unless you experience an event that enables you to change your election during the year (see Section called "May I change my elections during the Plan Year" on the pages above).

Will my reimbursement accounts earn interest?

No interest or other earnings will be credited to your reimbursement accounts. Except as provided by law, all amounts in reimbursement accounts will be the property of your Employer until paid out pursuant to the terms of the Plan.

Do limitations apply to participants who are highly compensated?

Under the Internal Revenue Code, "highly compensated participants" and "key employees" generally are participants who are officers, shareholders, or highly paid. You will be notified by the Plan Administrator each Plan Year if you are a highly compensated participant or a key employee. If you are within these categories, your contributions and benefits may be limited so that the Plan as a whole does not unfairly favor highly compensated participants, key employees, or their families. Federal tax laws state that a plan will be considered to unfairly favor key employees if they as a group receive more than 25% of all of nontaxable benefits provided under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated participants or key employees will apply. You will be notified of these limitations if you are affected.

What is the deadline for submitting reimbursement claims?

Under Internal Revenue Service rules, money you put into your reimbursement accounts that is not used to cover qualified expenses incurred during the Plan Year cannot be returned to you. The deadline for submission of reimbursement requests for expenses incurred during a Plan Year is within 90 days of the end of the Plan Year. The Plan year ends on December 31.

What if I don't spend the entire amount in my FSA?

Federal law requires that the balance of your contributions be forfeited after the deadline. *Because forfeiture is possible, you must carefully evaluate the amount you elect to contribute to the Plan.*

■ HEALTH SAVINGS ACCOUNTS (HSA)

Please note: The HSA is not an employer-sponsored employee benefits plan. It is a savings account established and maintained by an HSA trustee/custodian outside this Plan that is to be used primarily for reimbursement of qualified eligible medical expenses. The Employer has no authority or control over the funds deposited in an HSA. Even though the HSA may allow pre-tax payroll deducted contributions, it is not intended to be an ERISA benefit sponsored or maintained by the Employer.

How much may I elect to contribute to the HSA?

The federal law limits the amount you may set aside for an HSA. The maximum is determined by the level of high-deductible health coverage an individual has. The applicable limits for the upcoming year will be communicated to you in the Open Enrollment materials.

May I change my elections for the pre-tax contributions to my health savings account during the Plan Year?

You are permitted to elect to contribute to your HSA on a pre-tax basis or to change or revoke your election for health savings account contributions, such as increasing or decreasing the amount of your health savings account contributions, at any time during the Plan Year, subject to the following:

- Your election will be effective as soon as administratively practicable after the election is received by the Plan Administrator;

- If you become ineligible to make HSA contributions, you may revoke your elections to reduce your taxable Compensation for HSA contributions at any time.

Will the Employer make contributions to my HSA?

If you elect coverage under the Employer's HSA Plan and you establish to the satisfaction of the Employer that you are an HSA-Eligible Individual, the Employer may make an annual contribution to the HSA. Information about the Employer's annual HSA contribution will be provided as part of the annual Open Enrollment materials.

■ HEALTH CARE FLEXIBLE SPENDING ACCOUNT

The Health Care FSA is designed to help you pay for certain preventive care expenses prior to your meeting the annual deductible for your coverage under the health plan that is available through your employment. After meeting the deductible, the Health Care FSA may be used to help you pay for Qualified Medical Expenses that are not covered under any other plan. These expenses might include the cost of medical, dental, vision, and hearing services and supplies.

You may elect to reduce your pay by any amount up to the annual maximum established by your Employer to pay for Qualified Medical Expenses. You may be reimbursed for Qualified Medical Expenses up to the amount you elected for the full Plan Year. Medical expenses reimbursed through the Flexible Benefits Plan *cannot also be claimed as a deduction for income tax purposes.*

What are the requirements for "Qualified Medical Expenses"?

Qualified Medical Expenses must:

- Be incurred by you, your spouse, or your dependent;

- Be incurred during the Plan Year, while you are a participant; and

- Not be eligible for payment through any health insurance or other plan.

In addition, if you also participate in a HSA, prior to your meeting the annual deductible for your coverage under the health plan that is available in connection with your employment, Qualified Medical Expenses are limited to those which are for:

- Preventive medical care (e.g., periodic health examinations, annual physicals, immunizations, tobacco cessation programs, and screening services); and

- Dental and vision care.

