SUMMARY PLAN DESCRIPTION

and

WRAP PLAN DOCUMENT

for the

Aon Benefit Plan

Effective January 1, 2020

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Introduction

Aon Corporation ("Aon" or the "Company") is pleased to provide its colleagues a comprehensive package of benefit options. To assist you in better understanding these options, known as "Benefit Programs," we have prepared this Summary Plan Description and Wrap Plan Document (this "SPD"). The Benefit Programs include:

- Medical Insurance (including prescription drug coverage and Health Savings Account);
- Dental Insurance;
- Vision Insurance;
- Flexible Spending Account Program (Health Care and Dependent Care);
- Long-Term Disability Insurance;
- Group Term Life and Accidental Death and Dismemberment ("AD&D") Insurance;
- Commuter Benefit Program;
- Employee Assistance Program;
- Group Variable Universal Life Insurance;
- Legal Services Plan;
- Critical Illness Insurance;
- Long-Term Care Insurance;
- Severance Plan; and
- Supplemental Disability Income Plan.

Certain other benefits information is included in this document to help you make informed decisions. A summary of all the benefits available is shown in the chart below.

The Aon Benefit Plan (the "Plan") is comprised of this Summary Plan Description and Wrap Plan Document, any Summaries of Material Modification, all applicable contracts, policies, coverage summaries, and agreements ("Coverage Documents") provided by the Plan's insurance carriers ("Insurers") and third-party benefit claims administrators, and a sub-plan document for the Flexible Compensation Plan and the Aon Severance Plan. Please see the ***Administrative Information*** section of this SPD for more details.

The Aon Benefit Plan offers core and supplemental/voluntary coverage that allows you to design your own benefits package. Core coverage gives you basic protection; supplemental coverage allows you to add extra coverage based on your own personal situation. What's more, you can review and adjust your coverage each year to ensure that it continues to meet your needs. While some coverage is automatic, other options require you to elect and make contributions toward the coverage you choose.

Because you can design your own personal benefits program, take special care to review your coverage alternatives before making elections. You also may want to discuss your available benefits choices with your Spouse or Domestic Partner.

For U.S.-based colleagues, certain Benefit Programs offered under the Plan are intended to conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Internal Revenue Code of 1986, as amended (the "Code"), and other federal laws, in each case, to the extent applicable to each such Benefit Program. Further, it is intended that the Plan conform to the requirements applicable to cafeteria plans under Code Section 125 and Treasury Regulations thereunder and that the benefits a colleague elects to receive under the Plan, to the extent such benefits are Qualified Benefits, be eligible for exclusion from the participating colleague's income under Code Section 125(a). This means you have the opportunity to pay for certain benefits on a before-tax basis, as well as the ability to be reimbursed for eligible health care, dependent care, and commuter expenses on a before-tax basis.

For Puerto Rico-based colleagues, the Plan complies with all applicable federal laws as described above, but is subject to the Internal Revenue Code of Puerto Rico of 1994, as amended (the "PR Code"), which does not recognize the exclusion of benefits from income on a before-tax basis. All premiums deducted for Puerto Rico-based colleagues will be deducted on an after-tax basis. Puerto Rico colleagues are only eligible for the life, accidental death and dismemberment, and long-term disability plans described in this document. Any other limitations on benefits applicable to Puerto Rico colleagues are described in the insurance certificates issued by the Insurer for a particular Benefit Program.

The Health Care Flexible Spending Account (the "Health Care FSA") is intended to qualify as a "self-insured medical reimbursement plan" under Code Section 105, and eligible expenses reimbursed thereunder are intended to be eligible for exclusion from participating colleagues' gross income under Code Section 105(b).

The Dependent Care Flexible Spending Account (the "Dependent Care FSA") is intended to qualify as a "dependent care assistance plan" under Code Section 129, and eligible expenses reimbursed thereunder are intended to be excludable from participating colleagues' gross income under Code Section 129(a). Please note that this program is not subject to ERISA.

The Health Savings Account is provided under Code Section 223 and eligible expenses paid thereunder also are intended to be excludable from gross income. Please note that this program is not subject to ERISA.

The Commuter Benefit Program is provided under Code Section 132(f) and eligible expenses paid thereunder also are intended to be excludable from gross income. Please note that this program is not subject to ERISA.

Certain provisions of the Plan may apply differently to certain groups. Please review this entire SPD, including any applicable Appendices, to determine whether you are affected.

Below is a summary of the Benefit Programs available under this Plan as of January 1, 2020, to you and your Eligible Dependents, if applicable.

OTHER AON BENEFITS AVAILABLE TO YOU

The following optional benefits are noted in this SPD for reference purposes only, to assist you in making your benefit decisions, although they are not part of the Plan and are not subject to ERISA. Additional information on these benefits can be obtained directly from the Insurer or third-party administrator, or through ***UPoint***®, Aon's HR portal:

- Auto & Homeowners Insurance
- Group Personal Umbrella Liability Insurance
- Identity Theft Protection
- Pet Insurance

Options You May Elect	Company-Paid Coverage You Automatically Receive
Aon Active Health Exchange™ Options: ▪ Medical Insurance ▪ Dental Insurance ▪ Vision Insurance ▪ Supplemental Group Term Life Insurance ▪ Dependent Life Insurance ▪ Supplemental AD&D Insurance ▪ Dependent AD&D Insurance ▪ Legal Services Plan **Other Options:** ▪ Long-Term Disability ("LTD") Insurance ▪ Health Savings Account ▪ Aon Flexible Spending Account Program — Health Care Flexible Spending Account — Dependent Care Flexible Spending Account* ▪ Commuter Benefit Program* ▪ Critical Illness Insurance – Supplemental coverage ▪ Long-Term Care Insurance* ▪ Accident Insurance* ▪ Group Variable Universal Life Insurance – Supplemental** ▪ Supplemental Disability Income Plan**	▪ Basic Group Life and Basic Accidental Death and Dismemberment ("AD&D") Insurance ▪ Group Variable Universal Life Insurance – Basic* ▪ Critical Illness Insurance – Core coverage (if enrolled in Bronze, Bronze Plus, or Silver medical option) ▪ Employee Assistance Program ("Live and Work Well") ▪ Aon Severance Plan ***Note:*** *Short-term disability pay replacement is provided to all eligible colleagues. Benefits are not covered by this Plan but instead are treated as a payroll practice. Colleagues may select the "Benefits" tile under "HR Policies & Forms" on* ***UPoint*** *and then the "Leave of Absence" section to view the short-term disability pay replacement policy.*

*These programs are not subject to ERISA.
**Not available to all colleagues.

UPoint is a registered trademark of Alight Solutions LLC.
Aon Active Health Exchange is a trademark of Aon Corporation.

Important Notice

The Company reserves the right to amend, modify, suspend, or terminate the Plan, in whole or in part, at any time, at its discretion, with or without advance notice to Participants, for any reason, subject to applicable law. The Company further reserves the right to change the amount of required Participant contributions for coverage at any time, with or without advance notice to Participants.

In the event of a conflict between this SPD/Wrap Plan Document and any applicable insurance contract, policy, or agreement, the latter shall govern.

About This Document

As shown in the following chart, certain benefits under the Plan are fully insured while others are self-insured. For fully insured benefits, Aon has contracted with various Insurers to administer benefits and pay claims under the terms of an insurance contract. For self-insured benefits, Aon has contracted with third-party administrators to handle certain day-to-day administrative functions such as claims processing.

Information on fully insured Benefit Programs is available in the insurance certificates or coverage summaries provided by the Insurer. Additional information also can be found on ***UPoint***. You may also request a paper copy, at no cost to you.

Information about Benefit Programs that are self-insured by the Company can be obtained from ***UPoint*** or the claims administrator of a program. Detailed information on the Flexible Spending Accounts, Health Savings Accounts, and the Commuter Benefit Program are included in this SPD.

This SPD, along with the Coverage Documents, can help you better understand and use your benefits. In addition to these documents, as provided under the Affordable Care Act, Aon also provides a concise statement of your coverage in a Summary of Benefits and Coverage ("SBC") document that is prepared for each medical option available to you. This document(s) will be made available electronically for each colleague as part of the Annual Enrollment process. It summarizes the benefits and coverage for each medical option and includes a useful glossary of terms frequently used in health insurance coverage. The SBC also provides examples of certain medical conditions and what they would cost under the medical option. You can use this document to compare Aon's coverage to other coverage that you may have access to as you make your enrollment decisions for the coming year. The SBC is available on ***UPoint***. You may also request a copy, at no cost to you, from the ***Aon HR Service Center***.

Capitalized terms have the meanings provided in-text or in the ***Terms to Know*** section. It is important that you familiarize yourself with these terms, because they help specifically describe the coverage and benefits that are available to you.

Whom to Contact

	Contact	Reasons to Access
Aon HR Service Center	*UPoint* **www.digital.alight.com/aon** **1-855-625-5500** Representatives are available between the hours of 8 a.m. and 4:30 p.m. Central time, Monday through Friday	▪ Verify overall eligibility and coverage. ▪ Review personal benefits information. ▪ Obtain a benefit summary. ▪ Compare health care coverage options. ▪ Update beneficiary information.
Aon Active Health Exchange Medical Options (**NOTE:** Coverage for prescription drugs and supplies for all medical options is fully insured and offered through the medical insurance companies) ▪ Platinum Option ▪ Gold or Gold II* Option ▪ Silver Option ▪ Bronze Plus Option ▪ Bronze Option The following Insurers provide coverage for each option: ▪ Aetna ▪ BlueCross BlueShield of Illinois ▪ Cigna ▪ Dean / Prevea360** ▪ Geisinger** ▪ Health Net** ▪ Kaiser Permanente** ▪ Medical Mutual** ▪ Priority Health** ▪ UnitedHealthcare ▪ UPMC Health Plan** *In California, the Gold option is offered by Aetna, BCBS of Illinois, and UnitedHealthcare; the Gold II option is offered by Cigna, Health Net, and Kaiser. **Not available in all areas. In certain states, some options may cover in-network benefits only. **Aon Active Health Exchange Hawaii Medical Options** ▪ Platinum Option ▪ Gold Option The following Insurers provide coverage for each option: ▪ HMSA ▪ Kaiser Permanente **Non-Aon Active Health Exchange Option** ▪ Cigna Global—Expatriates	**Aetna (Insurer)—**Fully Insured **www.aetna.com** **1-855-496-6289** **BlueCross BlueShield of Illinois (Insurer)—Fully Insured** **www.bcbsil.com/member/register** **1-877-217-7986** **Cigna (Insurer)—Fully Insured** **https://my.cigna.com** **1-855-694-9638** **Dean / Prevea360 (Insurer)—Fully Insured** **aon.deanhealthplan.com** **1-877-232-9375** **Geisinger (Insurer)—Fully Insured** **https://www.geisinger.org/member-portal** **1-844-390-8332** **Health Net (Insurer)—Fully Insured** **https://www.healthnet.com/myaon** **1-888-926-1692** **Kaiser Permanente (formerly Group Health in WA) (Insurer)—Fully Insured** **https://wa-member.kaiserpermanente.org** **1-855-407-0900** **Kaiser Permanente (Insurer)—Fully Insured** **www.kp.org** **1-800-464-4000 (California)** **1-303-338-3800 (Colorado)** **1-404-261-2590 (Georgia)** **1-800-777-7902 (Mid-Atlantic)** **1-800-813-2000 (Northwest)** **Medical Mutual (Insurer)—Fully Insured**	▪ Request coverage information. ▪ Locate participating providers. ▪ Request information about a network provider, free of charge. ▪ Submit claims, if necessary. ▪ Check on the status of a claim. ▪ Call to avoid penalties if you have an emergency or need surgery, hospitalization, or certain other procedures requiring precertification. ▪ Order an ID card or print a temporary one. ▪ Fill or refill a prescription. ▪ Locate a participating pharmacy near you. ▪ Obtain prescription medication information (such as side effects). ▪ Learn about patient care. ▪ Estimate costs for common treatments. **Mail-Order Prescription Drugs:** Obtain prescription medication information (such as pricing and side effects). ▪ Print a mail-order form or extra mail-order envelopes. ▪ Send online member services inquiries. ▪ Order claim forms. ▪ Learn about patient care. ▪ Link to other sites for information about diseases, diagnoses, prevention, and treatment.

	Contact	Reasons to Access
	https://member.medmutual.com **1-800-541-2770** **Priority Health (Insurer)—Fully Insured** **https://member.priorityhealth.com/login** **1-833-207-3211** **UnitedHealthcare National (Insurer)—Fully Insured** **http://myuhc.com** **1-888-297-0878** **UPMC Health Plan (Insurer)—Fully Insured** **www.upmchealthplan.com/members** **1-844-252-0690** **Hawaii Medical Service Association (HMSA)—Blue Cross Blue Shield of Hawaii (Insurer)—Fully Insured** **login.hmsa.com/MyAccount** **1-800-651-4672** **Cigna Global—Fully Insured (Expatriate Plan)** **www.cignaenvoy.com** **1-800-441-2668**	
Aon Active Health Exchange Dental Options ▪ Platinum Option ▪ Gold Option ▪ Silver Option ▪ Bronze Option The following Insurers provide coverage for each option: ▪ Aetna ▪ Cigna ▪ DeltaCare USA ▪ Delta Dental of Illinois ▪ MetLife ▪ UnitedHealthcare **Non-Aon Active Health Exchange Option** ▪ Cigna Global—Expatriates	**Aetna (Insurer)—Fully Insured** **www.aetna.com** **1-855-496-6289** **Cigna (Insurer)—Fully Insured** **www.cigna.com** **1-855-694-9638** **DeltaCare USA (Insurer)—Fully Insured** **www.deltadentalins.com** **1-800-471-8073** **Delta Dental of Illinois (Insurer)—Fully Insured** **www.deltadentalil.com** **1-800-323-1743** **MetLife (Insurer)—Fully Insured** **www.metlife.com/mybenefits** **1-888-309-5526** **UnitedHealthcare—Fully Insured** **www.myuhc.com** **1-888-571-5218**	▪ Request coverage information. ▪ Locate a participating Dentist. ▪ Request a provider directory. ▪ Submit claims, if necessary. ▪ Check on the status of a claim. ▪ Obtain useful information about oral health. ▪ Order an ID card.

	Contact	Reasons to Access
	Cigna Global—Fully Insured (Expatriate Plan) **www.cignaenvoy.com** **1-800-441-2668**	
Aon Active Health Exchange Vision Options ▪ Gold Option ▪ Silver Option ▪ Bronze Option The following Insurers provide coverage for each option: ▪ EyeMed ▪ MetLife ▪ UnitedHealthcare ▪ VSP **Non-Aon Active Health Exchange Option** ▪ Cigna Global—Expatriates	**EyeMed (Insurer)—Fully Insured** **www.eyemedvisioncare.com/member/public/login.emvc** **1-844-739-9837** **MetLife (Insurer)—Fully Insured** **www.metlife.com/mybenefits** **1-888-309-5526** **UnitedHealthcare (Insurer)—Fully Insured** **www.myuhcvision.com** **1-888-571-5218** **VSP (Insurer)—Fully Insured** **www.vsp.com** **1-877-478-7559** **Cigna Global—Fully Insured (Expatriate Plan)** **www.cignaenvoy.com/signon.html** **1-800-441-2668**	▪ Verify vision care eligibility. ▪ Review your benefits. ▪ Locate a participating network provider. ▪ Speak with member services. ▪ Request or download a claim form.
Flexible Spending Account Program	**Your Spending Account™ ("YSA") through *UPoint*** **www.digital.alight.com/aon** **1-855-625-5500** Your Spending Account is a registered trademark of Alight Solutions LLC.	▪ Verify your Health Care and/or Dependent Care Account balance. ▪ Ask about covered expenses. ▪ Submit claims. ▪ Check on the status of a claim.
Long-Term Disability ("LTD") Insurance	**The Hartford (Insurer)—Fully Insured** **www.thehartfordatwork.com** **1-888-563-1124 or** **1-800-752-9713**	▪ Obtain information on how the LTD Plan works. ▪ Apply for LTD benefits. ▪ Request or provide updated information on an LTD claim.
Supplemental Disability Income Plan	**UNUM (Insurer)—Fully Insured** **Aon Executive Benefits** **1-877-236-3748**	▪ Ask questions about coverage or eligibility. ▪ Inquire about claims.
Group Term Life and Accidental Death and Dismemberment ("AD&D") Insurance	**The Hartford (Insurer)—Fully Insured** **www.thehartfordatwork.com** **1-888-563-1124**	▪ Inquire about statements of health. ▪ Inquire about claims.
Group Variable Universal Life ("GVUL") Insurance	**MetLife (Insurer)—Fully Insured** **https://mybenefits.metlife.com** **1-800-756-0124**	▪ Ask questions about coverage or eligibility. ▪ Submit claims.
Critical Illness Insurance	**MetLife (Insurer)—Fully Insured** **www.metlife.com/mybenefits** **1-800-438-6388**	▪ Ask questions about coverage or eligibility. ▪ Submit claims.
Commuter Benefit Program	**Your Spending Account ("YSA") through** *UPoint*	▪ Verify your account balance. ▪ Ask about covered expenses. ▪ Submit claims.

	Contact	Reasons to Access
	www.digital.alight.com/aon **1-855-625-5500**	▪ Check on the status of a claim.
Group Personal Umbrella Liability Insurance	**Chubb (Insurer)—Fully Insured** **www.chubb.com** **Contact the Aon HR Service Center at 1-855-625-5500**	▪ Ask questions about coverage or eligibility.
COBRA	***UPoint*** **www.digital.alight.com/aon** **1-855-625-5500** Representatives are available between the hours of 8 a.m. and 4:30 p.m. Central time, Monday through Friday.	▪ Ask questions about coverage or eligibility. ▪ Inquire about premium payments.
Long-Term Care Insurance	**John Hancock (for legacy Hewitt Participants)** **1-888-513-2072** **MetLife (for legacy Aon Participants)** **1-800-GETMET8 (1-800-438-6388)** **Genworth** **www.genworth.com/groupltc** **Group ID: AON** **Access Code: groupltc** **1-800-416-3624**	▪ Ask questions about coverage or eligibility. ▪ Submit claims.
Aon Active Health Exchange Legal Services Plan	**Hyatt Legal Plans (a MetLife Company)—Fully Insured** **www.legalplans.com** **Access code: 1640010** **1-800-821-6400**	▪ Verify your eligibility and coverage. ▪ Obtain plan services: — Office consultation or phone advice. — Small claims assistance. — Personal bankruptcy or debt collection defense. — Identity theft. — Tax audits. — Document preparation. — Separation or divorce. — Premarital agreements. — Wills and estate planning. — Real estate matters.
Aon Active Health Exchange Identity Theft Protection	**InfoArmor—Fully Insured** **www.infoarmor.com/exchange** **1-855-969-3373**	▪ Ask about covered services.
Aon Active Health Exchange Auto & Homeowners Insurance	**Liberty Mutual** **www.libertymutual.com/aon** **Client: #110512** **1-800-730-6975** **MetLife** **www.metlife.com/mybenefits** **1-800-GETMET8 (1-800-438-6388)** **Travelers** **travelers.com/aon**	▪ Ask questions about coverage or eligibility.

	Contact	Reasons to Access
	1-888-695-4640	
Aon Active Health Exchange Pet Insurance	**Healthy Paws® Pet Insurance** **www.healthypawspetinsurance.com/aon** **1-800-453-4054**	▪ Ask about covered services. ▪ Enroll or change your covered pets. ▪ Ask questions about coverage or eligibility.
Accident Insurance	**Chubb Workplace Benefits** **my.combinedinsurance.com** **1-866-445-8874**	▪ Ask questions about coverage or eligibility.
Wellbeing	See contact information under **Medical Options**.	▪ Medical Insurers may offer the following: — Access to online wellness tools, smoking cessation programs, and education programs. — Evaluation of health risk through online health assessments. — Online or telephonic health coaching sessions. — Storage and management of confidential health information. — Access to condition management resources.
	Employee Assistance Program ("EAP") **"Live and Work Well"** **Optum Health** **www.liveandworkwell.com** **(Access Code: Aon)** **1-800-510-9351**	▪ 24/7 toll-free telephone access. ▪ Obtain resource and referral information on: — Childcare. — Eldercare. — Adoption. — Legal consultation, including simple wills. — Finances. — Stress management. — Substance abuse. — Depression.

Eligibility

Active Coverage

You are **eligible** to participate in the Plan if you are a full-time or regular part-time U.S. colleague of Aon, or if you are paid on a U.S. payroll on international assignment (outside the United States). For benefits purposes:

- Full-time employment means that you maintain a regular full-time work schedule as designated at your work location; and
- Regular part-time employment means that you work at least 20 hours per week.

You are **not eligible** to participate in the Plan if you are not a common law employee of Aon. Individuals who are not common law employees include, but are not limited to, those who are employees of a staffing firm, payroll agency, or leasing organization or who are independent contractors or consultants.

If you are employed in Puerto Rico, or if you are paid on Puerto Rico payroll on international assignment (outside of Puerto Rico) and work a regular full-time work schedule, you are only **eligible** for life insurance, accidental death & dismemberment, and long-term disability benefits under the Plan. Contact your local HR team for information on medical, dental, vision, and other benefits offered to you locally.

If you are hired on a temporary or seasonal basis and will work 20 or more hours per week, you are only **eligible** for medical, dental, vision, and critical illness benefits.

If a court or any other enforcement authority or agency, such as the Internal Revenue Service ("IRS"), finds that an individual excluded from coverage should be considered an eligible common law employee of Aon, the individual still will be considered ineligible for coverage and benefits without regard to any court or agency decision determining common-law employment status, unless Aon determines and agrees that such individual should be reclassified; Aon will determine the effective date of reclassification.

Note: Special additional eligibility rules apply to the Bronze, Bronze Plus, and Silver medical options, which include your eligibility to participate in a Health Savings Account ("HSA") and a Health Care Flexible Spending Account ("Health Care FSA"). Please refer to the ***Your Medical Coverage*** and ***Your Flexible Spending Accounts (FSAs)*** sections for additional information.

For purposes of the Affordable Care Act, Aon offers Minimum Essential Coverage (medical coverage) that provides "minimum value" to eligible employees as described here. This coverage also is considered "affordable" for most eligible employees. As a result, if you enroll in coverage through a government exchange, also referred to as the "health insurance marketplace," and request a premium tax credit, you may not be eligible for the premium tax credit due to Aon's offer of coverage. You should refer to the health insurance marketplace notice that you have previously been provided (or you can find a copy of it on the "Legal Documents" page on the Aon Benefits Link website) if you are considering enrolling in a marketplace plan. If you enroll in Aon's coverage, you will not be eligible for a premium tax credit regardless of whether or not such coverage is affordable.

While the federal government no longer requires you to maintain Minimum Essential Coverage to avoid a federal tax penalty, a number of states do, including New Jersey (2019), California (2020), Rhode Island (2020), and Vermont (2020). Massachusetts continues to require that you maintain "Minimum Creditable Coverage" to avoid a tax penalty, as well. Aon's coverage is Minimum Essential Coverage and typically satisfies Massachusetts' requirements for Minimum Creditable Coverage. You should confirm with your tax advisor and your Insurer (to confirm whether your coverage is satisfactory) if a state tax mandate is a concern for you; additional states are considering adding this requirement as early as 2020.

Retiree Coverage

Pre-Age 65

You are eligible to participate in the medical, dental, vision, and critical illness Benefit Programs under the Plan as a retiree if, at the time you retire, you:

- Are at least age 50 (but under age 65); and
- Have at least 10 Years of Service (a "Year of Service" means that you have been an Aon colleague for 12 consecutive months).

If you meet these requirements, you and/or your Eligible Dependents may continue in the same medical, dental, vision, and critical illness coverage as offered to active colleagues, until you and/or your Eligible Dependents reach age 65 (see ***Age 65 and Over/Medicare-Eligible*** below). However, the cost of coverage for retirees will differ than the cost for active colleagues (see the ***Cost of Coverage*** section for additional information). Alternatively, you may elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). If you prefer to elect COBRA coverage or change medical options when you retire, you may call the ***Aon HR Service Center*** to request a change.

If you decline coverage upon retiring, you may enroll at a later date by contacting the ***Aon HR Service Center***. If you subsequently decline coverage, you will not be permitted to re-enroll in coverage. Effective with retirements on or after April 1, 2020, eligibility for retiree life insurance ($5,000 policy) will be the same as eligibility for the retiree medical subsidy (at least age 50 with at least 15 years of service at December 31, 2014). Pre-65 retirees who are enrolled in the Group Personal Umbrella (GPU) program and have 10 years of service at the time of retirement will have their GPU coverage automatically continued and the premium billed directly. You will not be eligible to participate in any other Benefit Programs offered under the Plan.

Age 65 and Over/Medicare-Eligible

If you retire on or after age 65 with 10 Years of Service, are retired and turn age 65 with 10 Years of Service, or otherwise become Medicare-eligible, you are eligible to participate in retiree dental and retiree vision coverage offered under the Plan. If you are enrolled in Medicare Parts A and B, you will be eligible to purchase individual Medicare Supplement insurance coverage through the Aon Retiree Health Exchange. The Aon Retiree Health Exchange has the freedom to offer plans from many of America's leading insurance companies, as well as impartial guidance and enrollment assistance. All of these services are offered at **no cost to you**; you will pay only the premiums for any insurance coverage in which you choose to enroll.

Please note that any coverage you elect through the Aon Retiree Health Exchange is not endorsed or sponsored by Aon. The specific cost of coverage will be based on the coverage you select. You may contact the Aon Retiree Health Exchange at **1-877-458-9655** or visit **https://retiree.aon.com/aon**.

All Other Retirees

If you retire without satisfying the age and Years of Service requirements outlined above, you will not be eligible to continue participation in the Plan unless you elect COBRA continuation.

Eligible Dependents

In general, your "Eligible Dependents" include your Spouse or Domestic Partner and your Children. In some cases, there are additional or different eligibility requirements that may apply (for example, for purposes of FSAs); those requirements are noted in the applicable sections of this SPD.

Spouse

The term "Spouse" means any person pursuant to a legal union defined as a "marriage" under any domestic or foreign jurisdiction having the legal authority to sanction marriages.

Domestic Partner

For you to have a Domestic Partner, you and such individual must be:

- Each other's same- or opposite-sex domestic partner.
- Not married to anyone else.
- Both at least 18 years old and mentally competent to enter into a marriage contract.
- Not related by blood to the degree of closeness that would prohibit your legal marriage in the state in which you reside.
- Living (and have lived) together in the same principal residence for at least six months and intend to do so indefinitely.
- Jointly responsible for each other's common wellbeing and financial obligations.

Alternatively, such individual may qualify as a Domestic Partner if you have registered through a governmental entity as Domestic Partners.

If this individual is not registered through a governmental entity as a Domestic Partner, you must complete an affidavit of domestic partnership, which can be obtained from the ***Aon HR Service Center***, before a Domestic Partner can be enrolled in the Plan. If at any time you do not meet all of the above criteria, you and/or your Domestic Partner must notify the ***Aon HR Service Center*** within 31 days of the date your partnership status changes.

Child

The term “Child” means any child of you, your Spouse, or your Domestic Partner who has not attained age 26 (although note that a Child will remain eligible for medical, dental, and vision coverage through the end of the calendar month in which the Child attains age 26). You, your Spouse, or your Domestic Partner also must be one of the following with respect to the Child:

- Natural or biological parent;
- Adoptive parent;
- Step-parent;
- Foster parent; or
- Legal guardian.

Imputed Income

Most Eligible Dependents are considered Tax Dependents. You are not taxed on imputed income for Tax Dependents.

If you cover an Eligible Dependent who is not a Tax Dependent, Aon is required to report imputed income for you that reflects the value of the coverage for tax-reporting purposes. This is known as imputed income. You will receive additional income reported on your W-2 annually for the value of coverage for any Eligible Dependent who is not a Tax Dependent.

Aon assumes **all Eligible Dependents** are Tax Dependents, except Domestic Partners and their Children. It is your responsibility to notify the Company if your Domestic Partner and his or her Children **are** your Tax Dependents or if you cover Eligible Dependents who are **not** Tax Dependents. Any change in the status of an Eligible Dependent will be made by Aon for the current tax year and on a prospective basis.

If you are retired and cover your Domestic Partner, you will receive a tax form from Aon reporting your imputed income. It is your responsibility to make sure that taxes are paid on this imputed income. You may wish to consult with a tax advisor.

If you and your Domestic Partner get married, contact the ***Aon HR Service Center***. With proof of marriage, adjustments will be made to your status on Aon’s benefit recordkeeping system on a prospective basis. With regard to Company-subsidized health care coverage, the taxable imputed income applicable to coverage for a Domestic Partner does not apply to coverage for a Spouse for either federal or state tax reporting purposes.

State Eligibility Laws and ERISA

States sometimes pass laws that require benefit plans to provide coverage and/or benefits to individuals who otherwise are not eligible. For example:

- A state might require an employer to provide coverage to an ex-Spouse or to a Child who is over age 26 and is not otherwise eligible for medical coverage under the Plan; or
- A particular state law may mandate coverage for a particular condition or medication that is not ordinarily covered by Aon’s group health coverage.

Enrollment

You can enroll for coverage after you meet the eligibility requirements (see the ***Eligibility*** section for more information).

As a New Colleague

As a newly eligible colleague, you will receive information and instructions about how to enroll for your benefits through ***UPoint***. You must make your initial enrollment election within 31 days of your hire date. Coverage begins on the first day you are actively at work for most benefit options. If you do not enroll at the time of hire, you will only have Basic Life, Basic AD&D, and Basic LTD (Life and AD&D is paid by the Company, and LTD is paid by you) and will not have another opportunity to enroll until Annual Enrollment or unless you have a Qualifying Life Event as described in the ***Changing Your Coverage*** section.

If you are rehired within 31 days within the same Plan Year after leaving the Company, your benefit elections will default to the choices you previously had in place, including your Health Care FSA and Dependent Care FSA elections. If your benefit option is no longer available upon rehire, you must contact the ***Aon HR Service Center*** in order to make another selection.

As a New Retiree

If you are enrolled in an Aon medical option on your date of retirement and meet the eligibility requirements for continuing coverage in the Plan as a pre-65 retiree, your coverage and that of your covered Eligible Dependents will be continued as long as you enroll and continue to pay the required premiums (although the cost of coverage will differ).

Note: You may also have the option to elect medical coverage continuation under COBRA. In some cases, the COBRA cost may be lower than the non-COBRA cost. If you prefer to elect COBRA coverage or change medical options when you retire, you may call the ***Aon HR Service Center*** to request a change.

Your Eligible Dependents

When you enroll your Eligible Dependents, you will need to provide their names, genders, birth dates, and Social Security numbers. See below for additional information about providing Social Security numbers.

In addition, you will be required to provide proof of Eligible Dependent status once enrollment is complete. Proof of Eligible Dependent status may include, but is not limited to:

- A marriage certificate.
- A birth certificate.
- Guardianship/adoption papers.

If you are unable to provide the required documentation, your Eligible Dependents will not be covered. From time to time, Aon may audit Eligible Dependents who are enrolled in the Plan. If you are unable to provide proof of Eligible Dependent status upon request, your Eligible Dependent will be dropped from coverage. In addition, you may be required to reimburse the Company for any costs associated with covering an individual who is not an Eligible Dependent and your, and your Eligible Dependents', coverage may be terminated.

Social Security Numbers Generally Required for Enrollment

Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), the Centers for Medicare & Medicaid Services ("CMS") generally require Social Security numbers for employees and Eligible Dependents to assist with reporting under the Medicare Secondary Payer requirements.

In addition, under the Affordable Care Act, the IRS generally requires Social Security numbers for employees and Eligible Dependents for purposes of tax reporting.

If you do not provide a Social Security number within the enrollment time frame, your Eligible Dependent may become ineligible for coverage. Your Eligible Dependent may not be allowed to enroll until the next Annual Enrollment or when you have a Qualifying Life Event.

A newborn Child may be enrolled under your coverage without a Social Security number (provided you enroll the newborn within 31 days of the birth). However, you should apply for the Child's Social Security number and provide it to the ***Aon HR Service Center*** as soon as possible.

Annual Enrollment

Each year, during a designated Annual Enrollment period, you will be given the opportunity to enroll in or drop coverage, change your coverage elections, or change the Eligible Dependents you cover. Your Annual Enrollment materials will provide the options available to you and your share of the premium cost for the coverages you elect. Your materials will also include what actions you must take to continue certain coverages and will explain any applicable default coverage that you will be deemed to have elected if you do not make the required elections by the specified deadline as explained below. The elections you make will take effect on January 1 and stay in effect through December 31, unless you have a Qualifying Life Event that permits you to make a mid-year election change.

Note: You should verify that the deductions made from your paycheck correctly reflect the elections you made during Annual Enrollment or after a mid-year election change. Contact the ***Aon HR Service Center*** immediately if a correction needs to be made.

