



**FRONTDOOR HEALTH & WELFARE
BENEFIT PLAN
&
SUMMARY PLAN DESCRIPTION**

(Restated Effective January 1, 2022)

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INTRODUCTION

THIS EMPLOYEE BENEFIT PLAN is formally known as the Frontdoor Health & Welfare Benefit Plan (the “Plan”).

The purpose of the Plan is to consolidate the multiple insured and/or self-insured health and welfare benefit plans sponsored and maintained by the Employer into a single, comprehensive health and welfare plan, for ease of administration and reporting. This type of Plan is sometimes referred to as a “wrap” or “umbrella” plan. While this document is designed to accomplish such consolidation, it is not the only document comprising the Plan. Rather, the entire Plan document is actually a series of documents, consisting of this document plus the various contracts and/or booklets that describe the specific benefits, rights and features under the various welfare benefit programs that are consolidated in this Plan. Together, this and such other documents comprise both the official “Plan document” and the “Summary Plan Description.”

This Plan is effective January 1, 2022, provided that certain provisions may have a different effective date as described elsewhere in the Plan, and amends and restates the existing comprehensive health and welfare plan maintained by the Plan Sponsor in its entirety.

This Plan will be maintained for the exclusive purpose of providing benefits to covered Employees and, where applicable, their Dependents, and is intended to comply with all applicable laws, including the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act of 1974, as amended.

ARTICLE I DEFINITIONS

The following terms, when used in this Plan, will have the following meaning, unless a different meaning is clearly required by the context. Capitalized terms are used throughout

the Plan for terms defined by this and other sections.

Affiliated Employer

“Affiliated Employer” means any entity that is affiliated with the Employer or any entity that is part of a group of entities that includes the Employer and constitutes: (a) a controlled group of corporations (as defined in Section 414(b) of the Code); (b) a group of trades or businesses, whether or not incorporated, under common control (as defined in Section 414(c) of the Code); (c) an affiliated service group within the meaning of Section 414(m); or (d) any other entity required to be aggregated with the Employer pursuant to regulations under 414(o) of the Code. Any Affiliated Employers participating in the Plan are listed in the Affiliated Employer Appendix.

Appendix

“Appendix” or “Appendices” means each of the appendices to the Plan. Each Appendix and any document included or incorporated therein will be considered a part of the Plan and may be amended by the Employer at any time for any reason without consent of any person except as otherwise provided by law.

Code

“Code” means the Internal Revenue Code of 1986, as amended, and including all regulations issued under that law.

Component Document and Component Program

“Component Document” means a written document identified in the Appendices and incorporated herein by reference. “Component Program” means the program of benefits described in a Component Document.

Covered Person

“Covered Person” means an Eligible Employee or eligible Dependent who elects coverage under

the Plan and has not for any reason become ineligible to participate in the Plan.

Dependent

A person is a “Dependent” of an Employee with respect to a benefit provided hereunder if such person is classified as a “Dependent” under the Component Document that describes such benefit and the classes of persons eligible therefore.

Eligible Employee

“Eligible Employee” means any Employee who meets the eligibility requirements under a Component Document. As described in the Eligibility Appendix or a Component Document, an Eligible Employee also includes proprietors, partners, corporate officers and directors, and retirees whether or not they are compensated by salary or wages. An Eligible Employee is an Eligible Employee only to the extent of, and only with respect to participation in, those portions of this Plan with respect to which he meets the eligibility requirements of the applicable Component Document.

Employee

“Employee” means any individual who is employed by an Employer, but (unless specifically included as an “Employee” under a Component Document) does not include any of the following:

(a) Persons classified and treated by an Employer as independent contractors; if someone so classified and treated is subsequently determined by the Employer or any governmental agency or court not to be an independent contractor, such person will not be considered an Employee until the day after the final determination that such person is not an independent contractor;

(b) Nonresident aliens who receive no United States source income from an Employer;

(c) Individuals characterized as leased Employees (as defined by Code Section 414(n)) or any individuals who would be leased Employees but for the fact they are common law Employees of an Employer; and

(d) Temporary or seasonal employees classified as such on the Employer’s payroll records.

In the event a person listed in one or more subsections above is specifically included as an “Employee” under a Component Document, he will be considered an Employee under this Plan only with respect to the benefit described within such Component Document, and not necessarily with respect to other benefits hereunder, described in other Component Documents.