Premiums paid for other health plan coverages for you, your spouse, or your dependents are not Qualified Medical Expenses. Qualified Medical Expenses also do not include non-prescribed dietary supplements which are merely beneficial to general good health and long-term care notwithstanding anything in Code Section 213(d) to the contrary.

Except as otherwise limited above, Qualified Medical Expenses includes all expenses that are considered medical expenses by the Internal Revenue Service.

■ DEPENDENT (DAYCARE) FLEXIBLE SPENDING ACCOUNT

The Dependent (Daycare) Flexible Spending Account is designed to help you pay for Qualified Dependent (Daycare) Expenses that make it possible for you and your spouse to work. It also may be used to help pay for the care of a disabled spouse or dependent.

You may elect to reduce your salary to pay for Qualified Dependent (Daycare) Expenses by any amount up to the maximum described in this Plan. No reimbursement will exceed the balance of your Dependent (Daycare) FSA at the time of the reimbursement. Dependent daycare expenses reimbursed through the Flexible Benefits Plan *cannot also be claimed as a credit for income tax purposes.*

What are the requirements for "Qualified Dependent (Daycare) Expenses"?

Under the Plan, you will be reimbursed only for dependent daycare expenses meeting all of the following conditions:

- The expenses are incurred during the Plan Year, while you are a participant;
- Each individual for whom you incur the expense is a dependent under age 13 whom you are entitled to claim as a dependent on your federal income tax return, or a spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself;
- The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed;
- If the expenses are incurred for services outside your household, they are incurred for the care of a dependent under the age of 13, or who regularly spends at least 8 hours per day in your household;
- If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations;
- The expenses are not paid or payable to a child of yours under age 19 at the end of the year in which expenses are incurred; *and*
- The expenses are not paid or payable to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

How do I request reimbursement of medical or dependent daycare expenses?

When you want to be reimbursed, you simply submit a claim form and the required attachments to the Plan Administrator. Claim forms are available from your Plan Administrator. Reimbursement payments will be made as soon as administratively feasible. Only expenses incurred while you are a participant and during the applicable Plan Year may be reimbursed.

Medical Expenses:

- The Plan Administrator may adopt procedures that enable you to have medical expenses that are not covered by the Employer's health plan automatically submitted for reimbursement from your healthcare FSA. This automatic claims processing approach reduces the amount of paperwork you need to prepare and helps to speed up the reimbursement process. If adopted, the Plan Administrator will provide you with more information about how automatic claims processing operates.

- In the absence of an automatic claims processing approach, you must submit a claim for medical expenses in order to receive reimbursement. With your claim, you must provide a statement from the medical provider (e.g., the doctor, hospital, or drug store) showing that the nature of the medical expense, the date incurred, the amount of the expense, and a statement that such expenses are not payable through insurance or another reimbursement plan.

Dependent (Daycare) Expenses:

- To submit a claim for dependent daycare expenses, you must provide a statement from the dependent care service provider showing for whom the expenses were incurred, the amount of the expense, and the date(s) the expenses were incurred.

The Plan Administrator may adopt procedures that enable you to use a debit card for reimbursements of medical and/or dependent daycare expenses. If implemented, the debit card can be used at any qualified service provider that accepts VISA signature-based Debit Cards. However, when you use the card for expenses which are not readily identifiable as qualified expenses, you may be contacted by e-mail or regular mail to submit your receipt via a toll-free fax number for verification. It is very important that you save your receipts for all expenses in case this verification is requested. If you use the card for non-qualified expenses, you will be required to reimburse the Plan. If adopted, the Plan Administrator will provide you with more information about how the debit card operates.

APPENDIX – QMCSO Procedures

SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS ONLY

A "QMCSO" is a QUALIFIED MEDICAL CHILD SUPPORT ORDER that applies only to group health plans.

ERISA requires that, as part of a divorce action, a court, domestic relations magistrate or administrator can enter an order (a Medical Child Support Order or MCSO) which grants a child the right to receive health benefits under one of his parent's group health plans, regardless of whether the parent is the custodial parent of the child. However, to be valid or "qualified" (QMCSO), the MCSO must meet certain statutory requirements which are identified below.