If You Do Not Enroll

If you do not enroll or confirm your coverage before your enrollment deadline, you will automatically be enrolled in the following coverages:

- **Medical, Dental, and Vision:**
  - With the exception of Hawaii and Expatriate colleagues, if you currently are enrolled in a medical, dental, or vision Benefit Program, you will be enrolled in the Bronze option with the same insurance company and covering the same Eligible Dependents as you had the previous year.
  - If you currently are not enrolled in medical, dental, and vision coverage, you will not be enrolled in any medical, dental, or vision coverage under the Plan.
  - Hawaii colleagues' medical coverage will default to the Gold option with the same insurance company. If you currently are not enrolled in medical coverage or elect No Coverage and do not return the Hawaii medical coverage waiver form (HC-5), you will be enrolled in the Gold medical option through HMSA. If you are currently enrolled in dental or vision coverage, you will be enrolled in the Bronze option with the same insurance company. If not enrolled in dental or vision coverage, you will have No Coverage under the Plan.
  - If you are an Expatriate colleague, your Cigna Global coverage will continue if you are currently enrolled. If you are not enrolled, you will have No Coverage under the Plan.
- **Health and Dependent Care FSAs, HSAs:** No contributions.
- **All other benefits:** Your elections will default to the same or most similar coverage as you had the previous year, if eligible.

You will not be able to enroll in or change coverage elections until the next Annual Enrollment period, unless you have a Qualifying Life Event that would allow you to change your coverage mid-year. See the ***Changing Your Coverage*** section for additional information.

Enrollment for Expatriates

As an expatriate colleague, you will enroll the same way as other U.S. colleagues. However, if you are an expatriate in the Middle East region, you will be required to submit additional documentation depending on your visa status. For example, a copy of your work visa, passport, and emirates ID card may be requested.

At the end of your assignment, your Cigna Global health care coverage ends and you'll be required to enroll in U.S. health care coverage. If you return to the U.S. during the last quarter of the year, you must enroll twice: once to have U.S. health care coverage for the balance of the year of your return to the U.S. and again to get the coverage you want for the subsequent year.

Enrollment Under a Qualified Medical Child Support Order ("QMCSO")

You may be required to provide medical, dental, and/or vision coverage for a Child under the terms of a QMCSO (or a National Medical Support Notice). This coverage applies when:

- You do not have legal custody of the Child.
- The Child is not dependent on you for support.

When the Company receives a valid QMCSO for your Child, you do not have to wait for the Annual Enrollment period to enroll the Child. However, the Child does have to otherwise meet the terms of an Eligible Dependent in order to be enrolled on your coverage.

You may obtain a copy of the QMCSO administrative procedures, free of charge, by contacting the ***Aon HR Service Center***.

Cost of Coverage

Active Employees

The amount you contribute toward the cost of your benefits generally is determined by several factors, which may include:

- The options you choose;
- The number of Eligible Dependents you cover;
- Your employment status (full-time/part-time);
- Your geographic location;
- Your age; and
- Your salary level.

Each year, Aon will evaluate all costs and may adjust the cost of coverage for the next year's coverage. Your cost for the upcoming year is communicated during the Annual Enrollment period. You can enroll online as described in your enrollment materials. Please note that the medical costs shown in your enrollment materials do not include the surcharge that will apply if you do not qualify for non-tobacco user status (see ***Premium Surcharge for Tobacco Users*** below).

With regard to medical, dental, and vision coverage, Health Care FSAs, and Dependent Care FSAs, you pay for coverage with dollars deducted from your pay before taxes are withheld. This also is referred to as a salary reduction election. Your contributions to a Health Savings Account or under the Commuter Benefit Program are also made on a before-tax basis.

Although before-tax contributions reduce your taxable pay, they do not affect your pay-related coverage. The Company considers your before-tax contributions to be a part of your base salary for purposes of calculating life insurance, AD&D Insurance, and LTD benefits.

Contributions are withheld as soon as administratively possible after you become eligible and enroll for coverage. The amount of the salary reduction election available to you to pay for coverage is equal to your share of the premium required to pay for coverage or, in certain cases, the amount you elect to contribute to an account.

The Company pays the full cost of your Basic Life Insurance and Basic AD&D Insurance coverage.

You pay for LTD, Supplemental and Dependent Life, and Supplemental and Dependent AD&D Insurance coverages with after-tax dollars deducted from your pay. Amounts you contribute on an after-tax basis are subject to federal and state income and employment taxes, just like the rest of your pay. These amounts will be taken into account when computing your federal Social Security benefit and for purposes of your pay-related benefits.

Deductions are withheld as soon as administratively possible after you become eligible, enroll, and are approved for coverage.

Generally, when you pay for coverage with after-tax dollars, the benefits you (or your beneficiary) receive are not subject to federal taxes. In a few cases, however, state taxes may apply. You should consult with your tax advisor to determine how these benefits apply to your specific tax situation.

If premium payments cannot be deducted from your paycheck for any reason, you will be billed directly for your premiums on a monthly basis by the ***Aon HR Service Center***. Failure to remit your premiums on a timely basis will result in cancellation of your coverage. If your coverage is canceled due to non-payment of premiums, you will not be eligible to re-enroll in coverage.

Pre-Age 65 Retired Aon Colleagues (Other Than Legacy Hewitt Colleagues)

If you reached age 50 and had at least 15 Years of Service by December 31, 2014, you are eligible to receive a contribution toward medical coverage you elect under the Plan when you retire before attaining age 65. The amount of the annual subsidy is:

- $2,880 toward you-only coverage;
- $5,760 if you cover yourself and your Spouse/Domestic Partner;
- $4,524 If you cover yourself and Children; or
- $7,404 if you cover yourself and a Spouse/Domestic Partner and Children.

Note: Subsidy amounts are not expected to increase in the future. The annual subsidy ends when you elect to stop participating in medical coverage under the Plan, reach age 65, become Medicare-eligible, or Aon decides to discontinue the program, whichever comes first.

If you did not meet the age 50 and 15 Years of Service requirement at December 31, 2014, you may still be eligible to participate in medical coverage under the Plan if you meet the eligibility requirements listed under ***Retiree Coverage***, but you will be required to pay the entire cost of coverage.

You will be required to pay the entire cost of coverage for dental and vision coverage under the Plan.

Pre-Age 65 Retired Legacy Hewitt Colleagues

If you had at least 10 Years of Service as of December 31, 2005, you are eligible to receive a contribution toward medical coverage under the Plan if you meet the retiree eligibility requirements. The amount of the annual subsidy is:

- $240 multiplied by your Years of Service (determined as of December 31, 2005) up to a maximum of 25 years.

The annual subsidy is reduced by 6% for each full and partial year by which your retirement precedes age 62. For example, if you had 10 Years of Service on December 31, 2005 and retire in 2017 at age 58, the subsidy is $1,824 per year ($240 x 10 years, reduced by 24%).

However, if you retire and become Medicare-eligible with at least 10 years of eligible service as of December 31, 2005, your subsidy will be reduced. The amount of the annual subsidy is:

- $60 multiplied by your Years of Service (determined as of December 31, 2005) up to a maximum of 25 years.

If you are disabled and Medicare-eligible before age 65 and meet the eligibility requirements, the annual subsidy is reduced by 6% for each full and partial year by which your retirement precedes age 62. For example, if you had 15 Years of Service on December 31, 2005 and retire in 2017 at age 59, the subsidy is $738 per year ($60 x 15 years, reduced by 18%).

Note: Subsidy amounts are not expected to increase in the future. In addition, the subsidy will end if you decline coverage or if Aon decides to discontinue the program, whichever comes first. If you meet the age and Years of Service requirements on or after January 1, 2006, you will not be eligible for the grandfathered legacy Hewitt retiree subsidy, but may be eligible for the Aon subsidy.

Premium Surcharge for Tobacco Users

The cost for coverage shown as part of your enrollment materials is a “non-tobacco user” rate. If you use tobacco products, you will be subject to a surcharge. If you are enrolled in a medical option and certify as a non-tobacco user during your initial enrollment as a new colleague or Annual Enrollment, you will not be subject to this surcharge. To qualify for non-tobacco user status, you must not smoke or otherwise use tobacco products. If you cannot attest to non-tobacco user status, you may still avoid the “tobacco user” surcharge if you meet a reasonable alternative standard, such as a tobacco cessation program that may be offered through your medical plan or any other program that is available at no charge to you, such as a program through the American Lung Association or the American Cancer Society.

At the time of enrollment in a medical option:

- If you certify yourself as a non-tobacco user, you will not be subject to the annual tobacco user surcharge.
- If you certify yourself as a tobacco user, you will be subject to the tobacco user surcharge.
- If you certify that you have completed a reasonable alternative standard (such as a tobacco cessation program through your medical option), you will not be subject to the “tobacco user” surcharge.

- If you certify during Annual Enrollment (before the beginning of the Plan Year) that you are a tobacco user but intend to meet a reasonable alternative standard (such as completing a tobacco cessation program) during the applicable Plan Year, you will not be subject to the tobacco user surcharge if you then meet the reasonable alternative standard during the Plan Year.

If Your Status as a Tobacco User Changes During the Year

If you have a change in tobacco user status after the beginning of the Plan Year (January 1), go to ***UPoint*** to have your status updated. For example, if you are currently certified as a tobacco user and have quit using tobacco products, go to ***UPoint*** or contact the ***Aon HR Service Center***. If, after the beginning of the Plan Year, you become tobacco-free, your surcharge will end as soon as administratively feasible following your certification for the months remaining in the Plan Year. However, if you meet the reasonable alternative standard, you may be eligible to avoid the surcharge for the entire Plan Year.

How the Reasonable Alternative Standard Works If You Have Difficulty Quitting Tobacco

Aon is committed to helping you achieve your best health. If you are a tobacco user, Aon offers tobacco cessation programs at no cost to you through the applicable Insurers. If you are a tobacco user and attest prior to the beginning of the Plan Year that you will complete and actually do complete the reasonable alternative standard by July 31, you will not be subject to the surcharge for the **entire** year.

If you are a tobacco user and do **not** certify that you intend to complete a tobacco cessation program before the beginning of the Plan Year and indicate later (for example, on or after January 1) that you would like to complete a tobacco cessation program, you may be eligible to avoid the tobacco surcharge for the months after you complete the tobacco cessation program.

While the ultimate goal is to help you become a non-tobacco user, you will not be subject to the annual surcharge as long as you satisfy the reasonable alternative standard. However, if you are unable to quit, you are required to complete another tobacco cessation program to avoid the non-tobacco user surcharge in a subsequent year.

If your personal Doctor determines that quitting tobacco or completing a tobacco cessation program is not medically appropriate for you, the Plan will provide a reasonable alternative standard that accommodates the recommendations of your personal Doctor with regard to medical appropriateness. Contact the ***Aon HR Service Center*** with the Doctor recommendations.

Also, you can contact the ***Aon HR Service Center*** to obtain more information on the reasonable alternative standard, including tobacco cessation programs that are available to you at no cost.

When Coverage Begins

New Colleagues

If you enroll within 31 days of your hire date, coverage generally begins on your hire date.

If enrolled when you are first eligible for coverage, your Eligible Dependents' coverage is effective on the day your coverage begins.

Current Colleagues

If you enroll during Annual Enrollment, participation for you and your enrolled Eligible Dependents begins on the next January 1.

New Retirees

If you meet the retiree age and Years of Service requirements, coverage for you and your Eligible Dependents begins on the first day after your coverage as an active employee ends. If you decline medical coverage as a retiree, you may enroll at a later date by contacting the ***Aon HR Service Center***. If you subsequently decline medical coverage, you will not be permitted to re-enroll in medical coverage (but you may enroll in dental and vision coverage).

Changing Your Coverage

During the Year

Once you enroll in coverage, your elections for health coverage and Flexible Spending Accounts generally stay in effect for the entire calendar year. However, you can make changes during the year with regard to these Plan benefits if one of the following occurs:

- A qualified change in status affects you or your Eligible Dependent's eligibility under the Plan (a "Status Change");
- You or your Eligible Dependent experiences an event that qualifies as a special enrollment right (a "Special Enrollment Right"); or
- Another specified change in circumstance (outlined below) occurs.

The above events are collectively referred to under the Plan as "Qualifying Life Events." Any change to your coverage made in connection with a Qualifying Life Event must be on account of and consistent with that event, and also made within specific deadlines.

Status Changes

A Status Change is a specific change in circumstance that affects your eligibility for certain Plan benefits or benefits provided under your Spouse's, Domestic Partner's, or Eligible Dependent's employer-provided plan:

- You get married, divorced, or legally separated, or your marriage is annulled.
- You gain a Domestic Partner or lose one through separation.
- Your Spouse, Domestic Partner, or Child dies.
- You have a baby, adopt, or have a Child placed in your care for adoption.
- You acquire an Eligible Dependent, or your Eligible Dependent loses eligibility status (for example, your Child attains age 26).
- You, your Spouse, Domestic Partner, or Child moves to a new place of residence, resulting in a loss or gain of eligibility for coverage.
- You, your Spouse or Domestic Partner, or your Child has a change in employment status resulting in a loss or gain of eligibility for coverage. For example, one of you begins or ends employment (this does not apply if you are rehired within 31 days).

Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") gives you additional flexibility regarding **whom and when you can enroll in medical, dental, and vision benefits** due to marriage, birth, adoption, or placement for adoption:

- **Non-enrolled colleague:** If you are eligible but not enrolled, you can enroll as of the date of the event.
- **Non-enrolled Spouse:** If you are enrolled, you can enroll your Spouse when you marry. In addition, you can enroll your Spouse if you acquire a Child through birth, adoption, or placement for adoption.
- **New Eligible Dependents/Spouse of a non-enrolled colleague:** If you are eligible but not enrolled, you can enroll your Spouse or Child as a result of the event. However, you also must enroll in coverage.

Under HIPAA's special enrollment rules, you also can make a change during the year if you elect "no coverage" because you have coverage elsewhere (for example, under a Spouse's plan) and that other coverage later ends. These loss-of-coverage rules also apply to a Spouse or Child. However:

- The coverage must end because of a loss of eligibility, such as a divorce, termination of employment, or the other employer not making contributions to that plan. You cannot make a mid-year change under this Plan if your other coverage is lost because of something you do or do not do, such as not making your required contributions.
- You must request enrollment **within 31** days after your or your Eligible Dependents' other coverage ends or after the other employer stops contributing toward the other coverage.

If you or your Eligible Dependent is eligible but not enrolled for coverage, you are eligible to enroll if you meet either of the following conditions and you request enrollment **no later than 60 days** after the date of the event:

- You or your Eligible Dependent loses eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage.
- You or your Eligible Dependent becomes eligible for premium assistance, with respect to coverage under the Plan, due to coverage with Medicaid or CHIP.

Other Changes in Circumstances

Certain other events also permit you to change your coverage during the year. The change you make must be consistent with the event:

- A QMCSO requires you or another individual to provide health care coverage for an Eligible Dependent.
- You or your Eligible Dependent becomes eligible for or loses Medicaid coverage.
- COBRA coverage from another employer for you or your Eligible Dependent is exhausted (however, this does not include situations where you lost COBRA coverage due to non-payment of premiums or for cause).
- The enrollment period of another plan—for example, your Spouse's—is different from Aon's Annual Enrollment period and a comparable election could be made under each plan.

See the chart below for a more complete description of events that permit you to change your coverage during the year.

How to Make Changes During the Year

You can report your Qualifying Life Event via ***UPoint*** or by contacting the ***Aon HR Service Center***. You must then submit the required paperwork within 31 days (60 days if due to CHIP or Medicaid eligibility) in order to make the change. Aon also requires documentation of a particular Qualifying Life Event within the 31-day period. So, for example, if your Qualifying Life Event is a new marriage, you will need to provide a marriage certificate. If your Qualifying Life Event is the birth of your Child, you will need to provide a birth certificate. (In the case of a newborn Child, Aon may allow you to provide alternative documentation, such as documentation of birth from the hospital, if you are unable to obtain an official birth certificate within the 31-day period.) If you do not report your mid-year change and provide the necessary documentation within the 31-day period, you will not be able to make changes until the next Annual Enrollment period, unless you experience a subsequent Qualifying Life Event during the year.

As long as you take the appropriate action through ***UPoint*** within the required time frame, coverage changes will take effect on the date of the event. For example, if you get married and you enroll your Spouse through ***UPoint*** after the marriage, but within 31 days of the marriage, your new Spouse's coverage will be effective retroactive to the date of your marriage.

The following chart shows the changes you may make to your health care and Flexible Spending Account coverage based on specific Qualifying Life Events, to the extent that the event impacts eligibility for coverage and the change you want to make is consistent with the event (which will be determined by the Plan Administrator in its sole discretion). For information on making changes to other coverage due to a Qualifying Life Event, contact the ***Aon HR Service Center***.

Qualifying Life Event	Allowable Changes (To the Extent Consistent With the Event)
Marriage **Domestic partnership**	▪ Change your existing coverage. ▪ Enroll yourself and/or an Eligible Dependent. ▪ Drop coverage for yourself and/or any Eligible Dependent if coverage was gained under your Spouse/Domestic Partner's plan. ▪ Increase/enroll in or drop your Health Care or Dependent Care FSA.
Divorce **Legal separation** **Loss of domestic partnership** **Annulment of marriage** **Spouse dies** **Domestic Partner dies**	▪ Change your existing coverage. ▪ Enroll yourself and/or an Eligible Dependent if coverage is lost under your former or deceased Spouse/Domestic Partner's plan. ▪ Drop coverage for your former or deceased Spouse/Domestic Partner and any Eligible Dependents if they become covered under your former Spouse/Domestic Partner's plan. ▪ Increase/enroll in or drop your Health Care or Dependent Care FSA.

Qualifying Life Event	Allowable Changes (To the Extent Consistent With the Event)
Birth **Adoption** **Legal guardianship** **Child gains coverage eligibility**	▪ Change your existing coverage. ▪ Enroll yourself and/or an Eligible Dependent. ▪ Drop coverage for yourself and/or any Eligible Dependent if you become covered under your Spouse/Domestic Partner's plan. ▪ Increase/enroll in or drop your Health Care or Dependent Care FSA. *In the event of a QMCSO, you can enroll only the Child(ren) named in the QMCSO plus you must enroll yourself (if you are not already covered).You may not use the event to enroll other Eligible Dependents.*
Child loses coverage eligibility under the Plan; Child dies (Your Child losing coverage eligibility may continue health care coverage through COBRA)	▪ Drop coverage for the affected/deceased Child. ▪ Increase/enroll in or drop your Health Care or Dependent Care FSA. *You may not make a change to your own or any other Eligible Dependent's existing coverage.*
Move to a new address that results in a coverage eligibility change	▪ Change your existing coverage. ▪ Enroll yourself and/or any Eligible Dependent. ▪ Increase/enroll in or drop your Dependent Care FSA. *You may not make a change to your Health Care FSA.*
Take a leave of absence	▪ Drop coverage for yourself and/or your Eligible Dependents if you lose eligibility for coverage. *Your Dependent Care FSA ends automatically.*
Return from a leave of absence	▪ Enroll yourself and/or your Eligible Dependents within 31 days from the date you return to active employment. *You may re-enroll in Dependent Care FSA, which automatically ended upon leave.*
You gain benefits eligibility due to a work situation change or you go on an expatriate assignment	▪ Enroll yourself and/or your Eligible Dependents. ▪ Enroll in Health Care or Dependent Care FSA.
You lose Plan benefits eligibility due to a work situation change	▪ Drop coverage for yourself and/or your Eligible Dependents. ▪ Drop your Health Care or Dependent Care FSA.
You lose benefits eligibility for another employer's group health plan	▪ Enroll yourself and/or your Eligible Dependents if coverage or a subsidy was lost under another employer's plan. ▪ Enroll in Dependent Care FSA. *You may not make a change to your Health Care FSA.*
You lose an employer subsidy from another employer's group health plan	▪ Enroll yourself and/or your Eligible Dependents if coverage or a subsidy was lost under another employer's plan. ▪ Enroll in Health Care FSA. *You may not make a change to your Dependent Care FSA.*
Family member gains benefits eligibility due to a work situation change	▪ Drop coverage for yourself and/or your Eligible Dependents. ▪ Drop your Health Care or Dependent Care FSA.
Family member loses benefits eligibility due to a work situation change	▪ Change your existing coverage. ▪ Enroll yourself and/or any Eligible Dependents. ▪ Enroll in or increase your Health Care or Dependent Care FSA.
Family member gains a benefit option	▪ Drop coverage for yourself and/or your Eligible Dependents. ▪ Enroll in, increase, or drop your Dependent Care FSA. *You may not make a change to your Health Care FSA.*

Qualifying Life Event	Allowable Changes (To the Extent Consistent With the Event)
Family member loses coverage under another employer's plan	▪ Change your existing coverage. ▪ Enroll yourself and/or any Eligible Dependents. ▪ Enroll in, increase, or drop your Dependent Care FSA. *You may not make a change to your Health Care FSA.*
Family member's cost for coverage increases significantly (Only if no other coverage is available under your family member's plans)	▪ Enroll yourself and/or your Eligible Dependents. Any changes to your Dependent Care FSA are only permitted if the provider is not a relative. *You may not make a change to your Health Care FSA.*
Family member's cost for coverage decreases significantly	▪ Drop coverage for yourself and/or your Eligible Dependents if coverage was gained under your Spouse/Domestic Partner's plan. Any changes to your Dependent Care FSA are only permitted if the provider is not a relative. *You may not make a change to your Health Care FSA.*
Family member makes new coverage choices during another employer's annual enrollment period	▪ Enroll yourself and/or your Eligible Dependent. ▪ Drop coverage for yourself and/or any Eligible Dependents. ▪ Enroll in, increase, or drop your Dependent Care FSA. *You may not make a change to your Health Care FSA.*
COBRA coverage from another employer expires or you discontinue COBRA coverage from another employer	▪ Enroll yourself and/or your Eligible Dependents. ▪ Enroll in or increase your Health Care FSA. *You may not make a change to your Dependent Care FSA.*
You or your family member becomes entitled to Medicare or Medicaid	▪ Drop coverage only for the person who becomes entitled to Medicare or Medicaid. ▪ Drop your Health Care FSA. *You may not make a change to your Dependent Care FSA. You may not make a change to any other Eligible Dependent's coverage.*
You or your family member loses Medicare or Medicaid	▪ Change your existing coverage. ▪ Enroll yourself and/or your Eligible Dependents. ▪ Enroll in or increase your Health Care FSA. *You may not make a change to your Dependent Care FSA.*
Your Child becomes eligible for premium assistance due to CHIP coverage	▪ Enroll yourself if you are not already covered. ▪ Drop coverage only for the person who becomes entitled to CHIP. ▪ Drop your Health Care FSA. *You may not make a change to your Dependent Care FSA. You may not make a change to any other Eligible Dependent's coverage.*
Your Child loses CHIP coverage	▪ Enroll yourself and/or your Eligible Dependent. ▪ Enroll in or increase your Health Care FSA. *You may not make a change to your Dependent Care FSA. You may not make a change to any other Eligible Dependent's coverage.*
You or your family member loses coverage under a government or educational institution's plan	▪ Change your existing coverage. ▪ Enroll yourself and/or your Eligible Dependent. *You may not make a change to your Health Care FSA or Dependent Care FSA.*

Additional Requirements for Changes to Health Care FSAs and Dependent Care FSAs

- **Health Care FSA.** Generally, election changes may not be made to reduce your Health Care FSA election mid-year. However, election changes may be made to cancel your Health Care FSA coverage completely due to the occurrence of the following events: death of your Spouse, divorce, legal separation, death of an Eligible Dependent, or someone ceases to be an Eligible Dependent (for example, a Child attains age 26). If you cancel Health Care FSA coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. In addition, special rules apply and generally limit the ability to make changes to the Health Care FSA.
- **Dependent Care FSA.** For the Dependent Care FSA, you may change or terminate your election with respect to a Qualifying Life Event only if: (1) such change or termination is made on account of and consistent with a Qualifying Life Event that affects eligibility for coverage under the Dependent Care FSA; or (2) your election change is on account of and consistent with a Qualifying Life Event that affects the eligibility of dependent care expenses for the available tax exclusion. For example, if your Child attains the age of 13 and he or she is no longer eligible as a dependent for Dependent Care FSA purposes, prospectively cancelling coverage would be consistent with that event.

The Aon Active Health Exchange

Aon offers medical, dental, vision, life insurance, and AD&D Insurance coverage (as well as the Auto & Homeowners Insurance, Pet Insurance, Identity Theft Protection, and the Legal Services Plan) through a private health exchange. The Aon Active Health Exchange is an innovative online marketplace that allows you to shop for coverage just as you would shop for other items online. You can choose from multiple coverage options and a variety of Insurers, depending on where you live. Please note that the Aon Active Health Exchange is **not** the state governmental exchanges required under the Affordable Care Act, but the process of selecting coverage is similar.

The Aon Active Health Exchange medical, dental, and vision options do not apply to expatriates, as they are covered by a separate health care plan.

What Is the Aon Active Health Exchange?

An exchange creates a centralized and efficient way to deliver health care coverage and also encourages you to compare options and prices.

How Do I Select Coverage Under the Aon Active Health Exchange?

It's important that you take some time to review your options and your coverage needs using the information and tools provided. Our goal is to ensure that you have clear and comprehensive information regarding your choices as well as instructions for the enrollment process.

For medical, dental, and vision coverage, options are named by a metallic level; *e.g.*, Platinum, Gold, etc. A number of Insurers are affiliated with each option. See the ***Whom to Contact*** chart in the ***Introduction*** section for the list of Insurers.

You'll have access to a number of resources before and during the enrollment process, including FAQs, benefit summary guides, comparison charts, a pricing modeler, and decision support tool. Visit the Aon Benefits Link for additional information about the exchange.

Your Medical Coverage

Aon provides several fully insured medical options through the Aon Active Health Exchange. Each medical option offers coverage for medical services and prescription drugs. Prescription drug coverage is included as part of your medical option through your selected Insurer. A Health Savings Account ("HSA") is also available if you are covered under the Bronze, Bronze Plus, or Silver option.

All options provide full—or 100%—comprehensive coverage for in-network preventive care (as defined by the Insurer) for you and your covered Eligible Dependents.

Please note that this section does not apply to expatriates as they are covered by separate medical options. See the applicable coverage summaries for more information.

What Medical Options Will Be Available?

You can choose from five coverage levels and a variety of medical insurance companies depending on where you live. Each coverage level is available from different insurance carriers at different costs.

To become a Participant under a medical option, you must meet all eligibility requirements and enroll in coverage. You may also enroll any Eligible Dependents. You will automatically receive ID cards for you and your enrolled Eligible Dependents when your enrollment is processed.

The Insurer for each medical option has provided detailed information about the various options available to you. These summaries are available on the ***UPoint*** website and can also be requested in print, free of charge, from the Insurer. The coverage summaries will:

- Include any cost-sharing provisions, such as copayments, coinsurance, deductibles, and out-of-pocket maximum amounts.
- Include any applicable annual maximums or other limits.
- Define in-network health care providers, such as a Doctor or hospital.
- Describe what preventive care services are covered and what other services and expenses are covered or not covered.

Overview of Options

When you enroll in coverage, ***UPoint*** will show the various options available to you based on where you live. You will have access to each Insurer that offers benefits in your geographic area that match the designated plan design for each health care option. Not all options will be available in all areas, so it's important to review your options and decide what coverage best meets the needs of you and your family.

PPO Option—Most Platinum and Gold Options

The Preferred Provider Organization ("PPO") medical options (most Platinum and Gold options) offer access to networks of Doctors, hospitals, and other health care providers that have agreed to provide medical care at negotiated rates. You and your Eligible Dependents are not required to use a primary care physician ("PCP") to coordinate care under the PPO option. You can receive care from any health care provider you choose, but benefits are paid at a higher level when care is received from network providers. If you or your Eligible Dependents receive care from a provider who is not in the PPO option's network, benefits are paid at a lower level or may be limited entirely in some areas.

Most PPO options also include an annual deductible that must be satisfied before the option pays benefits for covered services. In addition, you pay a copayment for office visits; for most other services, after you meet the annual deductible, you pay a percentage of the cost—known as "coinsurance"—which will be higher if you use out-of-network providers. Also, if your expenses for out-of-network care are more than the reasonable and customary ("R&C") charges, you will pay the excess amount. R&C is a charge for a service consistent with the average or usual charge for that service within your geographic area. The R&C amount is typically based on the amount Medicare pays.

HDHP Options With an Available HSA—Silver, Bronze, and Bronze Plus Options

The High-Deductible Health Plan ("HDHP") medical options with an available HSA (Silver, Bronze, and Bronze Plus options) are a type of consumer-driven health care plan using a PPO plan base paired with a high annual deductible that must be satisfied before medical and prescription drug benefits are paid. You can receive care from either in- or out-of-network providers. The HDHP does not require you to select or have your care coordinated through a PCP. You also do not need a referral to see a specialist. The HDHP may pay for preventive care, including preventive care as defined by the Affordable Care Act, before you reach your deductible. For details on what is considered preventive care for this purpose, please contact your Insurer.

While these options include a higher deductible than the other medical options, they may also be paired with a Health Savings Account that you can use to help satisfy your deductible. After you meet the annual deductible, you pay a percentage of the cost—known as "coinsurance"—which will be higher if you use out-of-network providers. In addition, if your expenses for out-of-network care are more than the R&C charges, you will pay the excess amount.

For all medical options, you should refer to the coverage summaries provided by the medical insurance companies for detailed information about limitations on benefits, covered preventive care services, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for obtaining in-network and out-of-network services. Any cost-sharing provisions, such as your deductible, copayment, coinsurance, or annual out-of-pocket maximum are also explained in the coverage summaries.

Health Savings Account

The Health Savings Account ("HSA") permits you to contribute a portion of your pay (subject to IRS limits) to a separate account that is maintained by a trustee or custodian outside of the Plan. Funds in your account may be used to pay for IRS-approved health care expenses on a before-tax basis, providing you with a tax benefit. Any unused funds remaining in your HSA at the end of the year automatically roll over to the following year and can be used for future eligible expenses, even if you are no longer employed by Aon. The terms and conditions of the HSA are governed by the HSA trust or custodial agreement, which is **not** a part of this Plan. You may obtain a copy of the HSA trust or custodial agreement from the Plan Administrator. If you have an HSA claims dispute over expenses, contact Your Spending Account.

Eligibility

You are considered an eligible individual and therefore eligible to make and receive contributions to an HSA if you are:

- Covered by an HDHP (Bronze, Bronze Plus, and Silver options);
- Not also covered by any non-HDHP, including a Health Care FSA, such as through your Spouse;
- Not enrolled in Medicare; and
- Not claimed as a Tax Dependent on another person's tax return.

IRS regulations state that before-tax dollars contributed to an HSA cannot be used to reimburse expenses incurred by Domestic Partners and their Eligible Dependents, unless the person receiving the reimbursement qualifies as your Tax Dependent. However, your Domestic Partner can open his or her own HSA and contribute up to the family HSA annual maximum (plus catch-up contributions, if applicable) in addition to your contributing up to the family HSA annual maximum to your HSA.

Enrollment in Medicare

If you are enrolled in Medicare, you cannot contribute to an HSA. This means that some individuals upon reaching age 65 will no longer be eligible to contribute to an HSA. Please consult a tax advisor about tax consequences if you apply for Social Security benefits or are beyond your full Social Security retirement age.

Coordination With FSA

If you elect to participate in either the Bronze, Bronze Plus, or Silver medical option, which are HSA-eligible plans, and you contribute to the HSA, you are permitted to participate only in a limited-purpose Health Care FSA. Likewise, if you elect to participate in a traditional Health Care FSA, you can participate in any medical option, but for the Bronze, Bronze Plus, or Silver medical options, you cannot contribute to the HSA. In general, a limited-purpose FSA allows you to reimburse yourself only for eligible vision and dental expenses, as well as other medical expenses incurred once your deductible is satisfied. See more information in the ***Your Flexible Spending Accounts (FSAs)*** section.

Health Maintenance Organizations

Depending on where you live, the HMO option, if available, offers access to networks of Doctors, hospitals, and other health care providers that have agreed to provide medical care at negotiated rates. You and your Eligible Dependents are required to use a PCP to coordinate care under the HMO option. If you or your Eligible Dependents receive care from a provider who is not in the HMO option's network, services are not covered. In accordance with the Affordable Care Act and as of January 1, 2017, if you cover an adult Child under an HMO, coverage will not be restricted based on where the adult Child (up to the age of 26) lives. For example, if your Child attends school outside of the HMO's service area, he or she will still be eligible for coverage. This special rule **only** applies to adult Children up to the age of 26.

Patient Protections Disclosure
The Affordable Care Act provides you with the following patient protections with respect to benefit packages, such as an HMO, that require the designation of a PCP:

- You have the right to designate any PCP who participates in the provider network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of participating PCPs, contact the applicable HMO.
- For Children, you may designate a pediatrician as the PCP.
- You do not need prior authorization from an HMO or from any other person (including a PCP) to obtain access to obstetrical or gynecological care from a health care professional in the 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 following procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the applicable HMO.