Notwithstanding the foregoing, if, for any period of time, an individual has not, on the Employer’s books and records, been treated as a common law employee of the Employer (or “full-time” common law employee, under the Employer’s policy for determining full-time employees under PPACA), where eligibility for coverage under a Component Program depends on full-time status), and a court or government agency subsequently makes a determination that the individual was in fact a common law employee during that period of time, such determination shall not entitle the individual to any retroactive rights under the Plan unless this Plan is amended to supply such retroactive rights, and the individual’s prospective rights under the Plan shall be determined solely in accordance with the terms of the Plan.

Employer

“Employer” means the Plan Sponsor and any Affiliated Employers that are approved by the Plan Sponsor to participate in this Plan; provided, however, the Plan Sponsor shall have the exclusive power and responsibility to perform all settlor-type functions under Sections 5.1, 5.2, 7.1 and elsewhere in the Plan.

ERISA

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended, and including all regulations issued under that Act.

FMLA

“FMLA” means the Family and Medical Leave Act of 1993, as amended, and including all regulations issued under that Act.

Plan

“Plan” means this Frontdoor Health & Welfare Benefit Plan, as amended from time to time.

Plan Administrator

“Plan Administrator” means the person or entity authorized to administer the Plan pursuant to Article V. If the Employer does not appoint a Plan Administrator, the Plan Administrator is the Employer.

Plan Sponsor

“Plan Sponsor” means Frontdoor, Inc. or any successor in interest.

Plan Year

“Plan Year” means the Plan’s 12-month fiscal year beginning each January 1 and ending the ensuing December 31. The coverage periods for the underlying Component Programs may be different than the Plan’s fiscal year.

PPACA

“PPACA” means the Patient Protection and Affordable Care Act of 2010, as amended, and including all regulations and other guidance under that Act.

USERRA

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations issued under that Act.

ARTICLE II PARTICIPATION

2.1 Eligibility and Enrollment

(a) Eligibility

Any person who is an Eligible Employee or Dependent under a Component Document will be considered a Covered Person in the Plan on the date such person, under the terms of such Component Document, acquires coverage for the benefit(s) described in such Component Document; in no event may an Eligible Employee or Dependent participate in this Plan with respect to a particular benefit provided under a Component Document until the date specified in such Component Document. The Eligibility Appendix reflects a *summary* of the eligibility rules that apply under the various Component Documents and benefit programs reflected in those documents. Other eligibility rules may be reflected in the Component Documents themselves, or other documents.

The Plan Sponsor in its discretion may designate different coverage effective dates for one or more Component Programs for reasonable classifications of Employees related to business transactions (e.g., a merger or acquisition), and such effective dates will be communicated to affected Employees.

(b) Enrollment

An Eligible Employee may elect participation in the Plan, for himself and for any eligible Dependent(s), with respect to any or all benefits described in Article III with respect to which the Eligible Employee and/or Dependent(s), as the case may be, are eligible for coverage under the terms of the applicable Component Document(s), by enrolling when the Eligible Employee and/or Dependent, as the case may be, first becomes eligible to participate. If an Eligible Employee (on behalf of himself and/or an eligible Dependent) does not elect to participate (or elects to participate only with respect to some, but not all, benefits) when first eligible, he may not elect to participate (or elect

to participate in those health benefits not selected) until the beginning of the next Plan Year, subject to Section 2.2 below and any change in enrollment rules under a Component Document or the qualified change in status rules under a Code Section 125 cafeteria plan.

A “qualified change in status” under a Code Section 125 cafeteria plan means an event with respect to an Employee that would allow the Employee to revoke or modify a pre-tax election during a coverage period, in accordance with IRS regulations or other IRS guidance. Code Section 125 and the regulations thereunder generally provide that existing elections may be modified or revoked under one or more of the following circumstances:

(a) If the Employee and/or his or her dependents are enrolling for group health coverage pursuant to HIPAA special enrollment rules;

(b) A change in the legal marital status of an Employee; a change in the number of an Employee’s dependents; a change in employment status (including worksite) of the Employee or his or her dependents; a dependent child ceasing to be eligible for dependent coverage; or a change in the place of residence of the Employee and/or his or her dependents. With respect to change in an Employee’s election relating to accident or health coverage or group-term life insurance, an Employee’s new pre-tax compensation reduction must be consistent with such event to the extent required by the rules and regulations of the Department of Treasury;