Upon receipt of a notice of a MCSO and request for coverage under the group health plan for one or more children of an employee or covered spouse, the following will occur:

- The Plan Administrator will send a letter acknowledging receipt of the MCSO. The letter will be sent to the Plan participant (the employee) and to each child affected by the MCSO.

  The Plan Administrator will review the MCSO to make certain that it:

  - was issued pursuant to a valid state domestic relations law;
  - specifically provides for a dependent (or dependents) to receive benefits under the group health coverage(s);
  - provides the name and last known mailing address of the employee (Plan participant) and each child covered by the MCSO;
  - provides a reasonable description of the coverage to be provided by the Plan(s) or the manner in which the coverage can be determined. The MCSO cannot require a Plan to provide any benefit or option that is not otherwise provided. If it does, it is not a qualified MCSO or "QMCSO";
  - specifies the time period to which the Order applies;
  - names each group health benefit to which the MCSO applies.

- The employee may be required to provide necessary identifying information about the child(ren), such as social security number(s), so that the Plan Administrator can comply with the requirements of the law.

- Upon completion of its review, the Plan Administrator will send a letter to the Plan participant (employee) and each affected child advising whether or not the MCSO has been determined to be a qualified MCSO – i.e., a QMSCO.

- If the MCSO is determined to be qualified, each child affected is entitled to all reporting and disclosure requirements to which other Plan participants are entitled under ERISA. Any child affected by the MCSO is also permitted to designate a representative to receive copies of any notices regarding this matter or any coverage or benefits matters. Any such designation should be sent to the Plan Administrator.

APPENDIX -- COBRA Continuation Coverage

SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS ONLY

■ In General

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

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

■ What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- ***Your hours of employment are reduced, or***
- ***Your employment ends for any reason other than your gross misconduct.***

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

■ When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

■ How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

■ **Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

■ **Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

APPENDIX – Required Notices

SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS ONLY

■ Rules Regarding Use and Disclosure of Protected Health Information Use and Disclosure of Protected Health Information

The Plan will use or disclose "Protected Health Information" (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations issued thereunder, as amended from time to time, including 45 CFR Parts 160 and 164, subparts A, D and E (HIPAA Privacy Rule) and 45 CFR Parts 160 and 164, subpart C (HIPAA Security Rule).

Use and Disclosure of PHI as Permitted by Authorization of the Participant or Beneficiary

As soon as practicable following the receipt of an authorization from a participant or his or her duly appointed personal representative, the Plan will disclose PHI in accordance with the authorization.

Disclosure to the Company

Upon request of the Company, the Plan will disclose summary health information and enrollment and disenrollment information to the Company as permitted pursuant to Section 164.504 of the HIPAA Privacy Rule.

The Plan will disclose PHI other than summary health information and enrollment and disenrollment information for purposes related to "plan administration," "treatment," "payment" and "health care operations" as described above to the Company only upon receipt of a certification from the Company that the applicable Plan documents have been amended to incorporate the provisions set forth in the remaining sections of this Appendix.

To receive PHI as described in the preceding paragraph, the Company shall certify to the Plan that it agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Company creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents, including a subcontractor, to whom the Company provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI or his or her duly appointed personal representative;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Company unless authorized by an individual;

- report to the Plan (i) any security incident as defined under the HIPAA Security Rule, and (ii) any Breach of Unsecured Protected Health Information; provided, however, that to avoid unnecessary burden on either party, the Company shall report to the Plan any unsuccessful security incidents of which it becomes aware of only upon request of the Plan. The frequency, content and the format of the report of unsuccessful security incidents shall be mutually agreed upon by the parties. The term "unsuccessful security incidents" mean security incidents that do not result in unauthorized access, use, disclosure, modification or destruction of electronic PHI;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made. Where the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible.

Adequate Separation Between the Plan and the Company Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- The Senior Vice President of Human Resources and Quality;
- The Vice-President of Human Resources;
- The Director of Compensation and Benefits; and
- Staff designated by any of the foregoing.

The persons described in this section may only have access to and use and disclose PHI for the purposes described above.

If the persons described in this section do not comply with this plan document, the Company shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

■ Women's Health and Cancer Rights Act of 1998

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

- All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable component benefit. Refer to the insurance certificate or benefit booklet for information on the deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, contact the Plan Administrator.

■ Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

■ Mental Health Parity and Health Insurance Coverage

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a recent amendment to the Mental Health Parity Act of 1996. These laws preclude medical plans from imposing financial requirements and treatment limitations on mental health or substance abuse benefits that are more restrictive than financial requirements and treatment limitations on medical and surgical benefits. MHPAEA also may prevent your large group health plan from placing annual or lifetime dollar limits on Mental Health and Substance Abuse benefits that are less favorable than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.

Although the law requires "parity", or equivalence, with regard to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does not require group health plans and their health insurance issuers to include these benefits in their medical plan.

Key changes made by MHPAEA include the following:

- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health and substance abuse benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits;
- Mental health and substance abuse benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, and the plan provides for out of network medical and surgical benefits, it must provide for out of network mental health and substance abuse benefits;

- Standards for medical necessity determinations and reasons for any denial of benefits relating to mental health and substance abuse benefits must be disclosed upon request.

■ The Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any Plan request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

■ Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within **60 days** after you or your dependents' coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

You also may have special enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). These rights occur when an employee or dependent child –

- loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program (acronym "CHIP," for children whose families do not qualify for Medicaid); or

- becomes eligible for premium assistance from Medicaid or CHIP allowing him or her to enroll in a group health plan.

However, you must request enrollment within **60 days** after the date of coverage loss or eligibility for Medicaid or CHIP premium assistance, whichever applies.

You must notify your Employer's Benefits Department within 60 days from the date you first experience one of these events (e.g., within 60 days of the marriage, birth, adoption, or placement for adoption) in order to be entitled to these special enrollment rights. All supporting documentation (e.g., marriage license, birth certificate, etc.) must be provided within 60 days of the date of the special" enrollment event. The Employer uses SEFLBenefits, an online benefits portal located at www.seflbenefits.hrintouch.com, for notification and enrollment purposes, and for the provision of supporting documentation. Information as to how to reach

the online benefits portal is provided to employees at their work location and may also be requested by contacting the Employer's Benefits Department. To request special enrollment or obtain more information, contact the Plan Administrator.

■ Status Under Health Care Reform Law

1. Grandfathered Status

Your Plan is not considered grandfathered for purposes of the Affordable Care Act.

2. The Following Changes Also Apply To The Health Care Component Benefits Under The Plan:

- **The elimination of any overall *lifetime* maximum** on the dollar value of essential health benefits that may have previously applied.

- **The elimination of any overall *annual* maximum** on the dollar value of essential health benefits that may have previously applied.

  NOTE: Lifetime or annual maximums may continue to apply to specific services if they are not considered essential health benefits. For guidelines on which services are considered "essential health benefits" contact the Plan Administrator.

- **Coverage for adult dependents until 26,** regardless of whether the dependent is unmarried, married or is a student. The provision of the law does not require coverage for children of covered dependents.

- **Coverage for preventative benefits with no member cost-sharing.** When preventative services are received from a network or participating provider, program deductibles, copayments or coinsurance will no longer apply. For a service such as a colonoscopy, related services such as operating room and anesthesia charges will also be covered at no cost to the member. For guidelines on which preventative services are affected, please consult http://www.healthcare.gov/ and search under Preventative Care.

- **Revisions to the appeals process.** An updated appeal process that complies with the new health care reform regulations now applies. For example, if an appeal is denied internally, covered employees will now be able to request a further review by an independent external review entity.

■ Patient Protection Disclosure

To the extent the Medical Benefit component plans require or allow for the designation of primary care providers by participants or beneficiaries,

- participants have the right to designate any primary care provider who participates in the network and who is available to accept the participant and the participant's covered family members;
- if the component plans require or allow for the designation of a primary care provider for a child, participants may designate a pediatrician as the primary care provider; and

- a participant or beneficiary does not need prior authorization from the component benefit plan 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 applicable 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, contact the insurance carrier.

Other required notices, including, but not limited to, the Marketplace Notice, the CHIP Notice, the Medicare Part D Notice of Creditable Coverage, and HIPAA Notice of Privacy Practices are available on our microsite at https://www.benefitsquest.com/sefl/. You should refer to our microsite for that important additional information.