Coverage Levels and Cost-Sharing at a Glance

You have several coverage levels to choose from, including:

All States but Hawaii	Hawaii
Bronze: A basic, high-deductible plan that is compatible with a Health Savings Account ("HSA") and includes prescription drug coinsurance. **Bronze Plus:** A buy-up to the Bronze option—a high-deductible option with an HSA and prescription drug coinsurance. **Silver:** A high-deductible plan with an HSA and prescription drug coinsurance. **Gold/Gold II*:** A PPO plan with prescription drug copayments. **Gold II applies only to California residents. Insurance carriers can offer either the Gold or Gold II option, not both. The Gold II option only offers in-network benefits.* **Platinum:** A PPO plan** with prescription drug copayments that covers in-network care and offers limited benefits for out-of-network care (or, for some Insurers in CA, CO, DC, GA, MD, OR, VA, and WA, an HMO plan with prescription drug copayments that covers in-network care only). ****California Residents:** Your plans might be a little different, depending on the Insurer you choose. Some of these plans may be HMOs. Contact the Insurers directly and/or see your enrollment materials for more information.*	**Hawaii Medical Service Association ("HMSA") Gold:** A comprehensive medical option with a deductible and separate medical and prescription drug out-of-pocket maximums. **Kaiser Gold:** An HMO option that covers in-network care only and has a deductible and prescription drug copays for most medications. **HMSA Platinum:** A PPO option with separate medical and prescription drug out-of-pocket maximums. **Kaiser Platinum:** An HMO option that covers in-network care only and has prescription drug copays for most medications.

Each coverage level outside Hawaii is available from different Insurers at different costs, except as noted for California residents in the Gold or Gold II option.

Annual Deductible and Out-of-Pocket Maximum

The deductible is what you pay out-of-pocket before your insurance starts paying its share of your costs. It doesn't include amounts taken out of your paycheck for health coverage.

Here's how the deductible works if you have family coverage:

The Bronze Plus and Silver coverage levels have a "true family deductible."	**The Bronze, Gold, and Platinum coverage levels have a traditional deductible.**
This means that the entire family deductible must be met before your insurance will pay benefits for any covered family member. There is no "individual deductible" in these plans when you have family coverage.	Once a covered family member meets the **individual** deductible, the plan begins paying benefits for that family member (*i.e.*, you or an Eligible Dependent). Charges for all covered family members will continue to count toward the family deductible. Once the family deductible is met, the plan pays benefits for all covered family members. **Note:** In California, the Bronze Plus and Silver coverage levels under Health Net and Kaiser feature a traditional deductible.

The out-of-pocket maximum is the most you and your covered family members would have to pay in a year for health care costs. It doesn't include amounts taken out of your paycheck for health coverage.

Here's how the out-of-pocket maximum works if you have family coverage:

The Bronze Plus and Silver coverage levels have a "true family out-of-pocket maximum."	**The Bronze, Gold, and Platinum coverage levels have a traditional out-of-pocket maximum.**
This means that the entire family out-of-pocket maximum must be met before the plan pays the full cost of covered charges for any covered family member. There is no "individual out-of-pocket maximum" in these plans when you have family coverage. This provision complies with the Affordable Care Act limitation on out-of-pocket maximums, because Aon's family out-of-pocket maximum for the Bronze Plus and Silver coverage levels are equal to the Affordable Care Act individual out-of-pocket maximum.	Once a covered family member meets the **individual** out-of-pocket maximum, the plan pays the full cost of covered charges for that family member. Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, the plan pays the full cost of covered charges for all covered family members. **Note:** In California, the Bronze Plus and Silver coverage levels under Health Net and Kaiser feature a traditional out-of-pocket maximum.

Deductibles and Out-of-Pocket Maximum (at a glance)

All States but Hawaii						
	Bronze	**Bronze Plus**	**Silver**	**Gold**	**Gold II**	**Platinum**
Annual Deductible (Individual/ family)	In-network: $3,300/ $6,600	In-network: $2,450/ $4,900[2]	In-network: $1,500/ $3,000[2]	In-network: $800/ $1,600	In-network: N/A	In-network: $250/ $500
	Out-of-network: $3,300/ $6,600	Out-of-network: $2,450/ $4,900[2]	Out-of-network: $1,500/ $3,000[2]	Out-of-network: $1,600/ $3,200	Out-of-network: N/A	Out-of-network: $5,000/ $10,000
Annual Out-of-Pocket Maximum (Individual/ family)[1]	In-network: $6,400/ $12,800	In-network: $3,900/ $7,800	In-network: $3,800/ $7,600	In-network: $3,600/ $7,200	In-network: $5,400/ $10,800	In-network: $2,300/ $4,600
	Out-of-network: $12,800/ $25,600	Out-of-network: $11,500/ $23,000	Out-of-network: $8,000/ $16,000	Out-of-network: $7,200/ $14,400	Out-of-network: N/A	Out-of-network: $11,500/ $23,000

[1] See the ***Affordable Care Act Protections for Medical and Pharmacy Benefits*** section for additional details regarding the in-network out-of-pocket expense maximum.

[2] In California, under Health Net and Kaiser, if you cover Dependents, no covered member pays more than $2,600 toward the family deductible. Under Health Net, the Bronze Plus family deductible is $4,550, and the Silver family deductible is $3,250.

Some Insurers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

Hawaii				
	HMSA Gold	**Kaiser Gold**	**HMSA Platinum**	**Kaiser Platinum**
Annual Deductible (Individual/family)	Combined in-network and out-of-network: $200/$600	In-network: $200/$400	In-network: N/A	In-network: N/A
	Combined in-network and out-of-network: $200/$600	Out-of-network: Not covered	Out-of-network: $100/$300	Out-of-network: Not covered
Annual Out-of-Pocket Maximum (Individual/family)[1]	Combined in-network and out-of-network: $2,200/$6,600	In-network: $2,200/$4,400	In-network: $2,500/$7,500	In-network: $2,500/$7,500
	Combined in-network and out-of-network: $2,200/$6,600	Out-of-network: N/A	Out-of-network: $2,500/$7,500	Out-of-network: N/A

[1] See the ***Affordable Care Act Protections for Medical and Pharmacy Benefits*** section for additional details regarding the in-network out-of-pocket expense maximum.

In-Network Benefits (at a glance)

All States but Hawaii					
	Bronze/ Bronze Plus	**Silver**	**Gold**	**Gold II**	**Platinum**
In-Network Preventive Care Covered in Accordance With the Affordable Care Act	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%	Covered 100%, no deductible
Doctor's Office Visit	You pay 25% after deductible	You pay 25% after deductible	You pay $25 for PCP visit with no deductible You pay $40 for specialist visit with no deductible	You pay $25 for PCP visit You pay $40 for specialist visit	You pay $25 for PCP visit with no deductible You pay $40 for specialist visit with no deductible
Emergency Room	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 30%	You pay 15% after deductible
Urgent Care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 30%	You pay 15% after deductible
Inpatient Care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 30%	You pay 15% after deductible
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	If not an office visit, you pay 25% after deductible	If not an office visit, you pay 30% after deductible	You pay 15% after deductible

Hawaii				
	HMSA Gold	**Kaiser Gold**	**HMSA Platinum**	**Kaiser Platinum**
In-Network Preventive Care Covered in Accordance With the Affordable Care Act	Covered 100%; deductible waived for most services	Covered 100%; deductible waived	Covered 100%	Covered 100%
Doctor's Office Visit	You pay $12 after deductible	You pay $15	You pay $12	You pay $15
Emergency Room	You pay 20% after deductible	You pay 20%; deductible waived	You pay 20%	You pay $75
Urgent Care	You pay $12 after deductible	You pay $15	You pay $12	You pay $15
Inpatient Care	You pay 20% after deductible	You pay 10% after deductible	You pay 10%	You pay $75 per day
Outpatient Care	Cost share based on place of service	Cost share based on place of service	Cost share based on place of service	Cost share based on place of service

The cost-sharing specified in this SPD is intended to be a summary of the most common covered services offered across Insurers. It does not cover out-of-network cost-sharing or special cost-sharing for California residents. To see a comparison of each medical option's details (including out-of-network cost-sharing and cost-sharing for California residents), when you enroll online, check the boxes next to medical plans that you want to review and click "Compare" (under the check marks). You may also call the Insurers directly and receive a copy of the summaries of coverage free of charge.

Primary Care Doctor

You are required to designate a primary care physician to coordinate your medical care if you:

- Choose Kaiser Permanente as your Insurer;
- Live in Northern California and choose Health Net as your Insurer; or
- Live in Southern California and choose Gold II as your medical option and Health Net as your Insurer.

See the Patient Protections Disclosure above for additional details.

Critical Illness Insurance

Critical Illness Insurance provides a limited benefit to you in the event you are diagnosed with certain specified diseases or have certain surgical procedures performed. If you enroll in either the Silver, Bronze, or Bronze Plus medical option, Critical Illness Insurance – Core Coverage in the amount of $3,000 is automatically included for you and your Eligible Dependent. No action is required on your part to participate.

For all other medical options or if you waive medical coverage, participation in Critical Illness Insurance is voluntary. You can elect Critical Illness Insurance – Supplemental Coverage. See the ***Your Critical Illness Insurance*** section for additional information.

Wellbeing

Aon offers both formal and informal programs to support your wellbeing and health. Below is an overview of the 2020 features.

Preventive Care Services

As required by the Affordable Care Act, each medical option, including prescription drug, covers a wide array of in-network preventive, routine care items, and services with no cost-sharing (*i.e.*, no copayment, coinsurance, or deductible). You may also refer to the coverage summaries for additional information about preventive care services provided with no cost-sharing, depending on your coverage.

In-network preventive care items and services that must be provided without cost-sharing change periodically. Information about what in-network preventive care items and services must be provided at no cost to you under the Affordable Care Act is available at **https://www.healthcare.gov/preventive-care-benefits/**.

In-network preventive care items and services with no cost-sharing include a number of screenings (*e.g.*, blood pressure, cholesterol, diabetes, and lung cancer screenings), immunizations, counseling (*e.g.*, alcohol misuse, obesity and tobacco use counseling), colonoscopies (including many related items and services, such as a specialist consultation, bowel preparation medications, anesthesia, and polyp testing), and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death.

For women, the Aon medical options also will cover in-network, with no cost-sharing, an annual well-woman visit (and additional visits in certain cases); screening for gestational diabetes; testing for the human papilloma virus; counseling for sexually transmitted diseases; counseling and screening for human immunodeficiency virus (HIV); FDA-approved contraceptive methods and counseling as prescribed for women; breastfeeding support (including lactation counseling services), supplies and counseling; and screening and counseling for interpersonal and domestic violence.

In addition, a woman who is at increased risk for breast cancer may be eligible for screening, testing, and counseling and if at low risk for adverse medication effects may be eligible to receive risk-reducing medications, such as tamoxifen or raloxifene, in-network, without cost-sharing. If your Doctor prescribes this type of medication to reduce your risk of breast cancer, contact your medical/prescription drug option to ensure that you satisfy the administrative requirements necessary to receive this benefit. You may be required to meet requirements beyond just submitting the prescription. For example, you and/or your Doctor may need to demonstrate that you are at an increased risk for breast cancer.

Note: The Plan generally may use reasonable medical management techniques to determine frequency, method, treatment, age, setting, and other limitations for a recommended preventive care service. When preventive and non-preventive care is provided during the same office visit, special rules apply regarding whether or not cost-sharing will be imposed.

If you have any questions regarding whether a particular preventive care item or service will be offered with no cost-sharing, contact your Insurer.

Medical Insurer Programs

Your Insurer offers other programs, including:

- Utilization review programs (*e.g.*, case management, behavioral health management, and healthy maternity program);
- Disease management programs, including:
  - Arthritis;
  - Asthma;
  - Cardiology;
  - Chronic obstructive pulmonary disease (COPD);
  - Congestive heart failure;
  - Coronary artery disease;
  - Depression;
  - Diabetes;
  - Hypertension;
  - Lower back pain;
  - Musculoskeletal; and
  - Oncology.
- 24-hour nurse line;
- Weight management program; and
- Smoking cessation program.

Note: Not every Insurer provides each of these programs. See the coverage summaries for what your Insurer provides.

Employee Assistance Program ("EAP")

See the ***Your Employee Assistance Program ("EAP")*** section for more information.

Rescission of Coverage

Health care coverage under the Plan may be rescinded (cancelled retroactively) if you or a covered Eligible Dependent performs an act, practice, or omission that constitutes fraud against the Plan or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage also may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-Spouse under the Plan. Coverage will be cancelled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered Eligible Dependent. Any rescission of coverage will comply with the Affordable Care Act. You will receive 30 days' advance written notice of any cancellation of coverage to be made on a prospective basis.

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

Continuation of Coverage Through COBRA

If your medical coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your Eligible Dependents may be eligible to elect to continue coverage under COBRA. You and your covered Eligible Dependents may continue coverage at your own expense for a specific length of time. See the ***Continuation Coverage Under COBRA*** section for additional information.

Your Prescription Drug Coverage

As part of your medical option election, prescription drug coverage is included for medications that are approved by the U.S. Food and Drug Administration ("FDA"), prescribed by a Doctor, and filled at a participating retail pharmacy or through the mail service program offered by the medical insurance company you select.

Detailed information about prescription drug coverage is included in the medical benefit coverage summaries available via ***UPoint***. These summaries can also be requested in print, free of charge, from the Insurer. The coverage summaries will include any cost-sharing provisions including copayments, coinsurance, and any applicable maximums or other limits.

Your prescription drug coverage includes two components:

- **Retail Pharmacy Program:** Up to a one-month supply of prescription drugs for immediate and short-term prescription drug needs. If refills are allowed, you can refill the prescription at a participating pharmacy generally after 75% of the initial prescription is used. You pay the retail copayment for the initial fill and the first refill. See your medical benefit coverage summary for additional information.

  If you buy your medications out-of-network, you pay the full cost and then submit a paper claim for reimbursement based on the eligible cost of the drug.

- **Mail Service Program:** Up to a three-month supply of medication for ongoing medical conditions (such as high blood pressure, asthma, etc.). Please note that mail order may be mandatory depending on which medical option you choose. Refer to the medical benefit coverage summary for additional information.

  Note: If you change Insurers from the previous year and you are taking a maintenance medication, you will need to request a new prescription from your Doctor to submit to the new Insurer as soon as possible.

Below is an overview of the in-network coverage for each coverage level.

All States but Hawaii				
	Bronze / Bronze Plus	**Silver**	**Gold/Gold II**	**Platinum**
Preventive Drugs (determined by the Insurer, as required by the Affordable Care Act)	You pay $0. You must have a Doctor's prescription for the medication—even for products sold over-the-counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.			
30-Day Retail Supply				
Tier 1: Generally Lowest-Cost Options	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $10	You pay $8
Tier 2: Generally Medium-Cost Options	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $40	You pay $30
Tier 3: Generally Highest-Cost Options	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $60	You pay $50
90-Day Mail-Order Supply				
Tier 1: Generally Lowest Cost Options	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $25	You pay $20
Tier 2: Generally Medium-Cost Options	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $100	You pay $75
Tier 3: Generally Highest-Cost Options	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $150	You pay $125

Hawaii				
	HMSA Gold	**Kaiser Gold**	**HMSA Platinum**	**Kaiser Platinum**
Preventive Drugs (determined by the Insurer, as required by the Affordable Care Act)	You pay $0. You must have a Doctor's prescription for the medication—even for products sold over-the-counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.			
Prescription Drug Annual Out-of-Pocket Maximum (individual/family)	$3,000/$7,200	Included in medical out-of-pocket maximum	$3,000/$5,700	Included in medical out-of-pocket maximum
30-Day Retail Supply				
Tier 1: Generally Lowest-Cost Options	You pay $7	You pay $5 for generic maintenance drugs; $10 for other generic drugs	You pay $5	You pay $5 for generic maintenance drugs; $10 for other generic drugs
Tier 2: Generally Medium-Cost Options	You pay $35	You pay $35	You pay $30	You pay $35
Tier 3: Generally Highest-Cost Options	You pay $75	Not covered	You pay $70	Not covered
90-Day Mail-Order Supply				
Tier 1: Generally Lowest-Cost Options	You pay $14	You pay $10 for generic maintenance drugs; $20 for other generic drugs	You pay $10	You pay $10 for generic maintenance drugs; $20 for other generic drugs
Tier 2: Generally Medium-Cost Options	You pay $70	You pay $70	You pay $60	You pay $70
Tier 3: Generally Highest-Cost Options	You pay $150	Not covered	You pay $140	Not covered

Covered Prescription Drugs and Supplies

Most prescription drugs that are prescribed to treat an illness or injury are covered. In general, the following prescription drugs and supplies, among others, **are** covered under each medical option:

- Drugs prescribed by a Doctor that require a prescription either by federal or state law;
- Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;
- Blood- and glucose-related agents such as lancets, testing strips, and alcohol swabs; and
- Insulin, disposable insulin pens, insulin cartridges, and pen needles (both diabetic and other).

However, other limitations, such as formularies, prior authorization, and Plan limits, may also apply in determining whether a particular prescription is covered.

Prior Authorization and Limits

Certain prescriptions may require prior authorization by the Insurer. This process allows the Insurer to verify that the drug is a part of a specific treatment plan and is medically necessary. If this applies to the drug you are prescribed, your Doctor will need to contact the Insurer with written documentation of the reason for prescribing the medication and the length of time it should be covered.

Other drugs may be approved only when specific drugs have not been shown to be effective in treating a specific medical condition. If you discover that a prescription requires prior authorization or requires additional information on prior treatment while at a retail pharmacy, you or the pharmacist will need to contact your Doctor, who must then contact the Insurer.

If your prescription is authorized by the Insurer, you will be able to fill your prescription at any participating pharmacy or through the mail service program. If authorization is not received, you will be required to pay the full cost of the prescription.

Certain drugs also may be limited by drug-specific quantity limitations per month, benefit period, or lifetime, based on medical necessity. For example, a lifetime limit may be imposed on infertility drugs. If your prescription is affected by these limits, your Doctor or your pharmacist should contact the Insurer to determine what information may be needed to obtain additional quantities.

Specialty Medications

Certain drugs are considered “specialty medications” and may only be purchased through a network pharmacy, except as required in an emergency. The following are the more common therapeutic classifications of specialty medications:

Arthritis	Blood modifiers
Growth hormones (to age 16 only)	Hemophilia
IGIV	Interferon
Multiple sclerosis	Oral oncologics
Pulmonary hypertension	Respiratory treatment

For information on ordering specialty medications, dispensing limitations, and your required copayment for these drugs, refer to the coverage summary for the medical option in which you are enrolled, located on ***UPoint***.

Plan Benefits, Limitations, and Exclusions

You should refer to the materials provided by the Insurer for information concerning drugs and expenses not covered, as well as any other limitations or exclusions that may apply.

Coordination With Medicare

If you are Medicare-eligible, see the ***Coordination of Benefits*** section for information about your prescription drug coverage and coverage under Medicare.

Affordable Care Act Protections for Medical and Pharmacy Benefits

The Affordable Care Act requires that medical and prescription drug plans, such as Aon's, implement additional changes—sometimes referred to as "group market reforms" or "consumer protections." Many of these changes have already been incorporated into the medical options and/or explained in the applicable section of the SPD. A few examples:

- The medical options do not impose any lifetime or annual dollar limit on essential health benefits.
- The medical options provide preventive care benefits, as required by the Affordable Care Act, in-network without cost-sharing.

The following additional "protections" have been incorporated into your benefits. Aon is explaining here, so that you are aware of these recent changes:

In-Network Out-of-Pocket Maximum

The Affordable Care Act requires that Aon ensure that your in-network out-of-pocket maximum meets specific requirements. In 2020, the dollar thresholds are $8,150 for individual coverage and $16,300 for family coverage. The dollar thresholds generally increase annually as determined by government guidance.

Costs that apply toward your total Affordable Care Act in-network out-of-pocket maximums include deductibles, copayments, coinsurance, and prescription drug expenses. Out-of-pocket expenses that do not apply toward your Affordable Care Act in-network out-of-pocket maximums include, for example, premium contributions, spending for non-covered items and services, non-essential health benefits, and potentially, the additional cost if you purchase a brand-name prescription drug in a situation where a generic drug was available and medically appropriate as determined by your Doctor. The Affordable Care Act also requires that your individual Affordable Care Act, in-network out-of-pocket maximum is embedded in the family out-of-pocket maximum so that the individual will never satisfy more than his or her individual amount. Please contact your Insurer for more details on what applies and does not apply towards your specific out-of-pocket maximum.

Provider Nondiscrimination

The medical options offered by the Plan will not discriminate against an eligible health care provider based on his or her license or certification to the extent the provider is acting within the scope of his or her license or certification under state law. This rule is subject to certain limitations and does not require the medical options to accept all types of providers into a network.

Coverage of Emergency Services

If you need "emergency services," the medical options offered by the Plan will provide you with coverage regardless of whether the provider for such "emergency" services is in-network or out-of-network. Also, "emergency services" are subject to special cost-sharing rules that require non-grandfathered group health plans, such as the Aon medical benefit options, to not impose a higher copayment or coinsurance, for example, for out-of-network emergency services than for in-network emergencies services, but in certain circumstances you may be "balance billed." For details on this requirement, including what constitutes an emergency service, contact your medical Insurer.

Coverage for Individuals Participating in Approved Clinical Trials

Under the medical options offered by the Plan, you are eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact your medical Insurer for details.

Availability of Summary Health Information Required

As a colleague, the medical benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Plan offers a series of medical coverage options. Choosing a medical coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage ("SBC"), which summarizes important information about any medical coverage option in a standard format, to help you compare across options.

As required by the Affordable Care Act, SBCs are available on ***UPoint***. If you would like a paper copy of the SBCs (free of charge), you may contact the ***Aon HR Service Center***.

Your Critical Illness Insurance

Critical Illness Insurance provides a limited benefit to you in the event you are diagnosed with certain specified diseases or have certain surgical procedures performed. This coverage supplements your medical coverage under the Plan.

If you are an active colleague or pre-Medicare retiree enrolled in either the Silver, Bronze, or Bronze Plus medical option, Critical Illness Core Coverage in the amount of $3,000 is automatically included for you and your Eligible Dependents at no cost to you. No action is required on your part to participate.

If you are enrolled in any other medical option under the Plan, or if you are enrolled in the Silver, Bronze, or Bronze Plus medical option and want additional coverage, participation in Critical Illness Insurance is voluntary. To elect Critical Illness Supplemental Coverage in the amount of $10,000, $15,000, or $20,000 for you and your Eligible Dependents, you must meet all eligibility requirements and enroll in coverage within 31 days of your initial eligibility. The premiums for coverage will be shown in your enrollment materials. Premiums are deducted on an after-tax basis.

This benefit is fully insured and provided by Metropolitan Life Insurance Company (“MetLife”). Benefits are more fully described in the insurance certificate and other benefit materials provided by the Insurer.

You should refer to the materials provided by MetLife for additional information on benefits, exclusions or limitations that may apply to specific covered conditions. You may also contact MetLife at **1-800-GETMET8** or visit their website at **www.metlife.com/mybenefits**.

If you are electing Critical Illness Insurance, be sure to read the disclosure statement available on ***UPoint*** before enrolling in coverage.

Your Dental Coverage

Regular dental care is important to your overall health. Dental coverage under the Plan is fully insured and offered through the Aon Active Health Exchange. Your coverage helps to pay for dental care for you and your covered Eligible Dependents.

To become a Participant in the dental Benefit Program, you must meet all eligibility requirements and enroll in coverage. You may also enroll your Eligible Dependents. Any required premiums will be deducted from your pay on a before-tax basis.

Detailed information about the dental coverage and the options available to you is included in the coverage summaries. These materials will provide any cost-sharing provisions, including copays, coinsurance, deductibles, and any applicable annual or lifetime maximums or other limits. In addition, they will explain what services are covered, such as exams, dental cleanings, fillings, and extractions. You may contact the Insurer to confirm that your provider participates in its dental network before receiving care.

Affordable Care Act and the Dental Benefit Program

The dental Benefit Program is technically considered a group health plan under the federal law known as ERISA. Accordingly, you are entitled to protections under ERISA such as COBRA and the ERISA claims and appeals process. However, this Benefit Program is an excepted benefit. This means that it is not eligible for the group market reforms (sometimes referred to as “consumer protections”) under the Affordable Care Act, such as in-network preventive care without cost-sharing, an independent review organization following the ERISA claims and appeals process, or the preparation of a Summary of Benefits and Coverage (“SBC”).

What Dental Options Will Be Available?

Coverage is provided through a basic dental Preferred Provider Organization (“PPO”), a buy-up to the basic PPO, and an enhanced PPO. A dental health maintenance organization (“DHMO”) is offered through the Platinum Plan (not available in North Dakota and some other limited areas). You may enroll in dental coverage even if you do not elect medical benefits under the Plan.

If you enroll in one of the PPO options, you may use any Dentist providing dental services for which he or she is licensed. However, if you receive dental services from a Dentist who participates in the provider network, your share of the cost generally will be lower. You may choose a different participating Dentist for each covered member of your family.

If you enroll in the DHMO, covered dental expenses are paid only when you receive benefits from a participating provider (in-network).

Overview of Options

When you enroll in coverage, the ***UPoint*** website will show the various options available to you based on where you live. You will have access to each dental insurance company that offers benefits in your geographic area that match the designated plan design for each dental care option. Not all options will be available in all areas, so it’s important to review your options and decide what coverage best meets the needs of you and your family.

UPoint gives a more detailed look at the dental options and does account for some Insurer adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the plans you want to review and click “Compare” (under the check marks). In order to get the most comprehensive information about any specific coverage, you will need to call the Insurer directly.

Bronze

The Bronze options cover in- and out-of-network care but do not cover major (*e.g.*, dental implants) or orthodontia expenses. You can receive care from any health care provider you choose, but benefits are paid at a higher level when care is received from network providers. If you or your Eligible Dependents receive care from a provider who is not in the option’s network, benefits are paid at a lower level or otherwise limited in some areas.

Preventive care is covered at 100%, and you pay the deductible plus a percentage of the cost—known as “coinsurance”—for minor restorative care. Also, if your expenses for out-of-network care are more than the reasonable and customary (“R&C”) charges, you will pay the excess amount. R&C is a charge for a service consistent with the average or usual charge for that service within your geographic area.

Silver

The Silver options have the same coverage as the Bronze, but they cover major care and, for Children up to age 19, orthodontia, and they offer a higher annual maximum.

Gold

The Gold options have the same coverage as the Silver, but they cover a greater percentage for major care and provide a higher annual maximum. They cover orthodontia for Participants of all ages, and the lifetime orthodontia maximum is higher than under Silver.

Platinum: Dental Health Maintenance Organizations ("DHMOs")

The DHMO option covers in-network care only. If you or your Eligible Dependents receive care from a provider who is not in the DHMO option's network, services are not covered.

You must designate a primary care Dentist to coordinate care in this option. Preventive care is generally covered at 100%, and there is no annual maximum or deductible. You'll pay coinsurance for minor care, major care, and orthodontia.

If Delta Dental Is Your Insurer…

If Delta Dental is your Insurer, there is a PPO network and a Premier network for the Bronze, Silver, and Gold options. The PPO network offers deeper discounts, so if your Dentist is part of the Premier network only, you will have to pay more. If you're in the Platinum option, DeltaCare is the network name. Make sure your Dentist is in the DeltaCare network, not just the Delta Dental network.

Annual Deductible and Plan Limits

The deductible is what **you** pay out of pocket before your insurance starts paying its share of your costs. The annual maximum is the most the Insurer will pay in a year for dental costs. The orthodontia lifetime maximum is the total amount the Insurer will pay per person.

	Bronze	Silver	Gold	Platinum[1]
Annual Deductible (individual/family)	$100/$300	$100/$300	$50/$150	None
Annual Maximum (excludes orthodontia)	$1,000 per person	$1,500 per person	$2,500 per person	None
Orthodontia Lifetime Maximum[2]	Not covered	$1,500 per Child	$2,000 per person	Varies by Insurer

[1] Not available in North Dakota and some other limited areas. Only the coverage levels for which you are eligible will show as options when you enroll online.

[2] If you switch Insurers, any orthodontic expenses you've already incurred under your current Insurer will count toward your new Insurer's orthodontia lifetime maximum.

Other In-Network Benefits

	Bronze	Silver	Gold	Platinum[1]
Preventive Care	Covered 100%; no deductible	Covered 100%; no deductible	Covered 100%; no deductible	Varies by Insurer; generally covered 100%
Minor Restorative Care (*e.g.*, root canal treatment, gum disease treatment, and oral surgery)	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	Varies by Insurer
Major Restorative Care (*e.g.*, implants, dentures)	Not covered	You pay 40% after deductible	You pay 20% after deductible	Varies by Insurer
Orthodontia	Not covered	You pay 50%; no deductible; Children up to age 19 only	You pay 50%; no deductible; for Children and adults	Varies by Insurer

[1] Not available in North Dakota and some other limited areas. Only the coverage levels for which you are eligible will show as options when you enroll online.

The charts above are a high-level listing of commonly covered benefits across Insurers and coverage levels for the Aon Active Health Exchange. The charts are intended to provide you with a snapshot of benefits provided across coverage levels. In general, Insurers have agreed to the majority of standardized plan benefits recommended by the exchange. Individual Insurers may offer coverage that differs slightly from the standard coverage reflected here.

Note: For additional comparison, you can find Benefit Summaries on ***UPoint***.

Continuation of Coverage Through COBRA

If your dental coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your Eligible Dependents may be eligible to elect to continue coverage under COBRA. You and your covered Eligible Dependents may continue coverage at your own expense for a specific length of time. See the ***Continuation Coverage Under COBRA*** section for additional information.

Retiree Dental

If you meet the eligibility requirements for coverage in the dental Benefit Program as a retiree, you can elect retiree dental coverage for you and your Eligible Dependents. You are required to pay the entire cost of coverage under the Plan.

Your Vision Coverage

Vision coverage is designed to help pay vision care expenses for you and your covered Eligible Dependents. You have a choice of vision plan options offered by several insurance companies through the Aon Active Health Exchange.

Your vision coverage offers:

- Access to thousands of private-practice credentialed optometrists and ophthalmologists across the United States. Strict guidelines are used to credential all participating Doctors.
- Protection for you and your family, including a thorough eye exam, which can detect and diagnose numerous medical problems.

Your coverage summaries provide additional information on how benefits are paid when you access in-network and out-of-network providers.

Detailed information about the vision coverage and the options available to you is included in the coverage summaries and insurance certificates that are available on ***UPoint***. These materials will provide any cost-sharing provisions, including copayments, coinsurance, deductibles, and any applicable annual or lifetime maximums or other limits. In addition, they will explain what services are covered, such as exams, eyeglass frames and lenses, and contact lenses. You may also contact the Insurer to confirm that your provider participates in the vision network before receiving benefits.

Affordable Care Act and the Vision Benefit Program

The vision Benefit Program is technically considered a group health plan under the federal law known as ERISA. Accordingly, you are entitled to protections under ERISA such as COBRA and the ERISA claims and appeals process. However, this Benefit Program is an excepted benefit. This means that it is not eligible for the group market reforms (sometimes referred to as “consumer protections”) under the Affordable Care Act, such as in-network preventive care without cost-sharing, an independent review organization following the ERISA claims and appeals process, or the preparation of a Summary of Benefits and Coverage (“SBC”).

Please note that this section does not apply to expatriates as they are covered by a separate vision plan option. See the applicable coverage summaries.

What Vision Options Will Be Available?

Coverage is provided through two types of plan options—a discount plan that covers eye exams only and PPO plans. You may enroll in vision coverage even if you do not elect medical benefits. If you enroll in one of the PPO options, you may use any vision care provider. However, if you receive vision care from a provider who participates in the provider network, your share of the cost generally will be lower. You may utilize a different participating provider for each covered member of your family.

Overview of Options

You have several vision options available that offer a range of coverage—from exams only to coverage for lenses, frames, and contacts. Your vision plan options will include:

- Bronze: An exam-only option that provides discounts for certain materials.
- Silver: A PPO option that covers in- and out-of-network care.
- Gold: An enhanced PPO option that covers in- and out-of-network care.

When you use out-of-network providers, the Plan pays an allowance of covered expenses to your provider, and you are responsible for the difference between what the Plan pays and what your provider charges. You may also be required to file claim forms for reimbursement. When you receive services from an out-of-network provider, request a copy of the itemized bill and send a copy to your Insurer for reimbursement of covered expenses. Your claim must be submitted within the time frame specified by the Insurer, generally six months from the date of service.