(c) If the Employee is required to enroll his or her child or foster child under an accident or health plan pursuant to a judgment, decree or order of a court;

(d) If the Employee or his or her dependents become entitled to or ineligible for Medicare (Part A or B) or Medicaid coverage (other than coverage consisting solely of coverage for pediatric vaccines);

(e) If there is a significant change in the cost or coverage of an accident or health plan; or

(f) If the Employee takes a leave pursuant to the Family and Medical Leave Act.

The Plan Administrator, in its discretion, will determine whether an Employee has incurred a qualified change in status based on all the relevant facts and circumstances and in accordance with the rules and regulations issued under Code Section 125.

2.2 Compliance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)

The Plan will comply with the special enrollment and nondiscrimination provisions of HIPAA, with respect to those benefits subject to HIPAA. To the extent HIPAA is applicable, the Plan will not establish a rule for eligibility or set any premium or contribution rate based on whether the Employee is actively at work (including whether the Employee is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated as being actively at work, as described in the HIPAA portability rules. See also Articles IX and X.

2.3 Termination of Participation

Participation in a benefit provided under a Component Document will terminate as provided in such Component Document. Participation by a person in this Plan will terminate when the person is no longer covered for a benefit provided by any Component Document.

Notwithstanding the foregoing, and unless expressly provided to the contrary in a Component Document, coverage of any person under a Component Program may be terminated where the Plan Administrator determines that the person is ineligible for coverage; that enrollment was obtained, or benefits claimed or provided, pursuant at least in part to a

misrepresentation pertaining to such person; that the person failed to supply information reasonably requested by the Plan Administrator; that premiums were not timely paid by the person or on the person's behalf; that the person failed to assist the Plan in its efforts to enforce its subrogation or reimbursement rights; or for any other reason where the Plan Administrator deems disenrollment is appropriate on account of the actions or inactions of the person (or any other person who acts or fails to act on behalf of the person). Where a Dependent is disenrolled due to such conduct, the Plan Administrator may in its discretion disenroll the Employee and/or one or more of the Employee's other Dependents where it appears such person(s) were complicit in the misrepresentation. Where an Employee is disenrolled due to such conduct, however, all enrolled Dependents will also be disenrolled.

Where coverage is terminated pursuant to the preceding paragraph, it may be terminated prospectively. Coverage may also be terminated retroactively to the date of (as applicable) the action giving rise to the termination or, where termination is due to ineligibility or failure to timely pay premium, to the date of the person's enrollment or, if later, the date the person became ineligible; provided, however, that with respect to Component Programs subject to the PPACA, coverage shall be terminated retroactively only in the event of fraud or material misrepresentation (both of which are hereby expressly prohibited by this Plan), or to the extent otherwise permitted by the PPACA or guidance issued thereunder (including but not limited to failure to timely pay required premiums or contributions), and upon appropriate notice to the person as may be required under the PPACA Act or regulations.

2.4 Continuation Coverage Rights

(a) Health Care Coverages

Certain health care coverages under this Plan may be subject to coverage continuation rights under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or similar state or federal law.

Where that is the case, such coverage rights are described in the applicable Component Documents. A former Covered Person who is eligible to, and elects to, continue coverage under the applicable coverage continuation law, may continue to participate in this Plan to the extent provided under the coverage continuation law.

(b) FMLA

Notwithstanding any other Plan provision providing for an earlier termination of coverage, in the event participation in a health care benefit offered through this Plan would terminate due to the Eligible Employee taking a leave of absence pursuant to the FMLA, eligibility for such benefit will be continued for the lesser of: the period of the leave or the maximum period of leave required under the FMLA; provided, however, other provisions of this Plan or the Employer's employment policies may provide for more generous continued eligibility. Coverage will continue only as long as any required Employee contributions are timely made. Employees on leave must make the same contribution as is required for active Employees. Coverage under other welfare benefits (other than health benefits) will continue or terminate during a period of FMLA leave to the same extent as such benefits continue or terminate during periods of leave under similar circumstances (that is, paid or unpaid leave, as the case may be) that is not FMLA leave.

(c) USERRA

Notwithstanding any other Plan provision regarding termination of coverage, in the event participation in health benefits offered through this Plan would terminate due to the Eligible Employee taking a USERRA leave of absence, such benefits will be continued for the lesser of: the period of leave or 24 months. Provided, however, coverage will continue only as long as any required Employee contributions are timely made. Employees on a USERRA leave of less than 31 days must make the same contribution as is required for active Employees; Employees on a USERRA leave of 31 days or longer must pay up to 102% of the full cost (Employee and

Employer contributions) of coverage, as determined by the Plan Administrator.

(d) State Mandated Continuation Coverage Rights

In addition to the continuation coverage rights discussed above, some states and localities provide additional continuation coverage rights, which the Plan will comply with to the extent applicable.

(e) Employer Approved Leaves of Absence

The Component Documents may include provisions relating to the continuation of coverage during an Employer-approved leave of absence, whether paid or unpaid. In addition, the Employer may have other established policies and procedures concerning such leaves. Eligible Employees should contact the Plan Administrator for additional information prior to the commencement of any such leave.

ARTICLE III BENEFITS

3.1 Benefits Incorporated by Reference

The benefits offered under this Plan are set forth in the Benefit Program Appendix attached to this document.

Each Covered Person may elect to receive coverage under the benefits offered under this Plan, subject to any additional eligibility conditions provided under the applicable Component Document. The terms, conditions and limitations of benefits offered under this Plan are contained in the applicable Component Documents referenced in the Benefit Program Appendix and which are incorporated herein in full, as amended from time to time. The benefits and the method of providing them may change from time to time and will be reflected in the applicable Component Documents.

ARTICLE IV FUNDING

4.1 Contributions

The benefits described in Article III will be funded by Employer contributions or Employee contributions, or a combination thereof, as determined from time to time by the Employer. Contributions will be paid to an insurance carrier or other third-party administrator or, with respect to a self-funded, self-administered benefit, amounts will be paid directly to or on behalf of a Covered Person.

If an insurer, health maintenance organization, pharmacy benefit manager or other party pays any rebate (including any medical loss ratio rebate pursuant to the Patient Protection and Affordable Care Act of 2010), allowance, credit, or other amount with respect to the Plan or an insurance policy relating to a Component Document (a "Recovery"), whether such Recovery be paid in cash or effected as a credit against future premium or similar payments in the current or ensuing year, the Recovery amount will not be an asset of the Plan, but instead will be retained by the Employer as part of the Employer's general assets, except as provided below or as otherwise may be required by law. Therefore, a Recovery will not reduce or offset contributions or other amounts paid by Employees (or Dependents) for coverage under the Plan and will not otherwise be shared with Employees (or Dependents). If a Recovery exceeds the total amounts paid by the Employer for medical coverage under the Plan for the relevant period, the excess amount may not be retained by the Employer but instead will be treated as an asset of the Plan to the extent required by applicable law.

4.2 Employee Contributions

Any Employee contributions may be deducted from an Eligible Employee's wages on a pre-tax basis (or after-tax basis if permitted by the Employer) and will be subject to the policies of the Employer and the terms and conditions of the particular Component Program(s) and any

cafeteria plan maintained by the Employer pursuant to Section 125 of the Code, and will be forwarded by the Employer to an insurance carrier or other third-party administrator or, with respect to benefits that are paid directly by the Employer, amounts will be collected by the Employer and paid directly to or on behalf of a Covered Person.

With respect to self-insured benefits provided under the Plan, contributions from a Covered Person will be deemed to be applied first to the payment of benefits. The intent of this provision is to establish that, in a case where such contributions from all Covered Persons do not exceed the amount of self-insured benefits paid under the Plan, any administrative expenses related to the self-insured benefits will be deemed paid other than from contributions from Covered Persons.

ARTICLE V ADMINISTRATION

5.1 Plan Administrator

The Plan Sponsor is the Plan Administrator of this Plan. The Plan Sponsor may delegate some or all of its duties and authority as Plan Administrator to one or more Employees, to a committee appointed by the Plan Sponsor, to a third-party claims administrator or such other persons as the Plan Administrator deems appropriate. The Plan Administrator may delegate duties and authority with respect to the different Component Programs to different persons with respect to each Component Program.