In-Network Benefits

	Bronze	Silver	Gold
Routine Vision Exam (once per Plan Year)	Covered 100%[1]	You pay $20	You pay $10
Frames (once per Plan Year)	Discount may apply	$100 allowance[1]	$200 allowance[1]
Lenses (once per year; premium lenses may cost more)			
Single Vision Bifocal Trifocal Standard Progressive[2] Lenticular	Discount may apply	You pay $20	You pay $10
Lens Enhancements			
UV Treatment	Discount may apply	You pay $15	You pay $15
Tint (solid and gradient)		You pay $15	You pay $15
Standard Plastic Scratch-Resistant Coating		You pay $15	You pay $15
Standard Anti-Reflective Coating		You pay $45	You pay $45
Standard Polycarbonate – Adults		You pay $40	You pay $15
Standard Polycarbonate – Children		You pay nothing	You pay nothing
Other Add-Ons		Discount only	Discount only
Contact Lenses			
Medically Necessary	Not covered	You pay $20	You pay $10
Elective	Not covered	$100 allowance[1]	$200 allowance[1]
Fit and Evaluation	Discount may apply	You pay $20	You pay $10
Laser Surgery	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price

[1] Allowance can be used for frames or elective contact lenses, but not both.
[2] Vision benefits are for standard progressives. Enhanced progressives may cost more and will vary by Insurer.

Continuation of Coverage Through COBRA

If your vision coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your Eligible Dependents may be eligible to elect to continue coverage under COBRA. You and your covered Eligible Dependents may continue coverage at your own expense for a specific length of time. See the ***Continuation Coverage Under COBRA*** section for additional information.

Retiree Vision

If you meet the eligibility requirements for coverage in the vision Benefit Program as a retiree, you can elect retiree vision coverage for you and your Eligible Dependents. You are required to pay the entire cost of coverage under the Plan.

Your Flexible Spending Accounts (FSAs)

Flexible Spending Accounts allow you to pay out-of-pocket (unreimbursed) medical expenses through the Health Care FSA or dependent care expenses through the Dependent Care FSA.

You contribute to the FSAs on a before-tax basis—before taxes are taken out of your pay. Since you do not pay federal income or Social Security ("FICA") taxes (and in most locations, state or local taxes) on your contributions to an FSA, your taxable income is lowered, and you pay less in taxes.

Your Spending Account ("YSA") assists in the administration of your Health Care FSA and Dependent Care FSA and applies the Plan's provisions to process claims for reimbursement. You can access YSA through ***UPoint***.

How the Accounts Work

When you enroll in an FSA, you determine the amount of money you want to deposit into the Health Care FSA or Dependent Care FSA or both of the accounts, up to the applicable limits, for the coverage period.

- For the Dependent Care FSA, you pay the bill out-of-pocket and send the itemized receipt to YSA for reimbursement.
- You will be issued a YSA "debit" card for the Health Care FSA, which will have your annual election amount as an available balance. Before you use the card, call the toll-free number shown on the card to activate it and sign the back of your card.
- Use your YSA card to pay for eligible expenses when you visit eligible providers and purchase eligible health care items or services. Using the YSA card for eligible health care expenses will save you from paying out of pocket. The YSA card has been designed for use at merchants and providers that primarily sell health care products (for example, pharmacies, physician's offices, hospitals, and Dentist's offices). Each time you use the card at an approved merchant location for an eligible health care expense, you'll be prompted to choose either "credit" or "debit."
  - If you choose the debit option, you may be required to enter your four-digit Personal Identification Number ("PIN") that you selected when your YSA card was issued.
  - If you select "credit," the transaction will require your signature.
- Save your itemized receipts, as you may be required to submit additional documentation later.
- File a claim to receive reimbursement (unless you use the YSA card to pay for eligible expenses at the time of service). You can use the YSA website or the "Reimburse Me" Mobile App for your Apple® or Android™ device. Once your claim has been processed, you'll receive notification regarding the status of your claim and whether any follow-up documentation is needed.
- Receive tax-free reimbursement from the appropriate account for the incurred expense.

Electing How Much to Contribute

To become a Participant in either the Health Care FSA or Dependent Care FSA, you must meet all eligibility requirements and enroll in coverage. If you are a new colleague, you must enroll within 31 days of your initial eligibility date or you cannot participate until the next Annual Enrollment period, unless you have a Qualifying Life Event and an election change is consistent with that event. To continue participation in either FSA in the next Plan Year, you must re-enroll each year during the Annual Enrollment period.

When you enroll in either FSA, you decide how much you want to contribute to each account. The claims administrator will establish a Health Care FSA and/or Dependent Care FSA on your behalf that will be maintained for recordkeeping purposes only and will not be funded. Each account established for a period of coverage (the Plan Year) will be credited with the before-tax contributions you authorize to be deducted for that period.

Coordination With Health Savings Account (HSA)

If you elect to participate in either the Bronze, Bronze Plus, or Silver medical option, which may be paired with an HSA, IRS regulations prohibit you from participating in the traditional Health Care FSA if you contribute to the HSA. Likewise, if you elect to participate in the traditional Health Care FSA, you can participate in the Bronze, Bronze Plus, or Silver medical option but only if you do not contribute to the HSA. However, if you elect to participate in either the Bronze, Bronze Plus, or Silver medical option and contribute to the HSA, IRS regulations permit you to participate in a **limited-purpose** Health Care FSA to reimburse eligible vision and dental expenses. Or, if your medical plan deductible is satisfied, your limited-purpose FSA may be used for eligible health care expenses for the remainder of the year. You may also submit eligible preventive care expenses that do not require satisfaction of the annual deductible.

Funds from both the HSA and the limited-purpose Health Care FSA are available for use on your YSA card. If you contribute to the HSA, HSA funds are withdrawn first until you meet your deductible. Once your deductible is met, limited-purpose Health Care FSA funds are withdrawn first. If you do not contribute to the HSA but have money remaining in that account, FSA funds are withdrawn first until they are depleted; then HSA funds from the prior year are withdrawn.

If an expense is eligible under both your limited-purpose Health Care FSA and your HSA, you may submit the expense for reimbursement under either account. However, the expense may not be submitted for reimbursement under both accounts. If you plan to enroll in both accounts, be sure to plan your contributions to each carefully.

You may also obtain IRS Publication 969 “Health Savings Accounts and Other Tax-Favored Health Plans” for a description of eligible expenses under an HSA and Health Care FSA.

Annual Limitation on Use of Flexible Spending Accounts
The maximum annual amount that you may contribute to the Health Care FSA is $2,700 for 2020 (or maximum amount indexed annually by the IRS); the maximum annual amount that you may contribute to the Dependent Care FSA is the lesser of $5,000 ($2,500 if you and your Spouse file separate federal tax returns) or the Earned Income limitation described in Code Section 129(b). The minimum amount you may contribute to either account for the Plan Year is $250.

If you experience a Qualifying Life Event, you may be able to change your FSA contribution elections mid-year if the election change is consistent with that event. If you make a mid-year change to your elections, any change in contributions will also change the maximum reimbursement amount for the balance of the period of coverage, commencing with the election change.

Eligible Health Care FSA Expenses

Eligible Health Care FSA expenses are out-of-pocket “medical care expenses” (as defined in Section 213(d) of the Internal Revenue Code and IRS Publication 502) for you and your Eligible Dependents who are not covered by another health care or insurance plan. Most, but not all, of the tax-deductible expenses are reimbursable through your Health Care FSA. See also ***Coordination With Health Savings Account (HSA)*** above.

Examples of expenses incurred during the Plan Year that are eligible for reimbursement include:

- Copayments, coinsurance, and deductibles for your medical, dental, and vision benefits.
- Prescription copayments.
- Eligible over-the-counter medical supplies (itemized receipt required). Examples include:
  - Pregnancy test kits;
  - Contact lens solution;
  - Insulin and other diabetic supplies;
  - First aid supplies;
  - Hearing aid batteries; and
  - Heat wraps.
- Eligible over-the-counter items requiring a Doctor’s prescription (YSA card may not be used) and filled by the pharmacist. Examples include:
  - Allergy medications (unless filled as a “prescription” by the pharmacist);
  - Anti-itch medications;
  - Cold and flu remedies;
  - Diaper rash ointment;

  - First aid creams;
  - Lactose intolerance pills; and
  - Pain relievers.

  If a Doctor's prescription is **not** provided, you will **not** be permitted to obtain reimbursement for an over-the-counter medication or drug.

- Acupuncture, chiropractic expenses, or physical therapy.
- Childbirth preparation classes.
- Diabetic supplies, respirators, and other medical supplies.
- Smoking-cessation programs.
- Medical/mental health counseling and psychotherapy.
- Vision correction surgery.
- Orthodontics.
- Hearing aids.

Ineligible Health Care Expenses

Examples of expenses that are **not** eligible for reimbursement under the Health Care FSA are:

- Expenses claimed on your income tax return.
- Expenses not eligible to be claimed as an income tax deduction.
- Expenses reimbursed by other sources, such as insurance companies.
- Fees for fitness clubs where there is no specific medical reason for membership.
- Hair transplants.
- Insurance premiums.
- Weight-reduction programs for general wellbeing.
- Over-the-counter medicines or drugs without a prescription.
- Over-the-counter medical supplies such as:
  - Cosmetic expenses;
  - Insect repellants;
  - Lip balms;
  - Shampoo and soap;
  - Sunscreen;
  - Toothpaste and toothbrushes;
  - Teeth whitening products; and
  - Wrinkle reducers.

To obtain a list of reimbursable expenses, contact the claims administrator. You may also refer to IRS Publication 502 for additional information. This publication can be obtained at **www.irs.gov**.

Health Care FSA Eligible Dependents

For purposes of Health Care FSA eligibility, an Eligible Dependent does not include your Domestic Partner or his or her Children. Accordingly, expenses for those individuals are not eligible for reimbursement, even if they otherwise satisfy the definition of Tax Dependent under the Health Care FSA. If you are divorced or separated, you can submit eligible expenses for your Child even if you do not claim him or her as a Tax Dependent. Under the Affordable Care Act, expenses incurred for any non-prescription medication or drug (other than insulin) are not eligible for reimbursement through your Health Care FSA without a prescription. This change does not apply to items for medical care that are not medicines or drugs, such as crutches, bandages, and blood sugar test kits.

Dependent Care FSA Eligible Dependents

For purposes of Dependent Care FSA eligibility, an Eligible Dependent is:

- A Child under the age of 13 who lives with you for more than one-half of the calendar year.
- Your Spouse, Child of any age, or any other Tax Dependent if he or she is physically or mentally incapable of caring for himself or herself and lives with you for more than one-half of the calendar year. In addition, he or she must be a U.S. citizen or resident.

If you are divorced or separated and are the:

- Custodial parent, your Child is an Eligible Dependent even if you do not claim him or her as a Tax Dependent.
- Noncustodial parent, you generally cannot treat your Child as an Eligible Dependent, even if you claim him or her as a Tax Dependent.

For this purpose, custodial parent means the parent that the Child lives with for the greater part of the calendar year.

Dependent care expenses must meet all of the following requirements to be eligible for reimbursement:

- The expenses must be provided primarily for the wellbeing and protection of the Eligible Dependent.
- The care provider must meet certain tax-identification requirements and comply with state and local laws.
- The care or service must be necessary for you to work or look for work and, if you are married, for your Spouse to work, look for work, or attend school full-time (unless your Spouse is disabled).

Dependent Care FSA Eligible Expenses

Dependent Care FSA eligible expenses are those expenses you incur for services necessary for the care of your Eligible Dependent—including child and/or elder day care services—in order for you to be gainfully employed, as long as:

- Such services are provided in your home; or
- If such services are provided outside your home, they are incurred either (a) for a Child under the age of 13; or (b) for another Eligible Dependent who regularly spends at least eight hours per day in your household.

If the services are provided outside your home, the facility providing care must comply with all state and local laws and regulations, including licensing requirements. Dependent Care FSA eligible expenses do not include amounts you pay to your Child who is under age 19, to your Spouse, or to your former Spouse.

Examples of expenses eligible for reimbursement through the Dependent Care FSA include:

- Before- and after-school care (if not included with tuition; *i.e.*, other than tuition expenses).
- Late pick-up fees due to work schedule.
- Day care centers (including adult day care facilities).
- In-home day care providers.
- Wages or salary paid to a care provider—such as a neighbor or a home health aide, whether inside or outside your home—so you can work.
- Nursery schools.
- Social Security (“FICA”) and other wage taxes you pay on behalf of a care/service provider.
- Expenses for certain household services, such as a housekeeper, maid, or cook, provided those services are related to the care of an Eligible Dependent.
- Occasional babysitter—evenings and overnight—to allow you to work late or travel for work.

Ineligible Dependent Care Expenses

Examples of expenses that are not eligible for reimbursement under the Dependent Care FSA are:

- Education expenses including kindergarten or private school tuition fees.
- Entertainment.
- Expenses reimbursable under any other plan or program.

- Expenses applicable to the care of a Child age 13 or over, unless the Child is: mentally or physically incapable of caring for himself or herself, lives with you for more than one-half of the calendar year, and is a U.S. citizen or resident.
- Food and clothing.
- Full-time nursing home care.
- Health care expenses.
- Overnight camp.
- Payments related to care of an Eligible Dependent while you are home from work due to illness.
- Transportation.
- Costs for dependent care when you—or your Spouse—are not working.
- Payments to an individual you claim or who could be claimed as a Tax Dependent by you or your Spouse.
- Payments to your Child who is under age 19.
- For each calendar year, expenses incurred before your participation in the Dependent Care FSA begins or after your participation ends.
- Charges for services of a care provider who has no Social Security or taxpayer identification number, excluding churches and other tax-exempt organizations.
- Expenses incurred for an individual you cannot claim as a Tax Dependent. An exception may apply if you are divorced or separated.

To obtain a list of covered expenses, contact the claims administrator. You may also refer to IRS Publication 503 for additional information. This publication can be obtained at **www.irs.gov**.

Payment of Eligible Health Care FSA Expenses

The maximum reimbursement you will receive for eligible Health Care FSA expenses will be the lesser of:

- The amount of eligible expenses you submit for reimbursement; or
- The total annual amount you have elected to contribute to your Health Care FSA for the Plan Year.

The full amount of your annual Health Care FSA contribution election is available to you at any point in the Plan Year (less any reimbursements previously paid to you during the Plan Year) even if you have not made all of the contributions to your account at the time you incur the expense. Reimbursement payments will be payable directly to you unless you request that payment be made directly to a service provider. Your Health Care FSA account will be reduced by the amount of each reimbursement previously paid to you.

Payment of Eligible Dependent Care FSA Expenses

You will be reimbursed for expenses you incur on behalf of an Eligible Dependent under the Dependent Care FSA. The maximum reimbursement you will receive for eligible Dependent Care FSA expenses at any point during a Plan Year will be the lesser of:

- The amount of allowable expense you submit for reimbursement; or
- The amount credited to your Dependent Care FSA at the time you incur the expense, less any reimbursements previously paid to you during the Plan Year.

No Dependent Care FSA reimbursement will be made for expenses incurred after the date on which you are no longer eligible to participate in the Benefit Program.

Filing an FSA Claim

You have several choices as to how to be paid for eligible FSA claims. You can:

- Submit a claim via ***UPoint***;
- Submit a claim using the “Reimburse Me” Mobile App for Apple and Android devices; or
- Use your YSA card.

Claims must be submitted by April 30 of the year following the year in which the claim was incurred. All claims must be submitted by that date. Claims submitted after that date will not be eligible for reimbursement and will be denied.

Submitting a Claim via *UPoint*

When you incur an eligible Health Care FSA or Dependent Care FSA expense, you can submit a claim via ***UPoint***. Simply log on to the website and select the "Your Spending Account" tab to continue filing your claim. You may be asked to send in additional information to support your claim (*e.g.*, a receipt or explanation of benefits ["EOB"]) that shows all of the following:

Health Care FSA	Dependent Care FSA
▪ Name of service provider or retailer ▪ Date of service or purchase ▪ Identification of drug or product, or description of service ▪ Purchase amount for each product or service ▪ Total purchase amount	▪ Name of service provider ▪ Specific date of service ▪ Name of dependent receiving services ▪ Description of service ▪ Purchase amount for each service ▪ Total purchase amount

For dependent care expenses, you are generally required to provide the taxpayer identification number of the dependent care service provider on your federal income tax return. Reimbursement for expenses that are determined to be eligible expenses will be made as soon as possible after your claim is received and processed.

If the expense is determined not to be an eligible expense, you will receive notification of this determination. If you are denied a benefit, you may file an appeal as explained in the ***Filing an ERISA Claim or Appeal*** section.

Submitting a Claim Using the "Reimburse Me" Mobile App

The YSA Reimburse Me Mobile App makes it easy for you to get current information about your FSA account on your Apple or Android device. You can submit claims, attach documents and receipts, check your account balances, and view the status of claims. Log on to YSA and click on *Reimburse Me Smart Phone Participant Guide* under "Other Documentation" on the Knowledge Center page. Follow the directions for adding the app to your Apple or Android phone. Once you enter your YSA User ID and password, you'll be ready to submit claims or access your accounts anywhere. You may also wish to print a copy of the YSA Mobile App Participant Guide booklet for future reference.

Paying Expenses Using Your YSA Card

The YSA card allows you to pay for eligible expenses at the time that you incur the expense. When you enroll in the Health Care FSA, you'll receive a package containing one YSA card issued in your name, activation instructions, a Cardholder Agreement, Additional Disclosures, and information explaining approved use of the card. You may request additional cards at no additional cost for your Spouse and/or Eligible Dependent(s) through the YSA website.

The YSA card remains active as long as your account is in good status, you continue to participate in a Health Care FSA, and you remain actively employed. Your card will be cancelled upon termination of employment—inactive Participants may not use the YSA card, even during a COBRA continuation coverage period.

By signing and using the card, you certify that:

- You'll only use the card for your own eligible health care expenses and those of your Eligible Dependents under the Health Care FSA.
- Incurred expenses were for health care services or supplies purchased on or after the date your Health Care FSA took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your Eligible Dependents are eligible.
- Any expense paid with the card has not been, or will not be, reimbursed by another source.

The YSA card can be used at providers that primarily sell health care products and services (for example, pharmacies, physicians' offices, hospitals, and Dentists' offices). Each time you use the card at an approved merchant location for an eligible health care expense, you'll be required to provide your signature or PIN. With each YSA card purchase, your available Health Care FSA balance is reduced by that amount. Other **ineligible** expenses, such as cosmetics or food items, must be paid for separately.

Validation of YSA Card Transactions

All YSA card transactions must be validated electronically at the point of sale or by submitting paper documentation afterward. This process involves requesting itemized receipts or other supporting documentation from you to verify that the card transaction is for an eligible health care expense. You should retain your itemized receipts for all transactions, as they may be required for validation purposes.

Receipts should be retained for one year following the close of the Plan Year in which the expense is incurred. You will receive a letter from the claims administrator when a third-party statement is needed.

Manual claim submission and supporting documentation are sometimes required for the purchase of any health care service or item that isn't validated automatically. These types of purchases are conditionally reimbursed, pending validation of the expenses. The process for supporting documentation is outlined below:

- The merchant is reimbursed for the amount of the charge, and your available Health Care FSA balance is reduced.
- You'll be sent a letter or email informing you that itemized receipts or other documentation are required to validate the YSA card transaction.
- If the documentation you provide is insufficient, you'll be sent a letter or email instructing you to provide more documentation.

Expenses for which you don't provide adequate documentation are considered ineligible and treated as overpayments. See ***Overpayment Process*** below for more information.

You must provide the third-party statement to the claims administrator within 45 days (or such longer period provided by the claims administrator) of the request. In accordance with applicable guidance, there may be situations in which the claims administrator does not ask for substantiation related to a card swipe.

Automatic Validation With Approved Merchants

When you purchase eligible health care items by using your YSA card with approved merchants, your transaction can be validated automatically without having to provide an itemized receipt or supporting documentation. To be "approved," a merchant must have an inventory information approval system (IIAS) installed. These IIAS-certified merchants have the ability to identify eligible items at the point of sale, which eliminates the need for additional documentation. They have programmed their systems to allow only eligible items and services to be processed on the YSA card.

Any ineligible items must be paid for with another form of payment. For a complete listing of eligible expenses and approved merchants, visit the YSA website. Please note that the listing is subject to change at any time.

Overpayment Process

If you purchase products or services with your YSA card that are ineligible for reimbursement through your Health Care FSA, you'll receive notification from YSA that your transaction has been deemed an overpayment.

The primary situations that could result in an overpayment are:

- You fail to respond to documentation requests for YSA card transactions after the initial request was sent by YSA.
- Your YSA card transactions were authorized at the point of sale, and then later deemed ineligible after the validation process was completed.
- Claim adjustments were made because of contribution amount changes, ineligible expenses, or improper processing of the claim.

You must pay back any improperly paid claims. YSA will allow you to resolve an overpayment on your account in several ways. You'll be given the option to:

- Resubmit your claim with additional information;
- Make a one-time payment transaction via the YSA website from your bank account;
- Submit a new claim to reduce the overpayment amount; or
- Repay your overpayment by mailing a check to the address provided.

In Case of Errors Relating to Your YSA Card

Call YSA at the number provided on the back of your card as soon as possible if you think a YSA card transaction is wrong, or if you need more information about a transaction listed in the statement or receipt. YSA must receive notification of any errors no later than 60 days after you received the first statement (either via the YSA website or by mail) in which the problem or error appeared. When you contact YSA, be prepared to:

- Provide your name, Social Security number (when applicable), and YSA card number;
- Describe the error or the YSA card transaction that you're unsure about, and explain the reason you believe there's an error or why you need more information; and
- Provide the dollar amount of the suspected error. If you call YSA, you may be required to send your complaint or question in writing within 10 business days.

YSA will coordinate with the YSA card issuer to determine whether an error occurred within 10 business days after it receives notification from you and will correct any error promptly. If more time is needed to correct the error, however, YSA may take up to 45 days to investigate your complaint or question. If this additional time is necessary, YSA will credit the amount that you think is in error, so that you will have use of the total amount during the investigation. If YSA requests that you put your complaint or question in writing and it doesn't receive the information within 10 business days, YSA may not provide this credit. You will be informed of the results within three business days after completing the investigation. If they determine that there was no error, a written explanation will be mailed to you. You may ask for copies of the documents that were used in the investigation.

Nondiscrimination Testing

Under the Code and related federal regulations, Flexible Spending Accounts are subject to nondiscrimination testing each year to ensure the Plan does not provide an unfair advantage to highly compensated employees. The Dependent Care FSA is also subject to an average benefits test.

Depending on the results of the annual tests, contributions of certain colleagues may be reduced or returned. You will be notified if this affects you.

Unused Balances

If you have any money remaining unused in your Health Care FSA at the end of the Plan Year (and after processing all claims for the Plan Year), you will be able to carry over up to $500 in unused funds to the next Plan Year. The amount that may be carried over to the following Plan Year is equal to the lesser of (1) any unused amounts from the immediately preceding Plan Year, or (2) $500.

This will not affect your ability to elect the maximum salary reduction amount in your account for the next Plan Year.

Amounts that are carried over can be used only to pay or reimburse qualified medical expenses in your Health Care FSA. The unused amounts may not be cashed out or converted to another type of taxable or non-taxable account. In addition, if you elect to participate in either the Bronze, Bronze Plus, or Silver medical option (high-deductible health plans) and contribute to the Health Savings Account (HSA), rolled over amounts will only be eligible as part of a **limited-purpose** Health Care FSA to reimburse eligible vision and dental expenses.

Reimbursements of all claims for expenses that are incurred in the current Plan Year are reimbursed first from unused amounts credited for the current Plan Year. After current Plan Year amounts have been exhausted, expenses will be reimbursed from unused amounts carried over from the preceding Plan Year.

Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense:

- Reduce the amounts available to pay your prior Plan Year qualified medical expenses during the run-out period (*i.e.*, by April 30 of the year following the year in which the claim was incurred);
- Count against your permitted carryover of up to $500; and
- Cannot exceed your permitted carryover amount.

Any unused amounts, up to $500, that you carry over to the next Plan Year will continue to be available to reimburse your qualified medical expenses even if you elect no salary reduction for the next Plan Year. However, please note that any unused amount in excess of $500 that remains unused as of the end of the Plan Year (and after processing all claims for the Plan Year) will be forfeited.

All forfeitures from Participants will be used by the employer to offset any losses it has incurred for benefit payments under the Health Care FSA and/or to reduce costs of administering the Plan. After this, forfeitures may be used in any manner authorized by relevant law.

If you have not used all the funds credited to your Dependent Care FSA as of the end of the Plan Year (and after processing all claims for the Plan Year), you will forfeit such funds and they will not be available to pay your future expenses. All forfeitures from Plan Participants will be used by the employer to reduce costs of administering the Plan or may be used in any manner authorized by relevant law.

Dependent Care FSA Annual Statement of Benefits

On or before January 31 of each calendar year, the Plan will provide you with a summary of all the dependent care benefits paid to you during the previous calendar year. This information is typically included on your Form W-2.

Dependent Care Tax Credit

The Dependent Care FSA is an alternative to taking a "tax credit" on your federal income tax return. You must choose whether to use the "tax credit" or the Dependent Care FSA. If you participate in the FSA, you are required to file an informational Schedule 2 or Form 2441 with your federal tax return to support the amount you contributed for the Plan Year and to notify the IRS of your use of the FSA. For more information about the child care tax credit, see IRS Publication 503 or IRS Form 2441 and the accompanying instructions. You may also wish to consult with your tax advisor to determine which option is best for your particular tax situation.

Termination of Participation

If your employment terminates, or if you otherwise cease to be an eligible Participant for purposes of the Dependent Care FSA, your contributions to the Dependent Care FSA will end in the last pay period of your employment or your eligibility. You may use any remaining balance in your Dependent Care FSA (funds you have contributed) for expenses you incur through the rest of the calendar year.

If your employment terminates, or if you otherwise cease to be an eligible Participant for purposes of the Health Care FSA, your participation in the FSA will end on that date unless you are eligible for COBRA continuation coverage for the Health Care FSA and you affirmatively make an election to continue your coverage. You may submit claims for you and your Eligible Dependents if incurred on or prior to the date your coverage terminates.

Affordable Care Act and the Health Care FSA

The Health Care FSA is technically considered a group health plan under the federal law known as ERISA. Accordingly, you are entitled to protections under ERISA such as COBRA and the ERISA claims and appeals process. However, the Health Care FSA is an excepted benefit under Section 732 of ERISA. This means that it is not subject to the group market reforms (sometimes referred to as "consumer protections") under the Affordable Care Act, such as in-network preventive care without cost-sharing, an independent review organization following the ERISA claims and appeals process as well as other nuances, such as the language requirements, applicable to non-grandfathered group health plans, or the preparation of a Summary of Benefits and Coverage ("SBC").

Continuation of Health Care FSA Participation Through COBRA

You may be able to continue your Health Care FSA under COBRA for the remainder of the Plan Year in which your participation terminates, but only if you have a positive Health Care FSA account balance at the time you become eligible for COBRA coverage. Generally, the contributions you make for COBRA coverage for Health Care FSA benefits are made on an after-tax basis. See ***Continuation Coverage Under COBRA*** for additional information.

Your Long-Term Disability (“LTD”) Coverage

LTD coverage is fully insured. The Insurer is The Hartford Life Insurance Company (“The Hartford”). If you are unable to work due to a disability that lasts for an extended period of time, the LTD benefit replaces a portion of your income, up to a monthly maximum amount, for a period of time until you return to work or retire. This section provides an overview of the LTD coverage. Refer to the insurance certificate for coverage details, exclusions, and limitations.

The Hartford administers the LTD Plan. Participation in the LTD Plan does not guarantee that benefits will be paid. The Hartford determines whether you meet the Plan’s definition of disability. You must meet this definition in order to receive benefits.

The following section does not address the details of the Supplemental Disability Income Plan (“SDIP”), applicable to executives who meet certain eligibility and income requirements. The SDIP is a voluntary, individually owned policy that provides supplemental LTD coverage by insuring a portion of your short-term and long-term incentive compensation (not covered by the LTD Plan) and base salary in excess of $300,000. You are eligible to participate in the SDIP after one Year of Service if you work at least 20 hours per week (for the most recent 180 days), have a minimum base salary of $75,000 and incentive compensation of no less than $10,000 or have a base salary of more than $300,000 as of April 15. You will receive detailed information about purchasing a policy under the SDIP if you meet the eligibility requirements for participation. The SDIP is an insured benefit provided through UNUM. A description of the benefit can be found on ***UPoint***.

Participation

The LTD Plan provides financial protection for you by replacing a portion of your income when you have an extended period of disability. The amount you receive is based on the amount you earned before your disability began. You are automatically enrolled in coverage when you first join Aon.

Your LTD coverage begins with your date of hire, provided you don’t opt out of coverage within 31 days of your initial eligibility. You must be “Actively at Work,” as such term is defined by the Insurer, in order for coverage to become effective.

Cost of Coverage

If you elect LTD coverage, you will be required to pay the entire cost for the coverage you elect. The options available to you and your premium for coverage will be shown in your enrollment materials and will be automatically deducted from your pay on an after-tax basis. The LTD benefit is structured to be paid on a tax-free basis; however, state taxes may apply in certain states. You should consult your tax advisor for information on your specific tax situation.

Each year during Annual Enrollment, you will be given an opportunity to elect or decline coverage, or confirm that your existing coverage is to be maintained for the following year.

If you become disabled, your premium for LTD coverage will be waived after six months of disability.

Evidence of Insurability

If you enroll in coverage more than 31 days after first becoming eligible, you must submit acceptable evidence of insurability in order for coverage to become effective. This may require a medical examination, at your expense. Your coverage will take effect after your evidence of insurability is approved.

Pre-Existing Condition

LTD benefits will not be payable for any disability that results from a pre-existing medical condition, unless the disability begins:

- After the last day of 90 consecutive days during which you have received no medical care for the pre-existing condition; or
- After the last of 365 days during which you have been continuously insured under this Plan.

Refer to your insurance certificate and coverage summary for additional information about pre-existing conditions and how they may affect your coverage.

When Benefits Begin

Before collecting benefits, you must satisfy an elimination period following your date of disability. Your elimination period ends as of the later of:

- The first 26 consecutive weeks of any one period of disability; or
- With the exception of benefits required under state law, the expiration of any Aon-sponsored short-term disability or sick time program.

Benefits accrue to the first day after the elimination period, and you will be paid a monthly LTD benefit if you:

- Are under the regular care of a Doctor;
- Become disabled while you are insured under this Plan;
- Are disabled throughout the elimination period;
- Remain disabled beyond the elimination period; and
- Submit a claim with proof of loss, as defined by the Insurer.

Benefits Provided

If you elect LTD coverage, your monthly benefit will be equal to 60% of your monthly base pay. The maximum annual base pay that will be considered is $300,000.

The maximum monthly benefit payable is $15,000. The minimum monthly benefit is the greater of $100 or 10% of your unreduced monthly LTD Plan benefit; that is, your full benefit amount prior to reduction for income payable to you from other sources.

Benefits may be limited for disabilities due to mental or nervous conditions and drug or alcohol abuse. Refer to the insurance certificate and coverage summary for additional information.

The Hartford makes the final determination of disability, based on objective medical evidence that you and your Doctor provide.

Plan Benefits, Limitations, and Exclusions

You should refer to the materials provided by the Insurer for information concerning waiting periods for coverage, benefits payable, exclusions, reductions for other income or benefits (including Social Security disability benefits), age reductions, subrogation, recurring disabilities, return to work incentives, rehabilitation and workplace modification benefits, conversion privileges, and survivor income benefits.

When LTD Coverage Ends

Your LTD coverage will end on the earliest of the following:

- You become a member of an employee class that is no longer eligible for coverage;
- You fail to pay the required premiums;
- You are no longer an active full-time or regular part-time colleague, including when you retire or stop working; or
- The Plan is terminated.

If you are disabled and are no longer actively employed, your insurance will continue during the elimination period while you remain disabled by the same disability and after the elimination period for as long as you are entitled to benefits under the Plan.

LTD benefits are payable until the earliest of:

- The date you are no longer disabled, as determined by the Insurer;
- The date you fail to furnish proof of loss, when requested;
- The date you are no longer under the regular care of a Doctor, or refuse a request to submit to an examination by a Doctor;
- The date you die;
- The date your current monthly earnings exceed the indexed pre-disability earnings amounts specified in your insurance certificate;

- The date you refuse to participate in a rehabilitation program or refuse to cooperate with or try work site modifications or adaptive equipment or devices that enable you to perform the essential duties of your occupation or any occupation if you are receiving benefits for being disabled from any occupation;
- The date you refuse to receive recommended treatment that is generally acknowledged by Doctors to cure, correct, or limit the disabling condition;
- The date no further benefits are payable under any Plan provision that limits benefit duration; or
- The maximum duration of benefits period based on your age when disability benefits begin, as shown in your insurance certificate.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific disability requirements that may change the provisions under the coverage(s) described above and the corresponding group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage and are made a part of your group insurance certificate. The Insurer will coordinate these benefits and provide you with information on how mandated state benefits may impact your disability benefits.

Your Life Insurance Coverage

Group term life insurance coverage is fully insured and provided through the Aon Active Health Exchange. The Insurer is The Hartford Life Insurance Company. You are eligible for coverage if you meet all eligibility requirements and your base annual earnings are less than $150,000. This section provides an overview of your life insurance coverage. Refer to the insurance certificate for coverage details, exclusions, and limitations.

Colleagues with annual base earnings of $150,000 or more are eligible for both basic and supplemental executive life insurance coverage through the Group Variable Universal Life ("GVUL") program offered by MetLife—see the MetLife GVUL certificate of insurance and coverage summaries for more details. Colleagues eligible for this coverage will have separate access to supplemental and dependent coverage.

Participation

You are automatically enrolled in Basic Group Term Life Insurance—no action on your part is required to participate in basic coverage.

Individuals who retire prior to July 1, 2020, at age 50 with 15 years of continuous, uninterrupted service with Aon are eligible for life insurance in the amount of $5,000.

Benefits Provided

Basic Group Term Life

Your coverage amount is equal to:

- **If you are under age 65:** Two times your annual base earnings, rounded up to the next higher $1,000 increment, up to a maximum of $300,000 of coverage.
- **If you are age 65 to 69:** 1.5 times your base earnings, up to a maximum of $250,000.
- **If you are age 70 or over:** One times your base earnings, up to a maximum of $150,000.

Imputed Income—Life Insurance
Under federal tax law, the "value" of employer-paid life insurance coverage over $50,000 is subject to federal income and Social Security tax. This tax liability is known as imputed income and is used when you receive the value of a benefit as opposed to actual cash. If you have imputed income, it will be added to your earnings and shown on your Form W-2. The imputed income value is determined by IRS tax tables based on age. It is your responsibility to make sure that taxes are paid on this imputed income. You may wish to consult with a tax advisor.

Supplemental Group Term Life

In addition to your basic coverage, you may also purchase Supplemental Group Term Life Insurance on an after-tax basis. You can purchase coverage up to six times your annual base earnings, rounded to the next higher $1,000. If you purchase coverage when you are first eligible, generally no statement of health ("SOH") form is required. However, a statement of health is required if any of these apply:

- You waive coverage and then want to enroll at a later date.
- You increase your coverage amount.
- You elect more than two times your base salary in supplemental coverage.

When you are required to provide a statement of health, your coverage amount remains at the highest level of coverage available to you (without documentation) until your application for supplemental coverage is approved. If your documentation is not approved, coverage remains at the highest level available to you without providing a statement of health form.

If you are not actively at work on the day your application is approved, your new coverage amount takes effect on the first day you return to work.

Cost of Coverage

Aon pays the full cost of your Basic Group Term Life Insurance coverage. You are not required to make any contributions. If you wish to elect voluntary Supplemental and/or Dependent Life Insurance (see below), you will be required to make a contribution for the coverage you elect. The premiums for voluntary coverage will be shown in your enrollment materials when you enroll in coverage and will be deducted from your pay on an after-tax basis.

Waiver of Premium

If you become totally disabled before age 60, you may be eligible to continue your Supplemental Group Term Life Insurance at no cost, until age 65. If you become totally disabled after age 60, you may be eligible to continue your Supplemental Group Term Life Insurance at no cost, for up to five years. You must apply for waiver of premium and your application must be approved by The Hartford.

Disability Extension

If you became disabled prior to age 65, you also may be eligible for a disability extension of your basic coverage. This may allow you to continue your life insurance coverage while you are disabled as long as premium payments are made.

Living Benefit Feature

If you become terminally ill and are under age 60, you may receive a one-time advance payment, called an accelerated benefit. For this purpose, terminally ill means that due to injury or sickness you have a life expectancy of less than 12 months. The Hartford will require proof of your terminal illness by requiring:

- A completed accelerated benefit claim form;
- A signed Doctor's certification that you are terminally ill; and
- An examination by a Doctor, upon request.

This feature applies to both Basic and Supplemental Group Term Life Insurance. Accelerated benefits are not taxable and may be used for any purpose. The life insurance benefit paid to your beneficiary after your death will be reduced by the amount of the accelerated benefit paid to you.

For additional information, refer to your insurance certificate or benefits materials provided by the Insurer.

Dependent Life

You may elect optional life insurance coverage for your Spouse/Domestic Partner and Children. Premiums for this coverage are deducted on an after-tax basis. You choose the amount of coverage for your Spouse/Domestic Partner and/or Children:

- **Spouse/Domestic Partner coverage options:** $10,000, $25,000, $50,000, $75,000, or $100,000.
- **Child coverage options:** $5,000, $10,000, $15,000, $20,000, or $25,000. Coverage applies to each unmarried Child under age 26 that you elect to cover.

You do not need to elect Supplemental Group Term Life Insurance coverage for yourself in order to elect Dependent Life Insurance coverage.

If you purchase coverage when you are first eligible or within 31 days of a qualified change in status, no SOH form is required. However, a statement of health is required if one of these applies:

- You waive Spouse/Domestic Partner coverage and then want to enroll at a later date.
- You increase your Spouse/Domestic Partner coverage amount.

A statement of health form is not required for Child coverage. You may elect coverage only when first eligible, within 31 days of a qualified change in status, or during Annual Enrollment for coverage beginning the first day of the following year.

Canceling Supplemental Coverage

If you want to cancel any of your supplemental/dependent coverages or if an Eligible Dependent is no longer eligible, contact the ***Aon HR Service Center***.

If you do not cancel coverage when an Eligible Dependent is no longer eligible, contributions for coverage will continue to be deducted from your pay until you advise the ***Aon HR Service Center*** to change your coverage.

Naming a Beneficiary

A beneficiary is the person, persons, estate, trust, or charity that will receive benefits if you die. You can designate one person or several individuals to receive benefits. Contact the ***Aon HR Service Center*** if you need assistance completing your beneficiary designation.

If you want benefits to be shared, you need to indicate the percentage (instead of a dollar amount) of the total benefit for each beneficiary. All percentages must be in whole numbers; no fractions are allowed. For example, you can designate 65% of the benefit for one person and 35% for another person, for a total of 100%.

Unless you choose otherwise, multiple beneficiaries will share equally in the benefit. For example, three beneficiaries would be allocated benefits at 34%, 33%, and 33% for a total of 100%. If one or more of your beneficiaries is no longer living when you die, the benefit that would have gone to that beneficiary will be redistributed among your remaining beneficiaries, unless you designate otherwise on your beneficiary designation form.

If you die and do not leave a surviving beneficiary, your benefits generally will be paid in the following order:

- Your surviving Spouse or Domestic Partner, if any.
- Your surviving Children equally, if there is no surviving Spouse or Domestic Partner.
- Your surviving parents equally, if there is no surviving Spouse or Child.
- Your surviving siblings equally, if there is no surviving parent.
- Your estate, if there is no surviving sibling.

Dependent Life Insurance Beneficiary

You are the beneficiary for any Dependent Life Insurance you elect—no beneficiary designation is required.

Assignment of Benefits

You can transfer your ownership rights to Basic and Supplemental Group Term Life Insurance by "assigning benefits." The assignee can be either a person or a trust. The assignment is an absolute assignment and assigns "all rights, title, and interest" under the policy. Only you can make an assignment. If you have dependent coverage in effect, the dependent coverage is also included in the assignment.

The assignment becomes effective on the date you sign the transfer but only after it is approved by the Insurer. After your assignment becomes effective, you can no longer make changes, including:

- Changing your beneficiary.
- Changing your coverage amount.
- Converting coverage.

These rights belong to the assignee.

Because of the various legal and tax implications involved, it is recommended that you consult with a lawyer or tax advisor before assigning your benefits. Contact the Insurer for additional information.

Limitations and Exclusions

Any limitations on benefits, age reductions, and exclusions are described in the insurance certificate provided by the Insurer.

Converting Coverage

You may be able to convert coverage to an individual policy, without providing a statement of health form, if your Basic and/or Supplemental Group Term Life Insurance ends or is reduced. In some situations, you also may be able to convert Dependent Life Insurance. You will receive information about how to convert coverage to an individual policy from the ***Aon HR Service Center***. You then will need to contact the Insurer within 31 days from your benefits termination date to initiate the conversion process.

Portability Benefits

Portability allows you and your Eligible Dependents to continue Supplemental Term Life Insurance coverage under a Group Portability policy when coverage would otherwise end due to certain events, such as your employment ending prior to age 70. You will receive information about portability from the ***Aon HR Service Center***. You then will need to contact the Insurer within 31 days from your benefits termination date to elect portability.

Your Accidental Death and Dismemberment (“AD&D”) Insurance

AD&D Insurance coverage is fully insured and offered through the Aon Active Health Exchange. The Insurer is The Hartford Life Insurance Company. This section provides an overview of AD&D coverage. Refer to the insurance certificate for coverage details, exclusions, and limitations.

Participation

You are automatically enrolled in Basic AD&D Insurance—no action on your part is required to participate in basic coverage.

Benefits Provided

Basic AD&D

Your coverage amount is equal to two times your annual base earnings, rounded up to the next higher $1,000 increment, up to a maximum of $1,000,000 of coverage. The minimum coverage amount is $10,000.

Supplemental and Dependent AD&D

In addition to basic coverage, you may also purchase Supplemental AD&D Insurance coverage for you and your Eligible Dependents. You can purchase additional coverage equal to one to 10 times your annual base earnings. The minimum amount you can elect is $10,000; the maximum amount is $750,000. Amounts must be in increments of $10,000. Requested amounts in excess of $500,000 cannot exceed the lesser of 10 times your earnings or the maximum above.

You also can elect coverage equal to a portion of your coverage amount for your family:

- **Spouse/Domestic Partner coverage:** 100% of your coverage amount if there are no Children; or 90% of your coverage amount if there are Children.
- **Child(ren) coverage:** 30% of your coverage amount for each unmarried Child up to age 26 years if there is no Spouse/Domestic Partner coverage, or 20% of your coverage amount if there is Spouse/Domestic Partner coverage.

Refer to the insurance certificate and coverage summaries for detailed information about the additional benefits payable for accidental death or dismemberment, including important terms to know.

Cost of Coverage

Benefits are guaranteed under the applicable insurance contracts. Aon pays the full cost of your Basic AD&D Insurance coverage. You are not required to make any contributions.

If you wish to elect voluntary Supplemental and/or Dependent AD&D Insurance, you will be required to make a contribution for the coverage you elect. The premiums for voluntary coverage will be shown in your enrollment materials when you enroll in coverage and will be deducted from your pay on an after-tax basis. Your supplemental AD&D benefits would be paid to you (or your beneficiary) on a tax-free basis.

Your Beneficiary

AD&D benefits are paid to:

- You, if you are dismembered or seriously injured as the result of a covered accident. The benefit payable to you is based on your salary on the date of the accidental injury.
- Your designated AD&D beneficiary, if you die in a covered accident. The benefit payable to your beneficiary is based on your base salary on the date of your death. You may designate one person or several individuals to receive benefits upon your death. This designation is separate from your life insurance beneficiary designation. The loss must occur within 365 days after the accident for the benefit to be payable.

Canceling Supplemental Coverage

If you wish to cancel any of your supplemental and/or dependent coverages or if an Eligible Dependent is no longer eligible, contact the ***Aon HR Service Center***.

If you do not cancel coverage when an Eligible Dependent is no longer eligible, contributions for coverage will continue to be deducted from your pay until you contact the ***Aon HR Service Center*** to change your coverage.

Assignment of Benefits

Except for the dismemberment benefits under the AD&D Insurance, you have the right to absolutely assign your rights and interests under the policy. The absolute assignment becomes effective on the date an executed assignment is filed with the Insurer.

Limitations and Exclusions

Basic and supplemental AD&D benefits are not paid if your or your Eligible Dependent's death or injury results from any loss caused by:

- Intentionally self-inflicted injury;
- Suicide or attempted suicide, whether sane or insane;
- War or act of war, whether declared or not;
- Injury sustained while on full-time active duty as a member of the armed forces of any country or any international authority except National Guard or organized Reserve Corps duty or the first 31 days of military leave;
- Injury sustained while committing or attempting to commit a felony; or
- Injury sustained while driving while intoxicated, as determined under the law of the state where the accident occurred.

Refer to the insurance certificate and coverage summaries for any additional exclusions or limitations that may apply to your coverage. If your claim is wholly or partly denied, you or your beneficiary will be furnished with written notification of the decision.

Converting Coverage

You may be able to convert coverage to an individual policy, without providing a statement of health form, if your Basic and/or Supplemental AD&D Insurance ends or is reduced. In some situations, you also may be able to convert dependent AD&D coverage. You will receive information about how to convert coverage to an individual policy from the ***Aon HR Service Center***. You then will need to contact the Insurer within 31 days from your benefits termination date to initiate the conversion process.

Your Commuter Benefit Program

The Commuter Benefit Program helps you with some of the expenses associated with commuting to work and is available to all U.S. Aon colleagues. Not only does it help the environment, it can save you money, too. Colleagues who commute by public transit or vanpool can set aside up to $255 each month to pay for mass transit/vanpool expenses. Colleagues who pay to park at their office, or pay a monthly parking fee at a transit station, also can set aside up to $255 monthly before taxes. The transit and parking expenses cannot be combined.

How to Enroll

The Commuter Benefit Program is considered a fringe benefit under Code Section 132(f) that allows you to pay for eligible transportation expenses with before-tax dollars. You can set up your commuter account at any time by visiting ***UPoint***. Click on the "Other Benefits" tab and select "Commuter Benefits." Click "Yes" at the bottom of the page to indicate your interest in using the Commuter Benefit Program. You will receive confirmation that your request has been successfully completed. Log off of ***UPoint*** and log back on to continue.

Next, click on the "Health and Insurance" tab and select "Spending Accounts." Click the "Manage Your Account" link to be taken to the Your Spending Account ("YSA") screen. Under the "Commuter" tab, select "Sign Up Now!" powered by **WiredCommute®**, the third-party claims administrator that coordinates Aon's Commuter Benefit Program and processes parking claims for reimbursement. From here, you can select your metropolitan area and choose your transit and/or parking provider or the type of pass or ticket you need. You can choose from over 100,000 types of tickets and passes. If you wish to learn more about the Commuter Benefit Program, select the "Commuter" tab.

You can set up your commuter account at any time. Orders must be placed with **WiredCommute** by the 10th of the month to be effective for the following benefit month. For example, an order placed by June 10 will be effective for the July benefit month. You may change your election from month to month.

If you take a leave of absence, your contributions will stop while you are absent from work. You will not be able to submit new orders and any recurring orders will be canceled. Once you return to work, you will need to re-enroll in the program and set up a new recurring order, if applicable. Depending on when your new request is submitted, your order may not take effect until the following month, so you should plan accordingly.

Participation

If you elect to participate in the Commuter Benefit Program, the claims administrator will establish a mass transit/vanpool or parking account for you that will be maintained for bookkeeping purposes only to keep track of your contributions. This account will then be credited with the amount equal to your salary reduction contribution for each pay period and debited to pay eligible commuter expenses.

Maximum Amount

The maximum benefit amount that you may elect under the program is $265 per month for eligible parking expenses and $265 per month for mass transit or vanpool expenses.

Eligible Mass Transit, Vanpool, and Parking Expenses

You may deposit up to $265 a month before-tax to your mass transit/vanpool account. This account will allow you to order a voucher to use to purchase a mass transit ticket or to buy a transit pass, such as a monthly rail commuting ticket or other type of fare card that allows you to use mass transit for traveling to or from your place of employment. You may also purchase a vanpool commuter check or select a prepaid MasterCard that can be used at transit agencies where transit passes, transit tickets, fare cards, or vanpool passes are sold.

Eligible expenses that can be paid through the vanpool account include the cost of a vanpool with seating capacity for six or more adults (excluding the driver) used mainly for transporting colleagues to and from their place of work. Reimbursement of mass transit or vanpool expenses is prohibited at this time.

Qualified parking expenses include the cost of parking a vehicle in a facility that is at or near your place of employment or parking at a location from where you commute to work (for example, a parking lot at a train station so that you can commute to work by train). Parking expenses do not include parking on or near your residential property. Parking vouchers can be used to pay parking providers directly or you can submit eligible parking expenses and be reimbursed from your account. Parking expenses can be submitted at any time.

If you have questions about what is considered an eligible expense, contact the claims administrator.

Payment of Commuter Spending Expense Account Claims

The maximum amount available to pay for qualified expenses at any time from your expense account will be the lesser of:

a) The amount of allowable transit expenses submitted for payment; or

b) The amount credited to your account at that time, reduced by any previous payments made during the year.

Requests for Payment

The Commuter Benefit Program can be accessed on ***UPoint*** under the YSA platform. You can access YSA as follows:

1. Log on to ***UPoint***.
2. Under the “Health and Insurance” tab, click “Spending Accounts” to access the YSA screen.
3. Click the “Manage Your Account” link, then select the “Commuter” tab.
4. Follow the instructions for placing a transit or parking order. If you enroll by the 10th of the month, you will receive your fare media around the 23rd of that month. The deduction for that fare media will be taken from the first check of the following month. If you select a parking voucher, it will be made payable directly to the parking provider you select. You can also select commuter check vouchers to purchase more than one type of parking. There is no limit to the number of vouchers you can request. Vouchers come in flexible denominations and are valid for 15 months, allowing use for both frequent and infrequent riders.
5. You may also select a Commuter Check Card Prepaid MasterCard to use at business entities that provide parking services. The MasterCard can also be used to purchase transit passes, tickets, cards, vanpool passes, or other fare media.
6. In lieu of prepayment, eligible parking expenses (only) may be reimbursed directly to you when you enroll in the Cash Reimbursement option. Simply follow the instructions on the **WiredCommute** website for submitting a Parking Reimbursement Request form in order to be reimbursed for eligible parking expenses.

Account Balance

Unlike the Flexible Spending Accounts, any unused amounts remaining in your transit or parking account at the end of the Plan Year are automatically carried forward to the next year. If you lose eligibility to participate in the program for any reason other than termination of employment, you may continue to use your account balance to pay for eligible transit or parking expenses up to the remaining balance in your account.

If you terminate employment, you may submit parking expenses incurred through your date of termination. Any transit voucher previously ordered can be used through the end of the month in which you terminate employment.

Forfeitures

If you terminate employment, any funds remaining in your transit or parking account as of the date your employment terminates will be forfeited and used to defray administrative expenses.

Your Employee Assistance Program (“EAP”)

The EAP is a confidential service designed to help you and your Eligible Dependents address problems in everyday living that may affect your health, family life, or job performance. This service is offered through Optum Health.

Participation

You are automatically enrolled in the EAP as of your date of hire. No action is required on your part to participate.

Benefits Provided

The benefits provided under the EAP are more fully described in the materials provided to you by the program’s administrator. These include:

- Up to six free EAP counseling sessions for you and your Eligible Dependents per issue per calendar year. During an EAP counseling session, individuals talk with an EAP provider who can provide an evaluation, short-term counseling, and/or a referral to another provider for additional assistance.
- Availability 24 hours a day, seven days a week. You or your Eligible Dependents may contact the EAP anytime, day or night, to speak with a professional counselor. The EAP website is also available anytime, day or night. The website explains how to obtain information on various topics such as adoption, elder care, finances, managing stress, pet services, and dealing with depression.

The information you provide to the EAP and the services you receive from the EAP are strictly confidential. Information about you or your Eligible Dependents will not be released to Aon or anyone else without your written permission, unless required by law.

Cost of Coverage

Aon pays the full cost of your coverage. You are not required to make any contributions.

EAP Limitations and Exclusions

You should refer to the materials provided by the EAP administrator for information on any exclusions, limitations, or reductions that may apply to your coverage.

Affordable Care Act and the EAP

The EAP is technically considered a group health plan under the federal law known as ERISA. Accordingly, you are entitled to protections under ERISA such as COBRA and the ERISA claims and appeals process. However, Aon’s EAP is an excepted benefit under Section 732 of ERISA. This means that it is not subject to the group market reforms (sometimes referred to as “consumer protections”) under the Affordable Care Act, such as an independent review organization following the ERISA claims and appeals process as well as other nuances, such as the language requirements, applicable to non-grandfathered group health plans, or the preparation of a Summary of Benefits and Coverage (“SBC”).

For More Information

To contact the EAP, visit their website at **www.liveandworkwell.com** (Access Code: Aon), or call them at **1-800-510-9351**.

Your Group Personal Umbrella Liability Insurance

The Group Personal Umbrella Liability ("GPUL") Insurance provides additional liability coverage for damages or costs you, or a covered family member, have to pay in a covered lawsuit. This insurance is in addition to any liability coverage provided under your primary auto, homeowners, renters, or similar policies. Coverage is underwritten by Chubb and serviced by Aon Private Risk Management.

Participation

Participation is voluntary, and all costs are paid by you. You can enroll in coverage any time during the year. Your coverage automatically renews each year unless you wish to make a change to your coverage.

Benefits Provided

Coverage of up to $50 million is available through the Chubb Group of Insurance Companies. Once you enroll, the insurance automatically covers you, your Spouse/Domestic Partner, any relative, or any person under age 25 who is in your or a relative's care, all of whom must be residents of the same household. Coverage also extends to anyone who uses a covered vehicle or watercraft with permission from you or a family member.

In addition to personal liability insurance, you may also purchase Employment Practices Liability Coverage to address specific liability needs if you employ five or fewer employees (such as a nanny or housekeeper) at all of your residential locations.

If you are an independent director on a not-for-profit board of directors, you may also purchase Personal Director's Liability Coverage. You can obtain up to $1 million in coverage to protect you against a claim.

Cost of Coverage

You pay the full cost of coverage. The specific cost of coverage will be based on the coverage you select and will be made via payroll deduction on an after-tax basis.

Limitations and Exclusions

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

For More Information

For additional information about this program, contact the Chubb Customer Center at **1-800-248-2208**.

Legal Services Plan

The Legal Services Plan provides personal legal services for you and your Eligible Dependents. These benefits are administered by Hyatt Legal Plans using a panel of carefully selected participating law firms that includes over 11,000 attorneys to choose from. To participate on the panel, a minimum of eight years of experience is required and, on average, plan attorneys have practiced law for 24 years. Refer to the coverage summary for more detailed information on this benefit.

You must elect and enroll in coverage within 31 days of your initial eligibility. Coverage will become effective with your date of hire. If you do not enroll within 31 days, you must wait until the next Annual Enrollment to elect coverage.

You pay the full cost of coverage. Your premium for coverage will be shown in your enrollment materials when you enroll in coverage and will be deducted from your pay on an after-tax basis. There are no fees, deductibles, or copayments for eligible services.

Through the Legal Services Plan, legal services are available with regard to such things as:

- Consumer protection matters;
- Small claims;
- Debt-related issues (bankruptcy, debt collection defense);
- Identity theft;
- Tax audits;
- Civil lawsuits;
- Document preparation and review (affidavits, demand letters, mortgages);
- Divorce and separation;
- Family law issues;
- Personal injury;
- Real estate matters;
- Traffic and criminal matters; and
- Wills and estate planning.

The services available through participating attorneys are more fully described in the materials provided to you by the Legal Services Plan's administrator. For a complete list of services provided, refer to your coverage summary and other program materials.

You should refer to the materials provided by the Legal Services Plan's administrator for information on any exclusions or limitations that may apply to your coverage.

To contact the administrator, contact the Hyatt Legal Plans Client Service Center at **1-800-821-6400** or go to **www.legalplans.com**.

Long-Term Care Insurance

Long-Term Care ("LTC") Insurance provides a comprehensive level of services such as nursing home, assisted living, adult day care, respite care, or hospice care. Long-Term Care Insurance is provided by Genworth Life Insurance Company. Colleagues pay the full cost of this voluntary benefit on an after-tax basis (payroll deduction is not available). The specific cost of coverage will be based on the coverage selected.

If you are enrolled in the Aon group long-term care insurance ("LTCI") plan, underwritten by Metropolitan Life Insurance Company ("MetLife") you can retain your current coverage. The MetLife LTCI plan is closed to new enrollees.

If you are a current Participant and have questions about your coverage, refer to your insurance certificate for contact information. This coverage is not endorsed by Aon nor is it covered by ERISA. Any claims dispute you may have should be directed to the Insurer.

Accident Insurance

Accident Insurance pays a benefit directly to you if you or an eligible Dependent suffers a covered injury. This benefit can help cover out-of-pocket expenses related to these injuries—such as hospitalization, physical therapy, transportation, and more. There are no health questions or physical exams required to enroll in this plan.

Participation in the Accident Insurance Plan is voluntary and provided by Chubb Workplace Benefits. Benefits are more fully described in the insurance certificate and other benefit materials provided by the Insurer.

You should refer to the materials provided by Chubb for additional information on benefits, exclusions, or limitations that may apply to specific covered conditions. You may also contact Chubb at **1-866-445-8874** or visit their website at **my.combinedinsurance.com**.

If you are electing Accident Insurance, be sure to read the disclosure statement available on ***UPoint*** before enrolling in coverage.

This coverage is not endorsed by Aon nor is it covered by ERISA. Participation in the plan is entirely voluntary and all costs are paid out-of-pocket on an after-tax basis by enrolled colleagues (payroll deduction is not available). The specific cost of coverage will be based on the coverage selected. Coverage becomes effective once your enrollment is completed and the applicable premium is paid. Any claims dispute you may have should be directed to the Insurer.

Additional Benefits Offered Through the Aon Active Health Exchange

The following optional benefits are offered on the Aon Active Health Exchange. These benefits are not part of the Plan and are not subject to ERISA; they are included here for reference only.

Identity Theft Protection

Identity Theft Protection is a voluntary benefit that monitors your personal and financial information 24 hours a day, seven days a week. It can also help you limit damage if your personal or financial information is stolen. Identity Theft Protection is administered by InfoArmor.

This benefit covers colleagues and eligible family members. Colleagues pay the full cost of this benefit on an after-tax basis. The cost for the benefit will appear on ***UPoint*** when you enroll. You can add or drop this benefit any time during the year. Any claims dispute you may have should be directed to the Insurer.

For a complete list of Identity Theft Protection services available, visit **www.infoarmor.com/exchange** or call **1-855-969-3373**.

Auto & Homeowners Insurance

The Auto & Homeowners Group Insurance Program is a voluntary personal insurance discount program designed to make shopping for auto and home insurance easier and less time-consuming. Coverage is available through Liberty Mutual Insurance Company (“Liberty Mutual”), Metropolitan Life Insurance Company (“MetLife”), and Travelers Indemnity Company (“Travelers”). The program offers attractive group rates that are not available to individuals.

The program provides you with:

- Coverage choices from national Insurers;
- Free, no-obligation quotes; and
- The convenience of paying your premiums through payroll deduction, electronic funds transfer, debit or credit card, or direct-bill payments.

This coverage is not endorsed by Aon nor is it covered by ERISA. Participation is entirely voluntary and all costs are paid by enrolled colleagues. The specific cost of coverage will be based on your individual needs and the Insurer you select for your auto and/or home insurance coverage. Coverage becomes effective once your enrollment is completed and the applicable premium is paid. Any claims dispute you may have should be directed to the Insurer.

To learn more about the Auto & Homeowners Group Insurance Program or to request additional information, contact:

- Liberty Mutual
  1-855-352-2149 (Client #110512)
  www.libertymutual.com/aon
- MetLife
  1-888-421-8511 (code: Aon)
  www.metlife.com/mybenefits
- Travelers
  1-888-695-4640
  www.travelers.com/aon

Pet Insurance

Healthy Paws Pet Insurance allows you to save up to 90% on pet medical care. This discount program offers unlimited lifetime medical benefits for your pet. Premiums vary depending on the number of pets you choose to cover under the program. You can add or drop coverage at any time. For additional information about this program, contact Healthy Paws at **1-800-453-4054** or **www.healthypawspetinsurance.com/aon**.

This coverage is not endorsed by Aon nor is it covered by ERISA. Participation in the program is entirely voluntary and all costs are paid out-of-pocket by enrolled colleagues (payroll deduction is not available). The specific cost of coverage will be based on the coverage selected. Coverage becomes effective once your enrollment is completed and the applicable premium is paid. Any claims dispute you may have should be directed to the Insurer.

When Coverage Ends

Coverage for you and your covered Eligible Dependents ends if:

- You or your Eligible Dependents no longer meet the eligibility requirements as designated by this SPD.
- You stop making required contributions. If you fail to pay any required premium for coverage (beyond any applicable grace period), coverage for you and your covered Eligible Dependents will be cancelled and no claims incurred after the effective date of cancellation will be paid.
- Aon indicates that a particular benefit is no longer available.
- Aon terminates the Plan.
- You no longer meet the eligibility requirements for retiree medical coverage.

Medical, dental, and vision coverage under the Plan ends at 11:59 p.m. (in your home time zone) on the last day of the month in which your employment ends (or the last day of the month prior to your separation, if your employment ends on the first of the month). Life (basic, supplemental, spousal, and child) and AD&D (basic, supplemental, spousal, and child) insurance coverage ends at 11:59 p.m. (in your home time zone) on the last day of the month in which your employment ends (or the last day of the month prior to your separation, if your employment ends on the first of the month). LTD insurance coverage ends as of the last day of the pay period in which your employment ends (or the last day of the pay period prior to your separation, if your employment ends on the first of the pay period). Refer to the insurance certificates and coverage summaries for additional information about when coverage ends.

You can elect COBRA continuation coverage for health care (medical, dental, vision, EAP, and Health Care FSA) coverage. You will receive the COBRA continuation notice and additional information from the ***Aon HR Service Center***. (See the ***Continuation Coverage Under COBRA*** section.)

You also may be able to convert or port your group term or group variable life, AD&D, and LTD insurance to individual policies. Any policy you obtain under direct-pay may not be identical to the coverage you currently have.

Your Eligible Dependents' coverage ends when they no longer meet the eligibility requirements.

If You Die While Covered Under the Company's Plans

If you die while working for Aon, your covered Eligible Dependents can continue medical, dental, and vision coverage under COBRA or under the retiree program, if eligibility requirements are met.

If you have not met the age and Years of Service requirements for retiree coverage at the time of your death, your Eligible Dependents' coverage under your name will end on the date of your death. Should your Eligible Dependents wish to continue coverage, COBRA may be elected for up to 36 months, or until your Eligible Dependents become enrolled in Medicare, whichever occurs first. If elected, the first six months of COBRA continuation coverage will be provided at no cost. After the first six months, the standard COBRA rates apply and will be billed on a monthly basis.

If you have met the age and Years of Service requirements for retiree coverage at the time of your death, your Eligible Dependents' coverage under your name will end on the date of your death, and a retiree account will automatically be established with the Insurer(s) for your covered Eligible Dependents. Retiree coverage may be continued until age 65, or until your Eligible Dependents become enrolled in Medicare, whichever occurs first. The first six months of retiree coverage will be provided at no cost. After the first six months, retiree rates apply and will be billed on a monthly basis.

In some cases, the COBRA cost may be lower than the cost of retiree coverage. If your Eligible Dependents prefer to elect COBRA, they may do so for up to 36 months, or until they become enrolled in Medicare, whichever occurs first.

If you die after you retire from the Company, your covered Eligible Dependents can continue their coverage up to age 65, or until they become enrolled in Medicare, whichever occurs first.

Coordination of Benefits

If you or your Eligible Dependents are covered under more than one health plan (for example, this Plan and your Spouse's medical plan), it is important to know about the coordination of benefits provision. The Plan coordinates benefits as follows:

- While you are covered as an active colleague, your primary coverage is Aon's coverage and your secondary coverage is with your Spouse/Domestic Partner.
- Your Spouse/Domestic Partner's primary coverage is through his or her employer and Aon's coverage is secondary.
- Children, if covered as Eligible Dependents, are determined by the "birthday rule." This rule looks at the month and day (not year) in which the parents were born. Whoever is born earliest after January 1 has the primary coverage and the other has secondary coverage.

When Aon's health plan is secondary, coordination of benefits is "carved-out." This means that the Plan will only pay as much as what would have been paid if there was no other coverage. In other words, the primary plan pays its amount and the secondary plan subtracts the primary plan's payment from what it was supposed to pay and pays the difference.

For example, if the primary plan covers 60% of a $1,000 hospital bill and the secondary plan covers 80%, the primary plan would pay $600 and the secondary plan would pay $200 (80% x $1,000 = $800 - $600 = $200). If the primary plan covers 90% and the secondary plan covers 80%, the primary plan would pay $900 and the secondary plan would pay $0 (80% x $1,000 = $800 - $900 = -$100 or $0).

Coordination With Medicare

If you are eligible for Medicare, the Plan pays benefits as if you are enrolled in Medicare Parts A and B, regardless of whether you actually are enrolled or receive Medicare benefits. So, if Medicare pays benefits before the Plan pays benefits (*i.e.*, if Medicare pays primary or "first"), it is critical that you and your Eligible Dependents enroll in Medicare Parts A and B as soon as you are eligible. Whether Medicare pays primary or secondary depends largely on your employment status and "why" you are receiving Medicare.

Medicare Eligibility

You generally become eligible for Medicare at these times:

- When you reach age 65.
- If you become disabled and have received Social Security disability benefits for 24 months.
- If you have End Stage Renal Disease ("ESRD").

However, just being eligible for Medicare does not necessarily make Medicare the primary payer. Instead, "coordination rules" define when Medicare is the primary payer and when it is the secondary payer.

Which Plan Is Primary?

Whether this Plan or Medicare is the primary payer or the secondary payer depends, in part, on your employment status. As a general rule, you have "current employment status" when you are actively employed by Aon. **This section assumes that you have "current employment status."** If you do not have "current employment status" or your "current employment status" changes, different Medicare coordination rules apply for you and your Eligible Dependents. You should contact Medicare for additional information regarding Medicare coordination when you no longer have "current employment status" with Aon.

If you have "current employment status," medical coverage under this Plan is the primary payer when any of these apply:

- You or your Eligible Dependent is not eligible to participate in Medicare.
- You or your Spouse is eligible for Medicare due to attainment of age 65.
- You or any other Eligible Dependent, including your Spouse, is under age 65 and is eligible for Medicare due to a disability. **Note:** The Aon medical plan will be the primary payer if you, the colleague, continue to work. However, if you, as the colleague, no longer continue to work, Aon generally will be the secondary payer (and Medicare the primary payer) after the first 24 months of Social Security disability entitlement.
- You or any other Eligible Dependent is eligible for or entitled to Medicare due to ESRD, but only for the first 30 months of Medicare eligibility. After the first 30 months of Medicare eligibility, this Plan becomes the secondary payer.

Medicare is assumed to be the primary payer when any of these apply:

- Your Eligible Dependent(s) other than your Spouse (such as a Domestic Partner) is eligible for Medicare due to attainment of age 65.
- Your Eligible Dependent(s) other than your Spouse (such as a Domestic Partner) is eligible for Medicare due to attainment of age 65 and subsequently becomes eligible for or entitled to Medicare due to ESRD. Medicare will continue to be the primary payer in this event.
- You or any other Eligible Dependent is eligible for or entitled to Medicare due to ESRD and you or your Eligible Dependent has been Medicare-eligible due to ESRD for more than 30 months.

For more information about Medicare, contact the Social Security Administration or the ***Aon HR Service Center***.

Medicare Part D Coverage

If you are Medicare-eligible, you should be aware that Medicare offers prescription drug coverage (known as Medicare Part D). You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Prescription Drug Plan (for example, an HMO or PPO) that offers prescription drug coverage (also referred to as an MA-PD). All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Plan will continue to provide your prescription drug coverage if you become eligible for Medicare.

Most, if not all, prescription drug coverage under this Plan is, on average, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered “creditable coverage.” If the medical option that you elect has prescription drug coverage that is considered to be creditable, you can keep your medical option’s prescription drug coverage and not pay a higher premium (a penalty) if you later choose to join a Medicare prescription drug plan. You will receive a notice of creditable (or non-creditable) coverage each year before October 15 that will tell you whether or not your coverage is creditable.

Continuing Coverage

In certain situations, coverage may continue for you and your Eligible Dependents when you are not at work, as long as you continue to pay any required premiums. Your payments will be made on an after-tax basis through direct-billing unless you are receiving your pay while you are on a paid leave from work, in which case your premium payments will continue to be deducted on a before-tax basis to the extent applicable. You will receive information from the ***Aon HR Service Center*** describing the options available for paying your share of costs if you are taking an unpaid leave of absence, including military or FMLA leave, or will be absent from work for an extended period of time.

Family and Medical Leave Act of 1993 ("FMLA" or "Act")

Health coverage remains in effect while you are on FMLA leave. The FMLA, as amended, allows eligible colleagues to take leave for up to a total of 12 work weeks in a 12-month period for one or more of the following reasons:

- The birth of your Child and to care for the newborn Child.
- The placement of a Child with you for adoption or foster care.
- You are needed to care for a family member (Child, Spouse, or parent) with a serious health condition.
- Your own serious health condition makes you unable to perform the functions of your job.
- Any qualifying exigency arising out of the fact that the colleague's Spouse, Child, or parent is a covered member in the U.S. Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

If eligible, you may also take leave for up to a total of 26 work weeks in a single 12-month period to care for a covered member of the U.S. Armed Forces with a serious injury or illness if you are the Spouse, son, daughter, parent, or next of kin of the "covered service member."

Uniformed Services Employment and Reemployment Rights Act ("USERRA")

Under USERRA, Aon will provide you with employer-provided health coverage (medical, dental, and life insurance) for up to 24 months at active colleague rates during an approved military leave of absence. You must continue to pay your portion of the premium. This may be paid on an after-tax basis during any uncompensated portion of a leave. Short- and long-term disability coverage and basic and supplemental AD&D coverage will end after the first 31 days of a colleague's most recent military leave. Health and Dependent Care Spending Accounts can be stopped if such election is made within 31 days of military duty. If no change is made within 31 days, the current spending account deductions will continue until next benefit enrollment cycle.

Beginning with the 25th month of leave, your health coverage will cease unless you choose COBRA continuation coverage and pay 102% of the premiums for those health care benefits in which you are enrolled. This continuation coverage, if elected, will continue for up to an additional 18 months. Contact the ***Aon HR Service Center*** to obtain additional information about your benefits while on military leave.

State or Local Family and Medical Leave Laws

Aon must comply with any state or local law that provides greater family or medical leave benefits than those provided under the federal FMLA. If your leave qualifies under both the federal FMLA and under a state or local law, you will receive the greater benefit.

Contact the ***Aon HR Service Center*** for additional information about leaves of absence. Or, click the "Ask HR" tile on ***UPoint*** for updated leave information.

If You Begin Receiving Long-Term Disability Benefits and You Are an Active Employee With the Company

If you are or remain an active employee with the Company and you are receiving LTD benefits, you and your Eligible Dependents may be eligible to continue coverage under certain employee benefit plans. You will receive additional information from the ***Aon HR Service Center*** if you begin receiving LTD benefits.

Administrative Information

This section contains important information about how your benefits are administered and funded. It also contains information about your rights and responsibilities as a Participant and steps you can take if certain situations arise. See the ***Your Rights Under ERISA*** section for more information.

Plan Numbers and Employer Identification Numbers

The Plan Numbers and Employer Identification Numbers (EIN) for the Benefit Programs covered are:

EIN: 36-3051915 **Plan Number: 501**	Aon Benefit Plan (Medical, Dental, Vision, Critical Illness, LTD, Life, AD&D, EAP, Legal Services, Health Care Flexible Spending Account, Life Insurance Plan for Executives, Supplemental Disability Plan, Aon Severance Plan)

Plan Name

The Aon Benefit Plan.

Type of Plan

The Aon Benefit Plan is a welfare plan as such term is defined by ERISA.

Plan Documents

The Plan documents consist of:

- This Summary Plan Description and Wrap Plan Document;
- Any Summaries of Material Modifications to the SPD;
- The sub-plan documents for the Aon Flexible Compensation Plan and the Aon Severance Plan and its SPD;
- Applicable contracts, booklets, policies, and agreements with Insurers and third-party benefit claims administrators.

Plan Funding and Type of Administration

Type of Administration	The Plan is administered by Aon through arrangements with the Insurers and/or third-party claims administrators.
Funding	Aon and employees both contribute to the Plan. For some Benefit Programs, benefits are paid solely by the Company; others are paid by a combination of Company and employee contributions, while others are paid by employee contributions only. All Benefit Programs under the Plan are fully insured, except for the Dependent Care FSA and the Commuter Benefit Program (which are not subject to ERISA), and the Health Care FSA (which is subject to ERISA). For fully insured benefits, Aon pays the Insurer a premium from Company general assets for providing coverage under the insured options. Benefits are offered under the applicable insurance contracts. The Insurer or its delegate processes claims and makes all benefit determinations. Any benefit funded by the purchase of insurance will be payable solely by the Insurer and the Company shall not have any further responsibility to pay such benefit. For self-insured benefits (*e.g.*, the Health Care FSA), Aon pays a fee to the claims administrators to process claims for the self-insured Benefit Programs. The Company has the right at any time to amend the funding arrangements for the Plan and to change Insurers, claims administrators, or third-party administrators.

Additional Plan Information

Plan Sponsor/Employer	Aon Corporation 200 East Randolph Street Chicago, IL 60601
Plan Administrator	Aon Administrative Committee 200 East Randolph Street, 6th Floor Chicago, IL 60601 The Plan Administrator can be reached by contacting the ***Aon HR Service Center*** at **1-855-625-5500**.
Claims/Appeals Related to Enrollment and Eligibility Issues	**Enrollment and eligibility claims and appeals:** ***1st Level*** Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 ***2nd Level*** Aon Administrative Committee 200 East Randolph Street, 6th Floor Chicago, IL 60601 Appeals are to be initiated by phone call to the ***Aon HR Service Center*** at **1-855-625-5500**. A claim initiation form will be sent to you.
Claims/Appeals Related to Dependent Verification	**Dependent verification claims and appeals:** ***1st Level*** DVS Claims and Appeals Management P.O. Box 7114 Rantoul, IL 61866-7114 ***2nd Level*** DVS Claims and Appeals Management P.O. Box 7114 Rantoul, IL 61866-7114 Appeals are to be initiated by phone call to the ***Aon HR Service Center*** at **1-855-625-5500**. A claim initiation form will be sent to you.
Insurers/Claims Administrators (Refer to the ***Whom to Contact*** section to learn which entities act as claims administrators and which entities act as Insurers.) The benefits listed in this section are fully insured (Insurer administration), except for the Flexible Spending Accounts and Commuter Benefit Program; they are subject to contract administration.	**Benefit claims and appeals:** ***Medical/Prescription Drug*** Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512 Phone: 1-701-221-1105; 1-701-221-1048; or 1-701-221-1126 Fax: 1-859-425-3379 BlueCross BlueShield of Illinois Claim Review Section P.O. Box 2401 Chicago, IL 60690 Phone: 1-800-538-8833 Fax: 1-888-235-2936 Cigna Global Health Benefits ATTN: Appeals Department

	P.O. Box 15800 Wilmington, DE 19850-5800 Phone: 1-800-441-2668 Fax: 1-800-243-6998 Dean/Prevea360 Dean Health Plan 1277 Deming Way Madison, WI 53717 Phone: 1-800-649-0258 Fax: 1-608-252-0812 Geisinger Geisinger Choice 100 N. Academy Ave. Danville, PA 17822-3220 1-844-390-8332 GWH—Cigna Network Great West Healthcare P.O. Box 668 Kennett, MO 63857 Health Net California P.O. Box 10348 Van Nuys, CA 91410 Phone: HMO: 1-800-522-0088; PPO: 1-800-676-6976 Fax: 1-877-831-6019 Health Net Oregon P.O. Box 10342 Van Nuys, CA 91410 Phone: 1-888-802-7001 Fax: 1-800-782-2352 HMSA Hawaii HMSA Member Advocacy and Appeals P.O. Box 1958 Honolulu, HI 96805-1958 1-800-462-2085 or 1-808-948-5090 Kaiser Permanente (California) Claims Department Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623 1-800-464-4000 Kaiser Permanente (Colorado) Appeals Program Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066 Phone: 1-888-370-9858 or 1-303-344-7933 Fax: 1-866-466-4042 Kaiser Permanente (Georgia) Appeals Department Nine Piedmont Center

	3495 Piedmont Road, NE Atlanta, GA 30305-1736 1-404-364-4862 Kaiser Permanente (Mid-Atlantic States) Member Services Appeals Unit Kaiser Permanente 2101 East Jefferson Street Rockville, MD 20852 Fax: 1-301-816-6192 Kaiser Permanente (Northwest) Member Relations Department Kaiser Permanente 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Phone: 1-503-813-4480 Fax: 1-503-813-3985 Kaiser Permanente (formerly Group Health of WA) Kaiser Permanente Member Appeals P.O. Box 34593, AMB-2 Appeals Seattle, WA 98124-1593 Phone: 1-866-458-5479 Fax: 1-206-630-1859 Medical Mutual Electronic Claims Payer ID: 29076 P.O. Box 6018 Cleveland, OH 44101-1018 Fax: 1-216-687-7990 Priority Health Grievance and Appeal Coordinator, MS 1145 P.O. Box 269 Grand Rapids, MI 49501-0269 Phone: 1-833-207-3211 Fax: 1-616-975-8894 UnitedHealthcare (National) Central Escalation Unit P.O. Box 30573 Salt Lake City, UT 84130-0573 Fax: 1-801-938-2100 UnitedHealthcare (California) Appeals and Grievances UnitedHealthcare P.O. Box 6107 Mail Stop CA124-0160 Cypress, CA 90630-9972 *File an online Grievance Form at **www.uhcwest.com*** UPMC UPMC Health Plan P.O. Box 2999 Pittsburgh, PA 15230-2999 1-888-876-2756

	Dental Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512 Phone: 1-701-221-1105; 1-701-221-1048; or 1-701-221-1126 Fax:1-859-425-3379 Cigna Member Services 1-800-Cigna24 (1-800-244-6224) Claim address varies by state **www.cigna.com** Cigna Global Health Benefits ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850-5800 Phone: 1-800-441-2668 Fax: 1-800-243-6998 Delta Dental of Illinois 111 Shuman Blvd. Naperville, IL 60563 MetLife Group Dental Claims P.O. Box 981282 El Paso, TX 79998-1281 1-800-942-0854 ***Vision*** Vision Service Plan (VSP) P.O. Box 2350 Rancho Cordova, CA 95741 1-800-877-7195 (provider appeals) 1-877-478-7559 (member appeals) EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 1-844-739-9837 MetLife Complaint & Grievances Unit P.O. Box 997100 Sacramento, CA 95899-7100 1-855-638-3931 UnitedHealthcare UnitedHealthcare Vision P.O. Box 30978 Salt Lake City, UT 84130 1-888-571-5218 Cigna Global Health Benefits ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850-5800

	Phone: 1-800-441-2668 Fax: 1-800-243-6998 ***Flexible Spending Accounts and Commuter Benefit Program*** Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 1-855-625-5500 ***Long-Term Disability*** The Hartford Disability Claims 3800 West American Blvd Bloomington, MN 55431 1-800-752-9713 ***Life and AD&D Insurance*** The Hartford—Group Benefits Division P.O. Box 2999 Hartford, CT 06104-2999 1-800-523-2233 ***Critical Illness Insurance*** Metropolitan Life Insurance Company P.O. Box 5923 Bridgewater, NJ 08807-5923 1-800-GETMET8 (1-800-438-6388) ***Employee Assistance Program (EAP)*** Optum Health/UnitedHealthcare Services, Inc. 185 Asylum Street Hartford, CT 06103-3408 1-800-510-9351 ***Legal Services Plan*** Hyatt Legal Plans, Inc. Director of Administration 1111 Superior Avenue, 8th floor Cleveland, OH 44114-2507 1-800-821-6400 ***Group Personal Umbrella Liability Insurance*** Chubb Customer Center 202 Falls Mill Road White House Station, NJ 08889 ***Accident Insurance*** Chubb Workplace Benefits Combined Insurance, Claim Department P.O. Box 6700 Scranton, PA 18505-0700 ***Auto & Homeowners Insurance*** MetLife Mail Processing Department P.O. Box 2204

	Charlotte, NC 28241-2204 1-800-854-6011 Liberty Mutual 1-800-2CLAIMS (1-800-225-2467) *To escalate a claim:* Email: **presidentialscvteam@libertymutual.com** 1-800-344-0197 Travelers 1-800-CLAIM33 (1-800-252-4633) **travelers.com/aon**
Agent for Service of Legal Process	Aon Corporation—ATTN: HR Senior Director, Rewards 200 East Randolph Street Chicago, IL 60601 Service of legal process may also be made upon the Plan Administrator or, for insured benefits, upon the Insurer.
Plan Year	January 1 – December 31

Insurers/Claims Administrators

The Plan Administrator has the full discretionary authority to interpret the Plan and each Benefit Program in accordance with its terms and the applicable provisions of ERISA and to resolve all disputed eligibility claims. In the case of insured benefits, the applicable Insurer has complete discretionary authority to determine eligibility for participation (although state eligibility laws may also apply) and benefit payment under the applicable Benefit Program.

The Plan Administrator has also delegated administrative duties to claims administrators who determine and pay claims. The claims administrators for self-insured benefits have:

- The authority to make determinations regarding eligibility and benefit claims under the Benefit Programs described in this SPD.
- Discretionary authority to:
  - Interpret the health and welfare plans based on provisions of the governing instruments and applicable law and make factual determinations about claims arising under such plans and programs.
  - Determine whether a claimant is eligible for benefits.
  - Decide the amount, form, and timing of benefits.
  - Resolve any other matter raised by a claimant or that is identified by the claims administrator.

In case of an appeal, the decision of the applicable claims administrator shall be final and binding on all parties to the full extent permitted under applicable law.

Payment of Benefits

Benefits will be payable to the covered Participant, unless otherwise assigned. The Plan Administrator, in its discretion, may authorize payments to be issued to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

No Guarantee of Tax Consequences

The Company is not liable for any taxes or other liability incurred by a Participant or any individual claiming benefits through a Participant by virtue of participation in the Plan. The Company does not represent or guarantee that amounts paid to or for the benefit of a Participant will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It is the obligation of the Participant to determine whether a payment is excludable from the Participant's gross income for federal, state, or local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that any such payment is not so excludable.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order ("QMCSO"), National Medical Support Notice ("NMSN"), or approved life insurance benefit assignment, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged, or garnished. The Plan Administrator has procedures for determining whether an order qualifies as a QMCSO or NMSN; Participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator.

Expenses

To the extent permitted by applicable law, all expenses incurred in connection with the administration of the Plan will be paid by the Plan except to the extent that the Company elects to pay such expenses.

Fraud

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

Indemnity

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

Refund of Premium Contributions

For fully insured Benefit Programs, the Plan will comply with Department of Labor ("DOL") guidance regarding refunds (*e.g.*, dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a Plan asset to the extent amounts are attributable to Participant contributions, such assets will be: (1) distributed to current Plan Participants within 90 days of receipt; (2) used to reduce Participants' portion of future premiums under the Plan (*e.g.*, premium holiday); or (3) used to enhance future benefits under the Plan. The determination of which option, or combination of options, shall apply will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of Participants, provided such method is reasonable, fair, and objective.

Nondiscrimination

In accordance with Code Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416(i)(1)) or Highly Compensated Individuals as to eligibility to participate or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. If, in the operation of the Plan, more than the legally permitted nontaxable benefits are found to be provided to Key Employees, or the Plan discriminates in any other manner, then notwithstanding any other provision contained herein, the Plan Administrator shall reduce or adjust such contributions and/or benefits under the Plan as shall be necessary to ensure that the Plan will not discriminate. All rules, procedures, and decisions of the Plan Administrator shall be adopted, made, and applied in such fashion to not discriminate in favor of Highly Compensated Individuals, Highly Compensated Participants, or Key Employees.

The Company shall have no liability with respect to the income tax consequences that may be experienced by Highly Compensated Participants, Highly Compensated Individuals, or with respect to amounts re-characterized by reason of discrimination testing under the Plan.

Right to Amend or Terminate

Although the Company presently intends to continue the Plan, it reserves the right to amend, modify, suspend, or terminate the Plan, in whole or in part, at any time, at its discretion, with or without advance notice to Participants, for any reason, subject to applicable law.

The Company further reserves the right to change the amount of required Participant contributions for coverage at any time, with or without advance notice to Participants.

No Enlargement of Rights

All terms of the Plan are legally enforceable. However, this SPD does not constitute a contract of employment nor does it interfere with the Company's right to terminate your employment, with or without cause.

Severability

If any provision of the Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the Plan shall be construed and enforced as if such provision had not been included, and the remaining provisions shall continue to be fully effective.

Corporate Actions

As a matter of prudent business planning, the Company continually reviews and evaluates various proposals for changes in its Benefit Programs. Because of the need for confidentiality, such proposals are not evaluated below high levels of management. Colleagues below such levels do not know whether future changes will be made and/or new Benefit Programs adopted. Unless and until the Company formally announces such changes, no one is authorized to give assurances that such changes will or will not occur.

Filing an ERISA Claim or Appeal

Disagreements about benefit eligibility or benefit amounts can arise. If the claims administrators (who are identified in the chart below for each ERISA-governed Benefit Program under the Plan) are unable to resolve the disagreement, the claims administrators have formal appeal procedures in place for ERISA-covered plans.

The claims administrators have discretionary authority to:

- Interpret the Plan based on their provisions and applicable law and make factual determinations about claims arising under the Plan.
- Determine whether you are eligible for benefits.
- Decide the amount, form, and timing of benefits.
- Resolve any other matter under the Plan that is raised by you or a beneficiary, or that is identified by either the claims or appeals administrator.

The claims administrators and the appeals administrators have sole discretionary authority to decide Benefit Program claims under the Plan and review and resolve any appeal of a denied claim. In case of an appeal, the appeals administrators' decisions are final and binding on all parties to the full extent permitted under applicable law, unless the Participant or a beneficiary later proves that any such decision was an abuse of administrator discretion.

This section explains the steps you or your authorized representative is required to take to file an ERISA claim or appeal. Please note that claims and appeals procedures for **severance claims** are outlined in the Aon Severance Plan SPD, and are not addressed below.

Note: References to "you" refer to the claimant, including his or her authorized representative.

Types of Claims

There are two types of claims that may be made under the Plan.

An **eligibility claim** is a claim to participate in a Benefit Program offered under the Plan or to change an election to participate during the year. Examples of eligibility claims include claims regarding whether you are enrolled in the correct benefit option, or claims related to whether you properly enrolled a Dependent. Eligibility claims do not address whether a particular treatment or benefit is covered under the Plan.

A **benefit claim** is a claim for a particular benefit under the Plan.

Eligibility Claims—All ERISA Benefit Programs

For initial eligibility claims for all Benefit Programs subject to ERISA, the Claims Administrator is Aon Claims and Appeals Management ("CAM"). To file an eligibility claim, you must request a Claim Initiation Form from the ***Aon HR Service Center***. You must return the form to CAM at the address on the form.

You will be notified of the decision (1) for medical (including prescription drug), health care FSA, dental, vision, and EAP benefits, within 30 days or within 72 hours (if you specify that it is an urgent care claim) of CAM's receipt of your Claim Initiation Form, (2) for long-term disability benefits, within 45 days of CAM's receipt of your Claim Initiation Form, or (3) for all other benefits, within 90 days of CAM's receipt of your Claim Initiation Form. If additional information is needed to process your eligibility claim, you will be notified within that initial period. The Plan may request an extension, not longer than (a) for medical (including prescription drug), health care FSA, dental, vision, and EAP benefits, an additional 15 days, (b) for disability benefits, up to two additional 30-day periods, or (c) for all other claims, 90 days.

CAM will notify you of the deadline to submit additional information, if applicable.

Notification of Initial Eligibility Claim Decision

If your claim is **approved**, CAM will notify you in writing.

If your claim is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.

- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary.
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal.

With respect to medical (including prescription drug) and long-term disability coverage, your denial notice will also include:

- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- Information sufficient to identify the claim involved.

Depending on where you live, you may be able to receive a medical (including prescription drug) or long-term disability denial notice in Spanish, Tagalog, Chinese, or Navajo.

Appeals

Before you can bring any legal action to recover Plan benefits, you **must** exhaust this process. Specifically, you must file an appeal as explained in this section and your appeal must be finally decided by the appeals administrator. For eligibility claims for all Benefit Programs, the appeals administrator is the Aon Administrative Committee. All decisions by the appeals administrator are final and binding on all parties.

If your claim is denied and you want to appeal it, you must file your appeal within 180 days (for medical [including prescription drug], health care FSA, dental, vision, long-term disability, and EAP benefits) or otherwise 60 days from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. To file your appeal, write to the appeals administrator for the Plan and include:

- A copy of your claim denial notice.
- The reason(s) for the appeal.
- Relevant documentation.

You will be notified of the decision within 60 days for medical (including prescription drug), health care FSA, dental, vision, and EAP benefits (unless it is an urgent care claim, in which case you will be notified within 72 hours of CAM's receipt of your appeal), 45 days for long-term disability (90 days when special circumstances apply), or 60 days (120 days when special circumstances apply) for all other ERISA-covered Benefit Programs.

If your appeal is **approved**, the appeals administrator will notify you in writing.

If your appeal is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to your benefit claim upon request.
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA, and information pertaining to any voluntary appeal procedures that may apply.

With respect to medical (including prescription drug) and long-term disability coverage, your denial notice will also include:

- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- Information sufficient to identify the claim involved.
- If the denial is for a rescission of medical (including prescription drug) coverage, information pertaining to your right to an external review and the availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process.
- If the denial is for a rescission of long-term disability coverage, any limitations period for bringing a civil action under Section 502(a) of ERISA, including the calendar date when the limitations period will expire.

Unless your eligibility claim pertained to a rescission[1] (a retroactive termination of coverage), the decision on your appeal is final. As a result, the appeals administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action under Section 502(a) of ERISA following your appeal. See ***Exhaustion of Administrative Remedies*** for additional information.

[1]A rescission (a retroactive termination of coverage) is eligible for an external review as explained under the Benefit Claims process and applies only to medical (including prescription drug) and long-term disability benefits under the Plan.

Benefit Claims—Medical (Including Prescription Drug), Health Care FSA, Dental, Vision, and EAP

To file a benefit claim for these types of benefits, you should contact the claims administrators (who are identified in the chart below for each of these Benefit Programs under the Plan). For purposes of determining the amount of, and entitlement to, benefits provided under Insurance or contracts, the respective Insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits, you must follow the claims procedure outlined by your Insurer/claims administrator. General procedures are outlined here, but your insurer/claims administrator may have more specific procedures. An explanation of benefits (EOB) generally is the response to a benefit claim.

You must include:

- A description of the benefits for which you are applying.
- The reason(s) for the request.
- Relevant documentation.

There are four categories of claims for benefits, each with somewhat different claims and appeal rules. The primary difference is the time frame within which claims and appeals must be determined.

- **Post-service:** A claim for reimbursement of services already received. This is the most common type of claim.
- **Pre-service:** A claim for a benefit for which prior authorization is required by the Plan.
- **Urgent care:** A claim for medical care or treatment that, if the longer time frames for non-urgent care were applied, the delay: (1) could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a Doctor with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.
- **Concurrent care:** A claim for ongoing treatment over a period of time or a number of treatments. For example, if you have been authorized to receive seven treatments from a therapist and during the treatment your therapist suggests 10 treatments, your claim is a concurrent care claim. Some concurrent care claims also are urgent care claims.

The claims administrator will decide claims and appeals in accordance with its reasonable claims procedures, as required by ERISA. The procedures outlined here align with ERISA; however the claims fiduciary may have slightly different procedures. Failure to timely file a claim may cause you to lose your right to file suit in a state or federal court, based on a failure to exhaust internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

Post-Service Claims

The claims administrator will decide an initial post-service claim within 30 days after receipt of the claim. Post-service claims must be filed within six months after the end of the Plan Year in which the service was incurred. If the claims administrator is unable to decide an initial post-service claim within this time frame due to matters beyond its control, it may take an extension of up to 15 days, provided that you are notified in writing before the expiration of the initial 30-day period. The extension notice shall include a description of the matter beyond the Plan's control that justifies the extension and the date by which a decision is expected. If your initial post-service claim is incomplete when filed, the claims administrator may either deny the claim or notify you that additional information is needed within the initial 30-day period, and you will have a period of at least 45 days in which to provide the necessary information. The claims administrator's time frame for deciding the claim will be suspended from the date you receive the request for additional information to the date you provide that information. If you do not provide the additional information, your claim will be decided based on the originally provided information.

Pre-Service Claims

If you or your authorized representative does not follow the Plan procedures for filing a pre-service claim, you will be notified of this failure and provided the proper procedure for filing the claim as soon as possible, but within five days of the claims administrator's receipt of your claim. Once a claim is properly filed, the claims administrator will decide an initial pre-service

claim within 15 days after receipt of the claim. If the claims administrator is unable to decide an initial pre-service claim within this time frame due to matters beyond its control, it may take an extension of up to 15 days, provided that you are notified in writing before the expiration of the initial 15-day period. The extension notice shall include a description of the matter beyond the Plan's control that justifies the extension and the date by which a decision is expected. If your initial pre-service claim is incomplete when filed, the claims administrator may either deny the claim or notify you that additional information is needed within the initial 15-day period, and you will have a period of at least 45 days in which to provide the necessary information. The claims administrator's time frame for deciding the claim will be suspended from the date you receive the request for additional information to the date you provide that information. If you do not provide the additional information, your claim will be decided based on the originally provided information.

Urgent Care Claims

If you or your authorized representative does not follow the Plan procedures for filing an urgent care claim, you will be notified of this failure and provided the proper procedure for filing the claim as soon as possible, but no later than within 24 hours of the claims administrator's receipt of your claim. Once a claim is properly filed, the claims administrator will decide an initial urgent care claim as soon as possible, taking into account the medical urgencies but no later than 72 hours after receipt of the claim. If your initial urgent care claim is incomplete when filed, the claims administrator may either deny the claim or notify you within

24 hours of the information needed to decide your claim, and you will have at least 48 hours in which to provide the necessary information. The claims administrator will decide the claim as soon as possible but not later than 48 hours after the earlier of: (1) the receipt of the specified information; or (2) the end of the time period provided to submit the specified information. If you do not provide the additional information, your claim will be decided based on the originally provided information.

Concurrent Care Claims

With regard to a claim to extend a concurrent care decision that involves urgent care, the claims administrator will decide the claim within 24 hours after the receipt of the claim if the claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments.

A decision by the claims administrator to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed, as explained below. Notification of a decision to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow you to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

Notification of Initial Benefit Claim Decision

If your benefit claim is approved, the claims administrator will notify you in writing (generally in the form of an explanation of benefits, or EOB).

If your benefit claim (benefit determination) is denied, in whole or in part, the claims administrator will notify you in writing, except for urgent care (in which case, you will be notified by telephone, which will be followed by a written denial notice within three days, and you will receive a description of the expedited appeals process applicable to urgent care claims). Your denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to your benefit claim upon request.
- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary.
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal.
- Any internal procedures or protocols or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request).

The following additional information will be included in a denial notice pertaining to medical benefit appeals (including prescription drugs):

- Information sufficient to identify the claim involved (date of service, the health care provider, claim amount (if applicable), and upon request, the availability of the diagnosis and treatment codes and their corresponding meanings).
- Reason(s) for the adverse benefit determination.

- Information pertaining to your right to an external review and internal appeal.
- The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process.

Further, your medical (including prescription drug) notice will be written in a culturally and linguistically appropriate manner. Depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo. If the claims administrator relies on new evidence to deny your claim, you will be notified in advance, free of charge, with the rationale so that you can respond in advance of the final internal adverse benefit determination. You have a right to review your claim file.

Appeals

You have the right to appeal an adverse decision on an initial benefit claim. You must exhaust the appeal process before you can bring any legal action to recover Plan benefits. Your appeal must be filed within 180 days following your receipt of the adverse benefit decision notice. You may request access, free of charge, to all documents relating to your appeal. You also have the right to testify, present evidence, and submit written comments, documents, records, and other information relating to your benefit claim. Your appeal should include:

- A copy of your claim denial notice.
- The reason(s) for the appeal.
- Relevant documentation.

The individual/committee (and any medical or vocational expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your appeal involves a medical judgment, the appeals administrator (who is identified in the chart below for each Benefit Program under the Plan) will consult with a health care professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request. The review of your appeal will take into account all documents, records, and other material submitted by you relating to your claim, without regard to whether it was submitted or considered in the initial benefit determination.

The appeals administrator will make a decision on your appeal on a post-service benefit claim within 60 days of receiving your appeal (or 30 days, if the appeals administrator offers two levels of mandatory appeal).

The appeals administrator will make a decision on your appeal on a pre-service benefit claim within 30 days of receiving your appeal (or 15 days, if the appeals administrator offers two levels of mandatory appeal).

The appeals administrator will make a decision on your appeal on a concurrent care claim before a reduction or termination of benefits would occur.

The appeals administrator will make a decision on your appeal on an urgent care claim (including a concurrent care claim that involves urgent care) within 72 hours of receiving your appeal.

Where the appeals administrator is the Aon Administrative Committee, there is only one mandatory level of appeal. Where the appeals administrator is the Insurer, there may be one or two levels of mandatory appeal. If a voluntary appeal is available, you will be notified.

Notification of Benefit Claim Appeals Decision

If your appeal (benefit determination on review) is **approved or denied**, the appeals administrator will notify you in writing. If your appeal is denied in whole or in part, your denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- A statement that you are entitled to receive and make copies of, upon request and free of charge, with reasonable access to, all records, documents, and other information relevant to your benefit claim upon request.
- Any internal procedures or protocols or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.”
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA and any additional, voluntary appeal offered by the Plan.

The following additional information will be included in a denial notice pertaining to medical benefit appeals (including prescription drugs):

- Information sufficient to identify the claim involved (date of service, the health care provider, claim amount (if applicable), and upon request, the availability of the diagnosis and treatment codes and their corresponding meanings).
- Discussion of the decision.
- Information pertaining to your right to an external review (and if applicable, any second level of internal appeal).
- The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process.

Further, your notice will be written in a culturally and linguistically appropriate manner. Depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo.

Medical (Including Prescription Drug) Benefit Claims—External Review Process

If your medical or prescription drug benefit claim is denied following the mandatory appeal(s), you generally have a right to file a civil action. However, under the Affordable Care Act, you also have a right to submit an external review to an Independent Review Organization (an "IRO") for any medical benefit claim or rescission. Please note that this only applies to medical and prescription drug benefits.

Your claim will be reviewed by an IRO, if it's eligible for the external review. The IRO is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Standard External Review

You may request a Standard External Review within four months after the date of receipt of notice of an adverse benefit determination or final internal adverse benefit determination.

Expedited External Revenue

You may make a request for an expedited external review at the time you receive:

- **An internal adverse benefit determination** if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- **A final internal adverse benefit determination**, if (1) you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function; or (2) the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

You should contact the appeals administrator for more details.

Preliminary Review

Within five business days following receipt of the request (or immediately, if the request relates to an urgent care claim), the claims administrator must complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care, item, or service was requested or provided;
- The adverse benefit determination does not relate to your failure to meet the eligibility requirements under the terms of the Plan, except for a rescission (external review generally does not apply to eligibility-type requests or claims);
- You have exhausted the Plan's internal appeal process (unless appealing an urgent internal adverse benefit determination); and
- You have provided all the information and forms required to process the external review.

The claims administrator is required to issue a written notice and explain its preliminary review determination within one business day (or immediately, if the request relates to an urgent care claim):

- If the request is eligible for external review, the claims administrator on behalf of the Plan must assign the review an IRO.
- If the request is incomplete, the notice must state what is needed to complete the request for external review. The information must be provided within the four-month filing period or 48 hours following notice, whichever is later.

- If the request is complete but not eligible for external review, the notice must state the reasons for ineligibility and provide EBSA's contact information (1-866-444-EBSA [3272]).

The claims administrator must provide the IRO any documents and information considered in making the adverse benefit determination within five business days after the date of assignment. If the underlying claim involves urgent care, please refer to ***Expedited External Review*** above.

The IRO must provide you with timely written notice of acceptance of external review request and include a statement that you may submit additional information in writing within 10 business days to be considered by the IRO. If the underlying claim is a concurrent care claim that involves urgent care, please refer to ***Expedited External Review*** above.

Upon receipt of additional information, the IRO has one business day to forward the information to the claims administrator.

Upon the IRO's receipt of any information submitted by you, the IRO must forward the information to the claims administrator. The claims administrator may then **reconsider its adverse benefit determination**, but will not delay the external review.

If the claims administrator **reverses** its decision, it must notify you and the IRO within one business day following the decision and the IRO must terminate the external review. The amount of time that it takes to review and reverse a decision may vary by claims administrator. If the underlying claim involves urgent care, please refer to ***Expedited External Review*** above.

The IRO must provide (oral or written) notice of the final external review decision to you and the claims administrator within

45 days (or 72 hours, if the underlying claim involves urgent care) after the IRO receives the request for external review. If the underlying claim involves urgent care and the initial notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the claims administrator within 48 hours.

IRO External Review Decision Notice

The decision notice must include:

- General description of the reason for the request for external review, including sufficient information to identify the claim (*i.e.*, date[s] of service, health care provider, claim amount (if applicable), diagnosis, and treatment codes and their meaning, and the reason for the previous denial);
- Date on which the IRO received the assignment to conduct the external review and the date of the IRO's decision;
- References to evidence or documentation in reaching the decision, including specific coverage provisions and evidence-based standards considered;
- Discussion of the principal reason(s) for its decision, including rationale and any evidence-based standards relied upon;
- Statement that the determination is binding except to the extent other remedies may be available under state or federal law to either the Plan or to the claimant;
- Statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

If the IRO reverses the claims administrator's decision, the claims administrator must provide coverage or payment for the claim immediately. If the IRO denies your appeal, you have the right to bring a civil action under Section 502(a) of ERISA.

Benefit Claims—Long Term Disability, Life and AD&D, and Legal Services

For purposes of determining the amount of, and entitlement to, benefits provided under insurance or contracts, the respective Insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits, you must follow the claims procedure outlined by your Insurer/claims administrator. General procedures are outlined here, but your Insurer/claims administrator may have more specific procedures.

To file a benefit claim for these types of benefits, you should contact the claims administrator.

You must include:

- A description of the benefits for which you are applying.
- The reason(s) for the request.
- Relevant documentation.

You will be notified of the decision within a reasonable time frame not to exceed 45 days for long-term disability claims (up to two additional 30-day extension periods may apply and you will be provided written notice of this extension before the end of the initial 45-day period) or 90 days for life, AD&D, and Legal Services Plan claims of the claims administrator's receipt of your written claim (an additional 90-day extension period may apply and you will be provided written notice of this extension before the end of the initial 90-day period).

If the claims administrator needs additional information to resolve an issue as part of an extension, you will be given 45 days to provide such information.

The claims administrator will notify you of the deadline to submit additional information, if applicable.

If your claim is **approved**, the claims administrator will notify you in writing.

If your claim (benefit determination) is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to your benefit claim upon request.
- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary.
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal.

The following additional information will be included in a denial notice pertaining to long-term disability claims:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not: (1) your health care professional; (2) the views of medical or vocational experts; and/or (3) a disability determination made by the Social Security Administration.
- Any internal rule, guideline, protocol, standards, or other similar criterion that was relied upon in making the determination.
- If based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Before you can bring any action at law or in equity to recover Plan benefits, you **must** exhaust this process. Specifically, you must file an appeal as explained in this section and your appeal must be finally decided by the appeals administrator. All decisions by the appeals administrator are final and binding on all parties.

If your claim is denied and you want to appeal it, you must file your appeal within 60 days (or 180 days, for a claim involving long-term disability) from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. You also have the right to submit written comments, documents, records, and other information relating to your benefit claim. To file your appeal, write to the appeals administrator for the Plan and include:

- A copy of your claim denial notice.
- The reason(s) for the appeal.
- Relevant documentation.

The review of your appeal will take into account all documents, records, and other material submitted by you relating to your claim, without regard to whether it was submitted or considered in the initial benefit determination.

For claims involving long-term disability, the individual/committee (and any medical or vocational expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your long-term disability claim appeal involves a medical judgment, the appeals administrator (who is identified in the chart below for each Benefit Program under the Plan) will consult with a health care professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request. Before the Plan will issue a denial on a long-term disability appeal, you will be provided, free of charge, with any new or additional evidence under consideration in connection with the claim and any rationale for a denial based on this new information in advance of the formal denial so that you are given a reasonable opportunity to respond.

For all claims other than those involving long-term disability, you will be notified of the decision within 60 days of the claims administrator's receipt of your appeal, unless special circumstances apply, in which case the claims administrator may take an additional 60 days to decide your claim (you will be provided written notice of this extension before the end of the initial 60-day period).

For long-term disability claims, you will be notified of the decision with 45 days of the claims administrator's receipt of your appeal, unless special circumstances apply, in which case the claims administrator may take an additional 45 days to decide your claim (you will be provided written notice of this extension before the end of the initial 45-day period).

If your appeal is **approved**, the claims administrator will notify you in writing.

If your appeal (benefit determination on review) is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to your benefit claim upon request.
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA, and information pertaining to any voluntary appeal procedures that may apply.

The following additional information will be included in a denial notice pertaining to long-term disability claims:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not: (1) your health care professional; (2) the views of medical or vocational experts; and/or (3) a disability determination made by the Social Security Administration.
- Any internal rule, guideline, protocols, standard, or other similar criterion on which the denial was based (or a statement that such information does not exist).
- If based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Any limitations period for voluntary appeals or bringing a civil action under Section 502(a) of ERISA, including the calendar date when the limitations period will expire.

In addition:

- **Coverage rescissions.** Certain rescissions (retroactive termination) of long-term disability benefits due to alleged misrepresentation of fact (*e.g.*, errors in the application for coverage) will be treated as an adverse benefit determination (*i.e.*, claim denial) which would trigger the Plan's appeal procedures.
- **Communication requirements in non-English languages.** Adverse benefit determinations of long-term disability benefits must be provided in a "culturally and linguistically appropriate manner." Depending on where you live, you may be able to receive such information in Spanish, Chinese, Tagalog, and Navajo.

The decision on your appeal is final. As a result, the claims administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action under Section 502(a) of ERISA following your appeal.

Exhaustion of Administrative Remedies

Before filing a lawsuit concerning a benefit claim, you must exhaust all administrative remedies; that is, you must first appropriately file a claim and follow the specified appeals procedures. Lawsuits should be directed to the appropriate party.

Deadline to file suit. The deadline for filing a lawsuit following your final appeal is one year from the denial of your final appeal by the Plan Administrator or the appropriate claim administrator or IRO, as applicable. Any lawsuit with respect to the plans, not related to a claim for benefits, must be filed within one year after the date you knew, or had reason to know, of the circumstances giving rise to the action.

Venue. Venue for any action arising under a benefit plan exclusively shall be in the federal or state court of proper jurisdiction in Cook County, Illinois, unless an applicable insurance contract expressly provides otherwise. Unless an applicable insurance contract expressly provides otherwise, the benefit plans shall be governed by and construed in accordance with the laws of the State of Illinois, without regard to conflicts of laws, to the extent that applicable federal law has not preempted the laws of the State of Illinois.

Legal fees. Any award of legal fees in connection with an action involving a Plan benefit or program will be calculated pursuant to the method that results in the lowest reasonable amount of fees being paid. In no event will legal fees be awarded for work related to administrative proceedings under the Plan, unsuccessful claims brought by a Participant, or any other person, or actions that are not brought under ERISA. In calculating any award of legal fees, there will be no enhancement for the risk of contingency, nonpayment, or any other risk, nor will a contingency multiplier or any other multiplier be applied. In any action brought by a Participant or any other person against the Plan, the Company, the Plan Administrator, any Plan fiduciary or their affiliates or their or their affiliates' officers, directors, trustees, employees, or agents, legal fees of these parties in connection with such action shall be paid by the Participant or other person bringing the action, unless the court specifically finds that there was a reasonable basis for the action.

Claims Administrators and Appeals Administrators

The following matrix identifies the claims administrators and claims fiduciaries for all Benefit Programs that are subject to the ERISA claims and appeals rules. For additional details regarding the claims and appeals process, contact the applicable claims administrator or the appeals administrator.

Claims Administrator—Benefit Claims	Claims Administrator—Eligibility Claims	Appeals Administrator—Benefit Claims	Appeals Administrator—Eligibility Claims
Medical Claims			
Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512 Phone: 1-701-221-1105; 1-701-221-1048; or 1-701-221-1126 Fax:1-859-425-3379	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Aetna* Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512 Phone: 1-701-221-1105; 1-701-221-1048; or 1-701-221-1126 Fax:1-859-425-3379	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
BlueCross BlueShield of Illinois Claim Review Section P.O. Box 2401 Chicago, IL 60690 Phone: 1-800-538-8833 Fax: 1-888-235-2936	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*BlueCross BlueShield of Illinois* Claim Review Section P.O. Box 2401 Chicago, IL 60690 Phone: 1-800-538-8833 Fax: 1-888-235-2936	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Cigna Global Health Benefits ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850-5800 Phone: 1-800-441-2668 Fax: 1-800-243-6998	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Cigna Global Health Benefits* ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850-5800 Phone: 1-800-441-2668 Fax: 1-800-243-6998	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Dean Health Plan 1277 Deming Way Madison, WI 53717 Phone: 1-800-649-0258 Fax: 1-608-252-0812	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Dean Health Plan* 1277 Deming Way Madison, WI 53717 Phone: 1-800-649-0258 Fax: 1-608-252-0812	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Geisinger Geisinger Choice 100 N. Academy Ave. Danville, PA 17822-3220 1-844-390-8332	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Geisinger* Geisinger Choice 100 N. Academy Ave. Danville, PA 17822-3220 1-844-390-8332	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385

Claims Administrator—Benefit Claims	Claims Administrator—Eligibility Claims	Appeals Administrator—Benefit Claims	Appeals Administrator—Eligibility Claims
Health Net (California) P.O. Box 10348 Van Nuys, CA 91410 Phone: 1-800-522-0088 HMO 1-800-676-6976 PPO Fax: 1-877-831-6019	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Health Net (California)* P.O. Box 10348 Van Nuys, CA 91410 Phone: 1-800-522-0088 HMO 1-800-676-6976 PPO Fax: 1-877-831-6019	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Health Net (Oregon) P.O. Box 10342 Van Nuys, CA 91410 1-888-802-7001 Fax: 1-800-782-2352	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Health Net (Oregon)* P.O. Box 10342 Van Nuys, CA 91410 Phone: 1-888-802-7001 Fax: 1-800-782-2352	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
HMSA Hawaii Member Advocacy and Appeals P. O. Box 1958 Honolulu, HI 96805-1958 1-800-462-2085 (toll free) 1-808-948-5090	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*HMSA Hawaii* Member Advocacy and Appeals P. O. Box 1958 Honolulu, HI 96805-1958 1-800-462-2085 (toll free) 1-808-948-5090	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Kaiser (California) Claims Department Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623 1-800-464-4000	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Kaiser (California)* Claims Department Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623 1-800-464-4000	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Kaiser (Colorado) Appeals Program Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066 Phone: 1-303-344-7933 or 1-888-370-9858 Fax: 1-866-466-4042	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Kaiser (Colorado)* Appeals Program Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066 Phone: 1-303-344-7933 or 1-888-370-9858 Fax: 1-866-466-4042	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Kaiser (Georgia) Appeals Department Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736 1-404-364-4862	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Kaiser (Georgia)* Appeals Department Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736 1-404-364-4862	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Kaiser (Mid-Atlantic) Member Services Appeals Unit Kaiser Permanente 2101 East Jefferson Street Rockville, MD 20852 Fax: 1-301-816-6192	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Kaiser (Mid-Atlantic)* Member Services Appeals Unit Kaiser Permanente 2101 East Jefferson Street Rockville, MD 20852 Fax: 1-301-816-6192	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385

Claims Administrator—Benefit Claims	Claims Administrator—Eligibility Claims	Appeals Administrator—Benefit Claims	Appeals Administrator—Eligibility Claims
Kaiser (Northwest) Kaiser Foundation Health Plan of the Northwest Member Relations Department 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-503-813-3985	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Kaiser (Northwest)* Kaiser Foundation Health Plan of the Northwest Member Relations Department 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-503-813-3985	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Kaiser Permanente (formerly Group Health of WA) Kaiser Permanente Member Appeals P.O. Box 34593, AMB-2 Appeals Seattle, WA 98124-1593 Phone: 1-866-458-5479 Fax: 1-206-630-1859	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Kaiser Permanente (formerly Group Health of WA)* Kaiser Permanente Member Appeals P.O. Box 34593, AMB-2 Appeals Seattle, WA 98124-1593 Phone: 1-866-458-5479 Fax: 1-206-630-1859	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Medical Mutual Electronic Claims Payer ID: 29076 P.O. Box 6018 Cleveland, OH 44101-1018	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Medical Mutual* Member Appeals Department P.O. Box 94580 Cleveland, OH 44101-4580 Fax: 1-216-687-7990	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Priority Health Grievance and Appeal Coordinator, MS 1145 P.O. Box 269 Grand Rapids, MI 49501-0269 Phone: 1-833-207-3211 Fax: 1-616-975-8894	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Priority Health* Grievance and Appeal Coordinator, MS 1145 P.O. Box 269 Grand Rapids, MI 49501-0269 Phone: 1-833-207-3211 Fax: 1-616-975-8894	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
UnitedHealthcare (National) UnitedHealth Group National Central Escalation Unit P.O. Box 30573 Salt Lake City, UT 84130-0573 Fax: 1-801-938-2100	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*UnitedHealthcare (National)* UnitedHealth Group National Central Escalation Unit P.O. Box 30573 Salt Lake City, UT 84130-0573 Fax: 1-801-938-2100	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
UnitedHealthcare (California) Appeals and Grievances UnitedHealthcare P.O. Box 6107 Mail Stop CA124-0160 Cypress, CA 90630-9972 File an online Grievance Form at **www.uhcwest.com**	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*UnitedHealthcare (California)* Appeals and Grievances UnitedHealthcare P.O. Box 6107 Mail Stop CA124-0160 Cypress, CA 90630-9972 File an online Grievance Form at **www.uhcwest.com**	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
UPMC UPMC Health Plan P.O. Box 2999 Pittsburgh, PA 15230-2999 Phone: 1-888-876-2756	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*UPMC* UPMC Health Plan P.O. Box 2999 Pittsburgh, PA 15230-2999 Phone: 1-888-876-2756	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385

Claims Administrator—Benefit Claims	Claims Administrator—Eligibility Claims	Appeals Administrator—Benefit Claims	Appeals Administrator—Eligibility Claims
Critical Illness Claims			
Metropolitan Life Insurance Company P.O. Box 5923 Bridgewater, NJ 08807-5923 1-800-GETMET8	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Metropolitan Life Insurance Company* P.O. Box 5923 Bridgewater, NJ 08807-5923 1-800-GETMET8	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Dental Claims			
Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512 Phone: 1-701-221-1105; 1-701-221-1048; or 1-701-221-1126 Fax:1-859-425-3379	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Aetna* Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512 Phone: 1-701-221-1105; 1-701-221-1048; or 1-701-221-1126 Fax:1-859-425-3379	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Cigna DHMO Member Services 1-800-Cigna24 Claim address varies by state	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Cigna DHMO* Member Services 1-800-Cigna24 Claim address varies by state	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Cigna Global Health Benefits ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850-5800 Phone: 1-800-441-2668 Fax: 1-800-243-6998	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Cigna Global Health Benefits* ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850-5800 Phone: 1-800-441-2668 Fax: 1-800-243-6998	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Delta Dental of Illinois 111 Shuman Blvd. Naperville, IL 60563	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Delta Dental of Illinois* 111 Shuman Blvd. Naperville, IL 60563	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
MetLife PPO (Actives) Group Dental Claims P.O. Box 981282 El Paso, TX 79998-1281 1-800-942-0854	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*MetLife PPO (Actives)* Group Dental Claims P.O. Box 981282 El Paso, TX 79998-1281 1-800-942-0854	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
MetLife PPO (Retirees) Group Dental Claims P.O. Box 981282 El Paso, TX 79998-1281 1-800-942-0854	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*MetLife PPO (Retirees)* Group Dental Claims P.O. Box 981282 El Paso, TX 79998-1281 1-800-942-0854	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385

Claims Administrator—Benefit Claims	Claims Administrator—Eligibility Claims	Appeals Administrator—Benefit Claims	Appeals Administrator—Eligibility Claims
Vision Claims			
Cigna Global Health Benefits ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850-5800 Phone: 1-800-441-2668 Fax: 1-800-243-6998	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Cigna Global Health Benefits* ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850-5800 Phone: 1-800-441-2668 Fax: 1-800-243-6998	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
EyeMed Vision Care Fidelity Security Life Insurance Company 4000 Luxottica Place Mason, OH 45040 1-866-800-5457	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*EyeMed Vision Care* Fidelity Security Life Insurance Company 4000 Luxottica Place Mason, OH 45040 1-866-800-5457	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
MetLife Complaint & Grievance Unit P.O. Box 997100 Sacramento, CA 95899-7100 1-855-698-3931	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*MetLife* Complaint & Grievance Unit P.O. Box 997100 Sacramento, CA 95899-7100 1-855-698-3931	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
UnitedHealthcare (UHC) UnitedHealthcare Vision P.O. Box 30978 Salt Lake City, UT 84130 1-888-571-5218	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*UnitedHealthcare (UHC)* UnitedHealthcare Vision P.O. Box 30978 Salt Lake City, UT 84130 1-888-571-5218	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
VSP Vision Service Plan (VSP) P.O. Box 997105 Sacramento, CA 95899-7105 1-800-877-7195	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*VSP* Vision Service Plan (VSP) P.O. Box 997105 Sacramento, CA 95899-7105 1-800-877-7195	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Long-Term Disability Claims			
The Hartford Insurance The Hartford Disability Claims 3800 West American Blvd. Bloomington, MN 55431 1-800-752-9713	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*The Hartford Insurance* The Hartford Disability Claims 3800 West American Blvd. Bloomington, MN 55431 1-800-752-9713	Aon Administrative Committee To initiate an appeal, contact: ***Aon HR Service Center*** P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385 The Administrative Committee does not make decisions regarding evidence of insurability, which are made exclusively by the carrier.

Claims Administrator—Benefit Claims	Claims Administrator—Eligibility Claims	Appeals Administrator—Benefit Claims	Appeals Administrator—Eligibility Claims
Life and AD&D Claims			
The Hartford Insurance The Hartford— Group Benefits Division P.O. Box 2999 Hartford, CT 06104-2999 1-800-523-2233	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*The Hartford Insurance* The Hartford— Group Benefits Division P.O. Box 2999 Hartford, CT 06104-2999 1-800-523-2233	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385 The Administrative Committee does not make decisions regarding evidence of insurability, which are made exclusively by the carrier.
Health Care Flexible Spending Account Claims			
Your Spending Account P.O. Box 64030 The Woodlands, TX 77387-4030 Phone: 1-855-625-5500 Fax: 1-888-211-9900	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Employee Assistance Program Claims			
Optum Health UnitedHealthcare Services, Inc. 185 Asylum Street Hartford, CT 06103-3408 1-800-510-9351	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Optum Health* UnitedHealthcare Services, Inc. 185 Asylum Street Hartford, CT 06103-3408 1-800-510-9351	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Legal Services Plan Claims			
Hyatt Legal (Metropolitan Life) Hyatt Legal Plans, Inc. Director of Administration Eaton Center, 1111 Superior Ave., 8th floor Cleveland, OH 44114-2507	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Hyatt Legal (Metropolitan Life)* Hyatt Legal Plans, Inc. Director of Administration Eaton Center, 1111 Superior Ave., 8th floor Cleveland, OH 44114-2507	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385
Accident Insurance Claims			
Chubb Workplace Benefits Combined Insurance, Claim Department P.O. Box 6700 Scranton, PA 18505-0700	Aon Claims and Appeals Management P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385	*Chubb Workplace Benefits* Combined Insurance, Claim Department P.O. Box 6700 Scranton, PA 18505-0700	Aon Administrative Committee To initiate an appeal, contact: Aon HR Service Center P.O. Box 7206 Rantoul, IL 61866-7206 Phone: 1-855-625-5500 Fax: 1-847-554-1385

Non-ERISA Benefit Program Claims. For claims that arise under the Dependent Care FSA or Commuter Benefit Program, contact the HR Service Center at **1-855-625-5500**. For claims under any other programs (*e.g.*, long-term care, etc.), please contact the Insurer or refer to your coverage document from the Insurer.

Continuation Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, is a federal law that allows continuation of your health care coverage under certain circumstances.

This section provides an overview of COBRA continuation coverage which will be provided by the Plan Administrator (or its designee) to the extent required by law. It includes important information about your right to COBRA continuation coverage and when it may become available. It also describes what you need to do to protect your right to receive COBRA coverage.

Affordable Care Act Note: 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 (**www.healthcare.gov**). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

For additional information about your rights and obligations under this Plan and under federal law, contact the ***Aon HR Service Center***.

What COBRA Continuation Coverage Is

COBRA coverage is a temporary continuation of health plan (*e.g.*, medical, dental, vision, EAP, or Health Care FSA) coverage when it otherwise would end because of a life event, known as a "COBRA qualifying event." (Specific qualifying events are listed later in this section.)

After a qualifying event, COBRA continuation coverage must be offered to each "Qualified Beneficiary." You, your Spouse, and your Children could become Qualified Beneficiaries if you are covered under a health plan on the day before the qualifying event and that coverage is lost because of the qualifying event. Qualified Beneficiaries also include any Children born to you or placed for adoption with you during the COBRA continuation period.

Qualified Beneficiaries who elect COBRA continuation coverage must pay for it on an after-tax basis.

Qualified Beneficiaries

- **Colleague.** You become a Qualified Beneficiary if you lose your coverage under the health plans because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than your gross misconduct.
- **Pre-65 Retirees.** You become a Qualified Beneficiary if you lose your coverage under the health plans because of one of the following qualifying events:
  - You become entitled to Medicare.
  - The Company declares bankruptcy.
- **Your Spouse.** Your Spouse becomes a Qualified Beneficiary if he or she loses coverage under the health plans because of one of the following qualifying events:
  - You die.
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You become divorced or legally separated from your Spouse.
  - You become entitled to Medicare when you were enrolled in pre-65 retiree coverage.
  - The Company declares bankruptcy when you were enrolled in pre-65 retiree coverage.
- **Your Dependent Children.** Children become Qualified Beneficiaries if they lose coverage under the health plans because of one of the following qualifying events:
  - You die.
  - Your hours of employment are reduced.

- Your employment ends for any reason other than gross misconduct.
- You become divorced or legally separated.
- Your Child loses eligibility for coverage.
- You become entitled to Medicare when you were enrolled in pre-65 retiree coverage.
- The Company declares bankruptcy when you were enrolled in pre-65 retiree coverage.

Note that Domestic Partners are not Qualified Beneficiaries for purposes of COBRA continuation; however, a Child of a Domestic Partner is a Qualified Beneficiary if he or she is your Tax Dependent.

Although Domestic Partners and their Child(ren) do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover such individuals even if they are not considered Qualified Beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA coverage terminates. Under ***How Long COBRA Coverage Lasts With Respect to Medical, Dental, Vision, and EAP Benefits*** below, please note that the two bullets regarding "Disability extension of 18-month period of continuation coverage" and "Second qualifying event extension of 18-month period of continuation coverage" are not applicable to these individuals.

When COBRA Coverage Is Available

The health plans offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. (See the ***Administrative Information*** section for contact information.)

Notification of Qualifying Events

When the qualifying event is the end of employment or reduction in hours of employment or death of the colleague, **the employer must notify** the Plan Administrator of the qualifying event.

For other qualifying events (divorce or legal separation of the colleague and Spouse or a Child losing eligibility for coverage) or the occurrence of a second qualifying event, **you or the Qualified Beneficiary must notify** the Company within 60 days after the later of the date the qualifying event occurs or the day you lose coverage on account of the qualifying event by contacting the ***Aon HR Service Center***. If you or the Qualified Beneficiary fails to notify the Company within 60 days after the qualifying event, then your Qualified Beneficiary will not be entitled to elect COBRA continuation coverage.

How COBRA Coverage Is Offered

After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each Qualified Beneficiary.

Information is sent to the COBRA claims administrator via ***UPoint***. The claims administrator provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event. You may also elect to receive notices electronically via the secure private mailbox on ***UPoint***. Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage.

Covered colleagues may elect COBRA continuation coverage on behalf of their Spouses and parents may elect COBRA continuation coverage on behalf of their Children. It is critical that you (or anyone who may become a Qualified Beneficiary) maintain a current address on file to ensure that you receive a COBRA enrollment notice following a qualifying event.

You and your Qualified Beneficiaries have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA. If you or your Qualified Beneficiary fails to elect COBRA coverage within the applicable time frame, then such individual will lose the opportunity to continue coverage under COBRA.

How Long COBRA Coverage Lasts With Respect to Medical, Dental, Vision, and EAP Benefits

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce or legal separation.
- A Child losing eligibility.

COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or reduction of your hours of employment. This 18-month period of COBRA continuation coverage can be extended in two ways:

- **Disability extension of 18-month period of continuation coverage.** If a Qualified Beneficiary covered under the health plans is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and all other Qualified Beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, if all of the following conditions are met:
  - Your COBRA qualifying event was a termination of employment or reduction in hours.
  - The disability started at some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.
  - A copy of the Notice of Award from the Social Security Administration is provided to the ***Aon HR Service Center*** within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA coverage.
  - An increased premium of 150% of the monthly cost of coverage is paid, beginning with the 19th month of coverage.
- **Second qualifying event extension of 18-month period of continuation coverage.** If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your Spouse and Children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the health plan (as described under ***Notification of Qualifying Events*** above).
- This extension may be available to your Spouse and any Children receiving continuation coverage if you die, get divorced, or if your Child is no longer eligible, but only if the event would have caused your Spouse or Child to lose coverage under the health plans had the first qualifying event not occurred.

COBRA Qualifying Events

	Maximum continuation period (months) for:		
Qualifying event	**You**	**Spouse**	**Covered Child**
You lose coverage because of reduced work hours or taking unpaid leave, other than leave under the FMLA	18	18	18
You terminate employment for any reason (other than gross misconduct)	18	18	18
You or your Spouse/Child is disabled—as defined by the Social Security Act—at the time of the qualifying event or during the first 60 days of COBRA continuation coverage	29 (Initial 18 months, plus additional 11 months)	29 (Initial 18 months, plus additional 11 months)	29 (Initial 18 months, plus additional 11 months)
Your covered Child is no longer eligible	N/A	N/A	36
You die	N/A	N/A	36
You and your Spouse divorce or legally separate	N/A	36	36
You become entitled to Medicare (applies only to those enrolled in the pre-65 retiree coverage)	36	36	36
Company declares bankruptcy (applies only to those enrolled in the pre-65 retiree coverage)	Special rule applies	Special rule applies	Special rule applies

Medicare Extension for Your Dependents

If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Qualified Beneficiaries will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

How Long COBRA Coverage Lasts With Respect to the Health Care FSA

You and your Qualified Beneficiaries may be eligible to continue participation in the Health Care FSA for **the remainder of the calendar year** in which participation otherwise would end due to a COBRA qualifying event. You will be given the opportunity to continue the same coverage you had in effect the day before the qualifying event on a self-pay basis.

COBRA coverage will be available to you only if you have a positive Health Care FSA balance at the time you become eligible for COBRA (taking into account all claims submitted by you before the date of the qualifying event). However, you will no longer have access to your YSA debit card. Coverage will cease at the end of the calendar year and will not be continued for the next year. The contributions you make under COBRA for the Health Care FSA will be made on an after-tax basis.

Any Health Care FSA amounts carried over from a prior Plan Year will also be available under COBRA, but the availability of any carried over amounts will end as of the calendar year.

What COBRA Coverage Costs

COBRA enrollees must pay monthly premiums for coverage.

Premiums are based on the full cost per covered person set at the beginning of the year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single colleague.

Payment is due at enrollment, but you have 45 days after electing coverage to submit your initial payment. The initial payment includes coverage for the first day on COBRA through the end of the following month as of your billing statement date.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

If you or a Qualified Beneficiary elects COBRA continuation coverage:

- You or your Qualified Beneficiary can keep the same level of coverage you had as an active colleague or choose a lower level of coverage.
- Your or your Qualified Beneficiary's coverage is effective as of the date of the qualifying event. However, if you waive COBRA coverage and then revoke the waiver within the 60-day election period, your elected coverage begins on the date you revoke your waiver.
- You or your Qualified Beneficiary may change your coverage:
  - During your Annual Enrollment period.
  - If you have a Qualifying Life Event.
- You may enroll any newly eligible Spouse or Child under Plan rules.

When COBRA Coverage Ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or any of your Qualified Beneficiaries become covered under another health plan.
- You or your covered Qualified Beneficiaries fail to make contributions by the due date as required.
- Aon stops providing health benefits to any colleague.
- You or your Qualified Beneficiaries become entitled to Medicare after electing COBRA.

Continuation coverage also may be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

For more information about your rights under the Employee Retirement Income Security Act of 1974 ("ERISA"), including COBRA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 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 the EBSA website at **www.dol.gov/ebsa**.

Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website.

Your Rights Under ERISA

As a Participant in one of the ERISA-covered plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan Participants are entitled 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, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan 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.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your Spouse, and/or your other Eligible Dependent if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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 a federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person 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 write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **1-866-444-3272**.

HIPAA Privacy

Federal privacy laws require employer-sponsored group health plans to develop privacy policies and procedures with respect to protected health information.

Health Insurance Portability and Accountability Act ("HIPAA")

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations in 45 CFR Parts 160 through 164, contain provisions governing the use and disclosure of Protected Health Information ("PHI") by group health plans, and provide privacy rights to Participants in those plans. An explanation of those rights as they pertain to your health insurance benefits and the Insurer's use and disclosure of your PHI will be provided by the Insurer, according to its policies described for each coverage. A separate "HIPAA Notice of Privacy Practices" contains additional information about the uses and disclosures the Plan may make of your PHI, your rights with respect to your PHI, the Plan's duties and obligations with respect to your PHI, and whom you should contact with questions or concerns, and is incorporated into this SPD by reference.

PHI is information created or received by HIPAA-covered health plans that relates to an individual's physical or mental health or condition (including genetic information), the provision of health care to an individual, or payment for the provision of health care to an individual, and that identifies the individual. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

To the extent it receives PHI, the Plan Administrator will comply with applicable privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA regulations and any other applicable federal, state, or local law. If a Plan Participant wants to exercise any of his or her rights concerning PHI, he or she should contact the Plan Administrator in care of the ***Aon HR Service Center*** (as described in the HIPAA Notice of Privacy Practices) or contact the specific Insurer or claims administrator involved with the PHI in question. The Insurer or claims administrator will advise the Plan Participant of the procedures to be followed.

The HIPAA Notice of Privacy Practices can be found on ***UPoint***. You may view the notice and/or print a paper copy from the website; or you also may request a paper copy, free of charge, by writing to the Aon Administrative Committee in care of the ***Aon HR Service Center***, P.O. Box 7206, Rantoul, IL 61866-7206, or by calling **1-855-625-5500**.

Your Maternity Rights (Newborns' and Mothers' Health Protection Act)

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).

Your Rights Following a Mastectomy (Women's Health and Cancer Rights Act of 1998)

Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered Eligible Dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- 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.
- Treatment of physical complications at all stages of mastectomy, including lymphedema.

Benefits will be subject to the same annual deductibles and coinsurance provisions as all other medically necessary procedures under your medical option are. Contact your Insurer for further details.

Reimbursement and Subrogation

The Plan may recover overpaid and erroneously paid benefits through their subrogation and reimbursement rights, as provided in the Plan documents and the applicable Benefit Programs. The Plan has many options for recovering the payment including reducing a future benefit payment for you or your Eligible Dependent by the amount of the overpayment.

The Plan Administrator may delegate its subrogation and reimbursement rights and third-party recovery rights to the Insurer or claims administrators. The Insurer or claims administrators will undertake reasonable steps to identify claims in which the Plan has a third-party interest and manage subrogation cases on behalf of the Plan.

For this section, “you” or “your” means a Plan Participant, including you, another covered person, such as an Eligible Dependent, a legal representative or the estate, or heirs of a covered person (sometimes collectively referred to as “you” or “your”).

Reimbursement

This section applies when you recover damages, by settlement, verdict, or otherwise, for an injury, illness, or other condition, including death.

If you have received, or in the future may receive, such a recovery, including a recovery from any Insurer, the Plan will not cover the treatment of the applicable illness or injury. These benefits are specifically excluded. If the Plan previously paid benefits to treat such an illness or injury, you must reimburse the Plan for the amounts that you received to cover those benefits (for example, if you receive a settlement pursuant to a car accident and the settlement covered all medical expenses).

The Plan is responsible only for those legal fees and expenses to which it agrees in writing. You may not incur any expenses on behalf of the Plan in pursuit of the Plan’s rights hereunder.

If you recover a lump-sum payment, the Plan will have first priority to such amounts.

The Plan will recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any Plan Participant.

Subrogation

This section applies when another party (including Insurers who are so financially liable) is, or may be considered, liable for your injury, illness, or other condition, including death, and the Plan has advanced benefits. Subrogation is similar to reimbursement, but allows the Plan to “step into your shoes” and obtain a benefit from a third party that was negligent or responsible for your injury or illness. This occurs when the Plan has to pay a benefit due to your injury, illness, or other condition but would not have owed the payment if the third party had not caused the problem.

In consideration for the advancement of benefits, the Plan is subrogated to all of your rights against any party that is liable for your injury, illness, or other condition, including death, or that is or may be liable for the payment for the treatment of such injury or occupational illness (including any Insurer), to the extent of the value of the health insurance benefits advanced to you under the Plan. The Plan may assert this right independently of you. This right includes, but is not limited to, the covered person’s rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers’ compensation coverage, or other insurance, as well as your rights under the Plan to bring an action to clarify your rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on your behalf but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

You are obligated to cooperate with the Plan and its agents in order to protect the Plan’s subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan’s subrogation claim and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of health expenses.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that you fail to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, offset from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan’s subrogation right is a first priority right and must be satisfied in full prior to any of your or your representative’s other claims, regardless of whether you are fully compensated for your damages. The costs of legal representation of the Plan in matters related to subrogation will be borne solely by the Plan. The costs of your legal representation are borne solely by you.

Right of Recovery

If, for some reason, a benefit is paid that is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person or agency that received or holds this benefit. This excess amount is subject to a constructive trust in favor of the Plan. The person receiving or holding Plan benefits must produce any instruments or papers necessary to ensure this right of recovery. Benefits paid because you or your Eligible Dependent misrepresented facts also are subject to recovery. If payment is not made to the Plan when requested, the Plan may reduce a future benefit payment for you or your Eligible Dependent by the amount of any overpayment.

Right to Use Social Security Number for Administration of Benefits

The Company retains the right to use your Social Security number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security numbers for benefit administration purposes, the Company generally takes the position that ERISA preempts such state laws.

Affordable Care Act

In March 2010, Congress passed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. For purposes of this SPD, they are collectively referred to as the "Affordable Care Act."

After-Tax Dollars

These dollars are deducted from your pay after taxes are withheld.

Before-Tax Dollars (Pre-Tax)

These dollars are deducted from your pay before taxes are withheld. Paying for coverage with before-tax dollars reduces your taxable income for federal, Social Security, and, in most cases, state income taxes.

Deductible

Generally, a deductible is an amount you must pay before the Plan pays benefits.

Dentist

This means a person who is trained and licensed to practice dentistry, according to the laws and regulations of the governing jurisdiction. The Plan will not recognize any relative, including, but not limited to, you, your Spouse, or a child, brother, sister, or parent of you or your Spouse as a Dentist or a claim that you submit.

Disabled Child

This refers to an unmarried individual over age 25 who meets the definition of "Child" in this SPD (disregarding the age requirement), who is your Tax Dependent, who relies on you for financial support and maintenance, and who has a mental or physical handicap that makes him or her incapable of self-sustaining employment. In addition, for your Disabled Child to continue coverage past age 25, you must submit proof of your Disabled Child's handicap and dependence to the ***Aon HR Service Center*** prior to the Disabled Child's attaining the age of 26.

Doctor

A Doctor is a person who performs tasks that are within the limits of his or her medical license and who:

- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery;
- Has a doctoral degree in psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- Is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

The Plan will not recognize any relative, including, but not limited to, you, your Spouse, or a child, brother, sister, or parent of you or your Spouse as a Doctor for a claim that you submit.

Illness

An illness is a bodily disorder or disease, including a mental health disorder or substance abuse.

Injury

An injury is an accidental physical injury to the body caused by unexpected external means.

Mental Health Disorder

This means a disorder that, in manifestation, cause, symptoms, or treatment, is mental in nature. This includes nervous disorders, neuroses, psychoneuroses, psychopathies, psychoses, personality disorders (classified as an Axis I Disorder in the *Diagnostic and Statistical Manual of Mental Disorders* [Fourth Edition—Text Revision] by the American Psychiatric Association [DSM-IV-TR]), and any other mental or emotional disease or disorder.

The Mental Health Disorder also must:

- Involve a clinically significant behavioral or psychological syndrome or pattern.
- Be associated with a painful symptom, such as distress.
- Impair a person's ability to function in one or more major life activities.

The Plan covers mental health treatment for Mental Health Disorders that are diagnosed by a licensed mental health professional. (A different definition of mental health may be used under the disability plans.) Refer to the benefit summaries and other materials provided by the Insurer for additional information pertaining to the definition of mental health disorder under both the medical and disability benefit options.

Minimum Essential Coverage

MEC generally includes employer-sponsored medical coverage, as well as other types of coverage, such as Medicare. Aon's medical coverage is Minimum Essential Coverage.

Participant

This means any colleague, retiree, or beneficiary who is eligible for and elects to participate in a benefit under the Plan.

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

This means a judgment from a state court or an order issued through an administrative process under state law that requires you to provide health care coverage for a Child under the Plan (medical, prescription drug, dental, and/or vision coverage).

You may obtain a copy of the QMCSO administrative procedures, free of charge, from the ***Aon HR Service Center***. To be qualified, the medical child support order must meet the requirements of Section 609 of ERISA, including:

- The name and last known mailing address of the Participant and the name and mailing address of each alternative recipient (Dependent Child subject to the order);
- A description of the coverage type to be provided by the Plan to each alternative recipient (*e.g.*, medical, prescription drug, dental, and/or vision); and
- The period to which the order applies.

In any case, if subject to an order, you and each child will be notified about further procedures. You should notify the Plan Administrator if you are subject to a QMCSO or NMSN.

Tax Dependent

A Tax Dependent for medical, prescription drug, dental, vision, and Health Care FSA plan purposes is an individual whose coverage under the Aon Benefit Plan does not result in additional income to you. It does **not** reflect who is eligible under the Aon Benefit Plan or the Flexible Compensation Plan, which is a separate requirement outlined under the ***Eligibility*** section. While Aon always recommends that you consult with a tax adviser, the definition provided here is a summary of these complex rules.

General Rule

Your Spouse is a Tax Dependent. In addition, your child (meaning your son, daughter, stepson, stepdaughter, or eligible foster child placed with you by an authorized placement agency or by order of a court of competent jurisdiction) who has not attained the age of 27 as of the end of the taxable year is a Tax Dependent. A son or daughter includes your legally adopted child or child who is lawfully placed with you for adoption.

Other Categories

Otherwise, an individual may be your Tax Dependent if he or she is a U.S. citizen or resident who is a "qualifying child" or a "qualifying relative."

A "qualifying child" generally is a person who meets the following criteria:

- Is younger than you.
- Is unmarried (*i.e.*, has not filed a joint tax return during the calendar year at issue).
- Is under the age of 19 (or 24 in the case of a student) or is permanently and totally disabled.
- Is your child, grandchild, brother, sister, stepbrother or stepsister or niece or nephew.
- Does not provide over one-half of his or her own support for the calendar year.
- Lives with you for more than one-half of the calendar year.

A "qualifying relative" generally is a person who meets the following criteria:

- Is not your qualifying child or any other taxpayer's qualifying child during the calendar year.
- Receives over one-half of his or her support from you for the calendar year.
- Is "related to you" or "lives with you for the entire calendar year as a member of your household."

Appendix: Provisions Related to the HIPAA Privacy and Security Rules

HIPAA Requirements

Effective as of April 14, 2003, or as otherwise provided for in this Appendix, the following terms and conditions shall apply:

Section 1. Definitions for HIPAA Requirements

Whenever used in this Appendix, the following terms shall have the respective meanings set forth below.

(a) **Affiliated Companies** shall mean the subsidiary and affiliated companies of the Employer that are participating employers in the Plan.

(b) **Affiliated Covered Entities** shall mean legally separate Covered Entities that are all under common control or common ownership and are designated as an affiliated group of covered entities in accordance with 45 CFR § 164.103. For purposes of this definition, "common control" exists if an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of another entity; and "common ownership" exists if an entity or entities possess an ownership or equity interest of five (5) percent or more of another entity.

(c) **CFR** shall mean the Code of Federal Regulations.

(d) **Covered Entity** shall mean: (i) a Health Plan, (ii) a Health Care Clearinghouse, or (iii) a Health Care Provider who transmits any Health Information in electronic form in connection with a transaction covered by HIPAA, as defined more fully in 45 CFR § 160.103. For purposes of this Appendix, a Covered Entity shall include the Plan.

(e) **Employee** shall mean an employee of the Employer or its Affiliated Companies.

(f) **Employer** shall mean Aon Corporation. For purposes of this Appendix, Employer shall also mean Plan Sponsor.

(g) **ERISA** shall mean the Employee Retirement Income Security Act of 1974, Title 29 United States Code, as amended.

(h) **Health Care** shall mean care, services, or supplies related to the health of an Individual within the meaning of 45 CFR § 160.103. Health Care includes, but is not limited to, the following:

  (1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to physical or mental condition or functional status of an Individual or that affects the structure or function of the body; and

  (2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

(i) **Health Care Clearinghouse** shall have the meaning set forth in 45 CFR § 160.103 and includes a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions:

  (1) Processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

  (2) Receives a standard transaction from another entity and processes or facilitates the processing of Health Information into a nonstandard format or nonstandard data content for the receiving party.

(j) **Health Care Component** shall mean a component or combination of components of a Hybrid Entity that are designated by the Hybrid Entity in accordance with 45 CFR § 164.105(a)(2)(iii)(D).

(k) **Health Care Operations** shall have the meaning set forth in Section 4 of this Appendix.

(l) **Health Care Provider** shall have the meaning set forth in 45 CFR § 160.103 and includes a provider of medical or health services, as well as any other person or organization that furnishes, bills, or is paid for Health Care in the normal course of business.

(m) **Health Care Treatment** shall have the meaning set forth in Section 4 of this Appendix.

(n) **Health Information** shall have the meaning set forth in 45 CFR § 160.103 and includes information, including genetic information, whether oral or recorded in any form or medium, including, but not limited to, verbal conversations, telephonic communications, electronic mail or messaging over computer networks, the Internet and intranets, as well as written documentation, photocopies, facsimiles and electronic data, that is created or received by a Health Care Provider, Health Plan, the Employer, life insurer, school or university, or Health Care Clearinghouse that relates to the past, present, or future physical or mental health or condition of an Individual, the provision of Health Care to an Individual, or the past, present, or future payment for the provision of Health Care to an Individual.

(o) **Health Insurance Issuer** shall have the meaning set forth in 45 CFR § 160.103 and includes an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan (within the meaning of 45 CFR § 160.103).

(p) **Health Plan** shall mean an individual or group plan that provides or pays the cost of medical care, and includes a group health plan, a Health Insurance Issuer, an HMO, and such other plans or arrangements as are set forth in 45 CFR § 160.103, including the Plan.

(q) **HIPAA** shall mean the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, as amended from time to time.

(r) **HMO** shall mean Health Maintenance Organization (as defined in 45 CFR § 160.103).

(s) **Hybrid Entity** shall mean a single legal entity that is a Covered Entity whose business activities include both covered functions and non-covered functions and that designates Health Care Components (in accordance with 45 CFR § 164.105(a)(2)(iii)(D)) for purposes of fulfilling the hybrid entity requirements of HIPAA, as defined in 45 CFR § 164.103. For purposes of this definition, "covered functions" means those functions of a Covered Entity, the performance of which makes the entity a Health Plan, Health Care Provider, or Health Care Clearinghouse.

(t) **Individual** shall have the meaning set forth in 45 CFR § 160.103 as the person who is the subject of Protected Health Information.

(u) **Individually Identifiable Health Information** shall have the meaning set forth in 45 CFR § 160.103 and includes information that is a subset of Health Information, including demographic information collected from an Individual, and: (1) is created or received by a Health Care Provider, Health Plan, Employer, or Health Care Clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an Individual, the provision of Health Care to an Individual, or the past, present, or future payment for the provision of Health Care to an Individual; and (3) that identifies the Individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual involved.

(v) **Organized Health Care Arrangement** shall have the meaning set forth in 45 CFR § 160.103 and includes:

(1) A group health plan (within the meaning of 45 CFR § 160.103) and a Health Insurance Issuer or HMO with respect to such group health plan, but only with respect to Protected Health Information created or received by such Health Insurance Issuer or HMO that relates to Individuals who are or who have been Participants or beneficiaries in such group health plan;

(2) A group health plan and one (1) or more other group health plans each of which are maintained by the same Plan Sponsor; or

(3) The group health plans described in paragraph (2) of this definition and Health Insurance Issuers or HMOs with respect to such group health plans, but only with respect to Protected Health Information created or received by such Health Insurance Issuers or HMOs that relates to Individuals who are or have been Participants or beneficiaries in any of such group health plans.

(w) **Plan** shall mean the Aon Benefit Plan, as it may be amended from time to time.

(x) **Plan Administration Functions** shall mean administrative functions performed by the Plan Sponsor on behalf of the Plan, excluding functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

(y) **Plan Sponsor** generally shall mean the entity defined in § 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B) and designated in the Plan.

(z) **Privacy Notice** shall mean the statement communicated to Plan Participants that sets forth the uses and disclosures of Protected Health Information that may be made by the Plan under HIPAA, as more fully described in 45 CFR § 164.520.

(aa) **Privacy Official** shall mean the Individual appointed by the Employer, or its delegate, on behalf of the Plan who is responsible for developing and implementing policies and procedures for protecting the privacy and confidentiality of Protected Health Information that is held by or on behalf of the Employer's Health Plans and Health Care Providers, in accordance with 45 C.F.R. § 164.530. References to Privacy Official in this Appendix may include such Privacy Official's designee, where applicable and appropriate.

(bb) **Protected Health Information** shall mean Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media, transmitted or maintained in any other form or medium, including oral or written information. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended (within the meaning of 20 U.S.C. 1232g), employment records held by the Covered Entity in its role as an Employer, other records described in 20 U.S.C. 1232g(a)(4)(B)(iv), and regarding a person who has been deceased for more than 50 years.

(cc) **Required by Law** shall mean a mandate contained in law that compels an entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law including, but not limited to, a court order, a court-ordered warrant, subpoena, or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to Health Care Providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits, as more fully described in 45 CFR § 164.103.

(dd) **Summary Health Information** shall have the meaning set forth in 45 CFR § 164.504 and includes information, that may be Individually Identifiable Health Information, and that summarizes the claims history, claims expenses, or types of claims experienced by Individuals for whom the Plan Sponsor has provided benefits under the Plan, and from which the following information has been removed:

(1) Names;

(2) Geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, aggregated to the level of a five-digit zip code as provided in 45 CFR § 164.504;

(3) All elements of dates (except year) directly relating to the Individual(s) involved (*e.g.*, birth date) or their medical treatment (*e.g.*, admission or discharge date), and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(4) Other identifying numbers, such as Social Security, telephone, fax, account, or medical record numbers, health plan beneficiary numbers, certificate/license numbers, e-mail or Internet addresses, URLs or Internet Protocol (IP) address numbers, vehicle identifiers and serial numbers, device identifiers and serial numbers;

(5) Facial photographs or biometric identifiers (*e.g.*, finger prints);

(6) Any other unique identifying number, characteristic, or code; and

(7) Any information of which the Employer has knowledge that could be used alone or in combination with other information to identify an Individual.

(ee) **U.S.C.** shall mean the United States Code.

Section 2. Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Employer and the Affiliated Companies if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan, including analyzing Plan costs and the effectiveness of the Plan's administration or for such other purposes as may be permitted under 45 CFR § 164.504(f)(1)(ii) and the provisions of this Appendix.

Section 3. Disclosure of Protected Health Information to Employer

The Plan will disclose Protected Health Information to the Employer or the Affiliated Companies only in accordance with 45 CFR § 164.504(f) and the provisions of this Appendix.

Section 4. Use and Disclosure of Protected Health Information

Protected Health Information disclosed by the Plan to the Employer or the Affiliated Companies in accordance with the provisions of this Appendix may only be used by the Employer or the Affiliated Companies for the following plan administration purposes related to payment for Health Care and Health Care Operations without the covered Individual's written authorization (that meets the requirements of 45 CFR § 164.508) (hereinafter "permitted uses and disclosures"):

(a) **Health Care Treatment.** The provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party, consultation between Health Care Providers relating to a patient, or the referral of a patient for Health Care from one Health Care Provider to another and such other forms of treatment as may be permitted under 45 CFR § 164.501.

Payment for Health Care. Activities undertaken by the Plan to obtain premiums or reimbursement, or to determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an Individual to whom Health Care is provided. These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage, and cost-sharing amounts, such as, cost of a benefit, Plan maximums, and copayments as determined for an Individual's claim;

(2) Coordination of benefits;

(3) Adjudication of health benefit claims, including appeals and other payment disputes;

(4) Subrogation of health benefit claims;

(5) Establishing Employee contributions;

(6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) Billing, collection activities, and related Health Care data processing;

(8) Claims management and related Health Care data processing, including auditing payments, investigating and resolving payment disputes, and responding to Participant inquiries about payments;

(9) Obtaining payment under a contract for reinsurance, including stop-loss and excess of loss insurance;

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including precertification, preauthorization, concurrent review, and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number, name and address of the Health Care Provider and/or health plan);

(13) Reimbursement to the Plan; and

(14) Such other payment activities as may be permitted under 45 CFR § 164.501.

Health Care Operations. The activities of a Covered Entity under 45 CFR § 164.501 including, but not limited to:

(1) Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;

(2) Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, disease management, contacting Health Care providers and patients with information about treatment alternatives and related functions that do not include treatment;

(3) Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner performance, rating Health Care provider and plan performance, including accreditation, certification, licensing, or credentialing activities;

(4) Except as prohibited under 45 CFR § 164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, securing or placing a contract for reinsurance of risk relating to Health Care claims, including stop-loss insurance and excess of loss insurance;

(5) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning related analysis associated with managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) Business management and general administrative activities of the Plan, including, but not limited to:

  (i) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or

  (ii) Customer service, including the provision of data analysis for policyholders, plan sponsors, or other customers;

(8) Resolution of internal grievances;

(9) The sale, transfer, merger, or consolidation of all or part of the Covered Entity with another Covered Entity (within the meaning of 45 CFR § 160.103), or an entity that following such activity will become a Covered Entity (within the meaning of 45 CFR § 160.103), and due diligence related to such activity;

(10) Consistent with the applicable requirements of 45 CFR § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity; and

(11) Such other Health Care Operations as may be permitted under 45 CFR § 164.501.

Organized Health Care Arrangement. On behalf of the Plan, the Employer may designate, with the concurrence of the Privacy Official, that the Plan, or any Health Care Component of the Plan, is part of an Organized Health Care Arrangement. If the Plan participates in an Organized Health Care Arrangement, it may disclose Protected Health Information about an Individual to another Covered Entity that participates in the Organized Health Care Arrangement for any Health Care Operation activities of the Organized Health Care Arrangement.

Pursuant to an Authorization. The Plan shall disclose Protected Health Information pursuant to an authorization that meets the requirements of 45 CFR § 164.508.

Section 5. Employer Certification and Responsibility

The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose Protected Health Information to the Employer or Affiliated Companies and acknowledges receipt of a written certification from the Employer that the Plan has been so amended to comply with the requirements of 45 CFR § 164.504(f). Additionally, the Employer and Affiliated Companies agree:

(a) To use or disclose Protected Health Information to the extent permitted in Section 4, to the extent provided under HIPAA, or as otherwise Required by Law;

(b) To ensure that any and all of their agents or subcontractors to whom the Employer or Affiliated Companies provide Protected Health Information received from the Plan agree to the same restrictions and conditions as are imposed upon the Employer and Affiliated Companies;

(c) Not to use or disclose Protected Health Information for employment-related actions or in connection with any other benefit or employee benefit plan of the Employer and Affiliated Companies;

(d) To report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the permitted uses and disclosures in Section 4 of which it becomes aware;

(e) To make Protected Health Information available to Individuals in accordance with 45 CFR § 164.524;

(f) To make Protected Health Information available for Individual's amendment and incorporate any amendments in accordance with 45 CFR § 164.526;

(g) To make the information available that will provide Individuals with an accounting of disclosures in accordance with 45 CFR § 164.528;

(h) To make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services upon request for purposes of determining compliance with HIPAA;

(i) If feasible, to return or destroy all Protected Health Information received from the Plan that the Employer or Affiliated Companies maintain in any form and retain no copies of such information when such Protected Health Information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer or Affiliated Companies, as applicable, will limit further uses and disclosures of the Protected Health Information to those purposes that make the return or destruction of the information infeasible; and

(j) To ensure that adequate separation required by 45 CFR § 164.504(f) and provided in Sections 6, 7, and 8 of this Appendix between the Plan, and the Employer and Affiliated Companies, is established and maintained.

Section 6. Employees with Access to Protected Health Information

In accordance with HIPAA, the Plan shall disclose Protected Health Information only to the following Employees or classes of Employees:

(a) Senior Director, Benefits; Senior Director, Rewards M&A; and their staff members of Human Resources Total Rewards Departments at the Employer and each of the Affiliated Companies

(b) Legal and Compliance Department

(c) HIPAA Privacy Official and HIPAA Security Official

(d) Aon HR Service Center

(e) Aon Administrative Committee; and

(f) Any other Individual who is under the control of the Employer or Affiliated Companies and who receives Protected Health Information relating to payment, Health Care Treatment, or Health Care Operations of, or other matters pertaining to, the Plan in the ordinary course of business (within the meaning of 45 CFR § 164.504(f)(2)(iii)) and who has been designated, in writing, by the Privacy Official.

Section 7. Limitations to Protected Health Information Access and Disclosures

Access to and use of Protected Health Information by the Individuals described in Section 6 above shall be restricted to those Plan Administration Functions that the Employer or Affiliated Companies perform for the Plan and/or the uses set forth in Section 4 of this Appendix. Such access or use shall be permitted only to the minimum necessary extent for these Individuals to perform their respective duties for the Plan.

Section 8. Noncompliance

Instances of noncompliance with the permitted uses and disclosures of Protected Health Information set forth in Section 4 by Individuals described in Section 6 shall be addressed in the following manner:

(a) **Potential Sanctions:** The Plan shall establish and communicate a set of sanctions that are applicable to a wide variety of breaches of covered health policies and procedures. The range of sanctions may include:

(1) Additional/remedial privacy training;

(2) Counseling by supervisor;

(3) Notation in personnel files;

(4) Letter of reprimand from supervisor;

(5) Removal from being within the firewall;

(6) Removal from current position;

(7) Suspension from current position;

(8) Termination of employment; and

(9) Other sanctions as the Privacy Official shall deem appropriate.

(b) **Administration of Sanctions:** The Plan, in consultation with the Privacy Official, shall develop a procedure for:

(1) Determining the appropriate sanction to be administered to a member of its "workforce" for a breach of a covered health policy or procedure;

(2) Determining who (*e.g.*, the Privacy Official, etc.) has responsibility for assessing the sanction against the "workforce" member; and

(3) Determining a process for administering any sanctions.

For purposes of this subparagraph, "workforce" shall mean an Employee, volunteer, trainee, or other person who performs duties under the direct control of the Covered Entity, whether or not he or she is paid by the Covered Entity.

(c) **Documentation of Sanctions:** The Privacy Official, on behalf of the Plan, shall develop and implement a system for maintaining a record of each sanction administered. The record of sanctions shall conform to the recordkeeping and documentation standards and implementation specifications required under HIPAA. The Plan will have the option of having this record maintained by the Privacy Official or his or her designee.

Section 9. Nondisclosure of Protected Health Information by HMOs

A Health Insurance Issuer or HMO that provides services to the Plan is not permitted to disclose Protected Health Information to the Employer except as would be permitted by the Plan under this Appendix and only if a Privacy Notice is maintained and provided as required by 45 CFR § 164.520(a)(2)(ii).

Section 10. Notice to Employees

The Plan shall not disclose, and may not permit a Health Insurance Issuer or HMO providing services to the Plan to disclose, Protected Health Information to the Employer or Affiliated Companies unless a separate statement, as set forth in 45 CFR § 164.520(b)(1)(iii)(B), describing the intention of the Plan to make such disclosure, is included in a Privacy Notice that is maintained and provided as required by 45 CFR § 164.520.

Section 11. Policies and Procedures

The Employer shall adopt, on behalf of the Health Plan, policies and procedures as necessary to administer the terms and conditions of this Appendix and the Health Plan's obligations under HIPAA. Such policies and procedures shall meet the requirements of 45 CFR § 164.530(i).

Section 12. Hybrid Entity Designation

On behalf of the Plan, the Employer may designate, with the concurrence of the Privacy Official, one or more Health Care Components as part of a Hybrid Entity for purposes of complying with this Appendix and the HIPAA requirements. Pursuant to this section, the Employer designates the Plan as a Hybrid Entity. With respect to such designation, the following rules shall apply:

(a) References to:

(1) The Plan or a Covered Entity in this Appendix shall refer to the Health Care Component of the Plan or Covered Entity;

(2) Health Plan, Health Care Provider, or Health Care Clearinghouse in this Appendix shall refer to the Health Care Component of the Covered Entity if such Health Care Component performs the functions of a Health Plan, Health Care Provider, or Health Care Clearinghouse, as applicable;

(3) Protected Health Information in this Appendix shall refer to Protected Health Information that is created or received by or on behalf of the Health Care Component of the Plan or Covered Entity; and,

(4) Electronic Protected Health Information shall refer to electronic Protected Health Information that is created, received, maintained, or transmitted by or on behalf of the Health Care Component of the Plan or Covered Entity.

(b) The Plan shall be responsible for complying with the requirements of HIPAA, as set out in this Appendix, and as fully set forth in 45 CFR § 164.105(a), including, but not limited to, ensuring:

(1) That the Health Care Component does not disclose Protected Health Information and electronic Protected Health Information to another component of the Plan under circumstances where HIPAA would prohibit such disclosure if the Health Care Component and the other component were separate and distinct legal entities;

(2) That the Health Care Component protects electronic Protected Health Information with respect to another component of the Plan to the same extent that it would be required under the electronic data security standards requirements of HIPAA to protect such information if the Health Care Component and the other component were separate and distinct legal entities; and

(3) That if a person performs duties for both the Health Care Component in the capacity of an Employee, volunteer, trainee, or other person performing duties under the direct control of such component and for another component of the entity in the same capacity with respect to that component, such Employee, volunteer, trainee, or other person performing duties under the direct control of such component must not use or disclose Protected Health Information created or received in the course of or incident to the member's work for the Health Care Component in a manner prohibited by HIPAA.

(c) The Plan shall retain documentation of the Hybrid Entity designation for six (6) years from the date it was created or was last in effect, whichever is later, in accordance with 45 CFR § 164.530(j).

Section 13. Affiliated Covered Entities Designation

On behalf of the Plan, the Employer may designate, with the concurrence of the Privacy Official, that the Plan, or any Health Care Component of the Plan, is part of a single Affiliated Covered Entity for purposes of complying with this Appendix and HIPAA. If such designation is made, the following rules shall apply:

(a) The Affiliated Covered Entity shall ensure that Affiliated Covered Entity shall comply with the requirements of HIPAA, as set forth in this Appendix, and as set forth in 45 CFR § 164.105.

(b) If the Affiliated Covered Entity combines the functions of a Health Plan, Health Care Provider, or Health Care Clearinghouse, the Affiliated Covered Entity shall meet the requirements of 45 CFR § 164.504(g) regarding multiple covered functions.

(c) The Plan shall document, in writing or electronically, which Health Care Components of the Plan constitute the Affiliated Covered Entities and retain such documentation for six (6) years from the date it was created or was last in effect, whichever is later, in accordance with 45 CFR § 164.530(j).

Section 14. Electronic Data Security Standards

The Plan shall apply the following provisions (a) and (b) to enable it to disclose electronic Protected Health Information to the Employer and Affiliated Companies and acknowledges receipt of a written certification from the Employer that the Plan has been so amended to comply with the requirements of 45 CFR § 164.314(b).

(a) Except when electronic Protected Health Information is disclosed to the Employer or Affiliated Companies with the safeguards set forth in (1) through (3) below, the Plan and Employer shall reasonably and appropriately safeguard electronic Protected Health Information that is created, received, maintained, or transmitted to or by the Employer or Affiliated Companies on behalf of the Plan.

(1) The Plan may disclose electronically Summary Health Information to the Employer or Affiliated Companies if requested by the Employer or Affiliated Companies for the purpose of obtaining premium bids from Health Plans for providing health insurance coverage under the Plan, or for modifying, amending, or terminating the Plan in accordance with 45 CFR § 164.504(f)(1)(ii).

(2) The Plan, a health insurance issuer, or HMO with respect to the Plan, may disclose electronically to the Employer or Affiliated Companies information on whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a Health Insurance Issuer or HMO offered by the Plan in accordance with 45 CFR § 164.504(f)(1)(iii).

(3) The Plan may disclose Protected Health Information to the Employer or Affiliated Companies for which it has obtained from the Individual about which the Protected Health Information concerns, a valid authorization that meets the requirements of 45 CFR § 164.508.

(b) Additionally, effective April 21, 2005, the Employer agrees on behalf of itself and the Affiliated Companies to comply with 45 CFR § 164.314, including the following:

(1) The Employer and Affiliated Companies shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

(2) The Employer and Affiliated Companies shall ensure that the separation requirements applicable to the Plan set out in Sections 6, 7, and 8 of this Appendix and 45 CFR § 164.504(f)(2)(iii) shall be supported by reasonable and appropriate security measures.

(3) The Employer and Affiliated Companies shall ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information.

(4) The Employer shall report to the Plan any security incident (within the meaning of 45 CFR § 164.304) of which it becomes aware.

(c) The Plan and the Employer and Affiliated Companies shall take any such further action as is required to comply with the electronic data security standards requirements of HIPAA as set forth in 45 CFR Parts 160 and 162 and Part 164.

Section 15. Disclosure of Enrollment and Disenrollment Information

The Plan, a Health Insurance Issuer or HMO with respect to the Plan, may disclose to the Employer or Affiliated Companies information on whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a Health Insurance Issuer or HMO offered by the Plan in accordance with 45 CFR § 164.504(f)(1)(iii).