5.2 Duties and Authority of Plan Administrator

Except to the extent an insurance company, under the terms of a Component Document, retains for itself or any other third-party (other than the Employer) the duties and responsibilities described below, the Plan Administrator will have the following duties and responsibilities:

(a) Administrative Duties

The Plan Administrator will administer the Plan consistent with the nondiscrimination rules described later in this Article, for the exclusive purpose of providing benefits to Covered Persons and their beneficiaries. The Plan Administrator will perform all such duties as are necessary to supervise the administration of the Plan and to control its operation in accordance with the terms thereof, including, but not limited to, the following:

(i) make and enforce such rules and regulations as it will deem necessary or proper for the efficient administration of the Plan;

(ii) interpret the provisions of the Plan and determine any question arising under the Plan, or in connection with the administration or operation thereof, including questions of fact;

(iii) determine all considerations affecting the eligibility of any individual to be or become a Covered Person;

(iv) determine eligibility for and amount of benefits for any Covered Person;

(v) authorize and direct all disbursements of benefits under the Plan;

(vi) authorize the recovery of benefit payments made in error; and

(vii) delegate and allocate, specific responsibilities, obligations and duties imposed by the Plan, to one or more employees, officers or such other persons as the Plan Administrator deems appropriate.

(b) General Authority

The Plan Administrator will have all the powers necessary or appropriate to carry out its duties, including the discretionary authority to interpret the provisions of the Plan and the facts and circumstances of claims for benefits, and to decide questions of fact related thereto. Any

interpretation or construction of or action by the Plan Administrator with respect to the Plan and its administration will be conclusive and binding upon all parties and persons affected hereby, subject to the exclusive appeal procedure set forth in Sections 5.7 and 5.8.

5.3 Forms

All forms (written or electronic) and other communications from any Covered Person or other person to the Plan Administrator required or permitted under the Plan will be in the manner prescribed from time to time by the Plan Administrator, will be mailed first-class mail or delivered to the location specified by the Plan Administrator, will be deemed to have been given and delivered to the location specified by the Plan Administrator, and will be deemed to have been given and delivered only upon actual receipt thereof. Each Covered Person will submit such pertinent information as the Plan Administrator may specify. However, to the extent the terms of a Component Document provide for different or contrary rules in this regard, and such terms are permitted by law, the terms of the Component Document will control.

5.4 Examination of Documents

The Plan Administrator will make available to each Covered Person or beneficiary this Plan document, including the Appendices and Component Documents, for examination at reasonable times during normal business hours. In the event a Covered Person or beneficiary requests copies of documents, the Plan Administrator may charge a reasonable amount to cover the cost of furnishing such documents.

5.5 No Assets

Notwithstanding any Plan provision to the contrary, no assets will be segregated for the purposes of providing benefits under the Plan unless a separate trust has been established for the Plan. The Employer will pay benefits under this Plan out of its general assets, to the extent such benefits are not paid under the terms of insurance contracts.

5.6 Reports

The Plan Administrator will file or cause to be filed all annual reports, returns, and financial and other statements required by a federal or state statute, agency or authority within the time prescribed by law or regulation for filing said documents; and to furnish such reports, statements or other documents to such Covered Persons and beneficiaries as required by federal or state statute or regulation, within the time prescribed for furnishing such documents.

5.7 Claims Procedure

A Covered Person will apply for Plan benefits in the manner required by the Plan Administrator or its delegate, unless a claim is filed directly by a provider of benefits. A claim for reimbursement of expenses must be submitted in a manner and within the time period specified in the applicable Component Documents. Claims will be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and will be approved or denied in accordance with the terms of the Plan including the Component Documents.

The following claims procedures will apply, but only to the extent the applicable Component Document does not apply at least as extensive procedures. If the claim and appeal rules in this document apply, they will be construed and applied in a manner consistent with applicable federal regulations as in effect on the date the claim was received:

(a) Notice of Action

Any time a claim for benefits receives an adverse determination, the Employee or beneficiary (“Claimant”) will be given written notice of such action within the “applicable period” after the claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, the Claimant will be notified of the extension and the reason for the extension within the initial applicable period.

If any urgent health care claim or pre-service health care claim is approved, the Claimant will be notified of such approval and provided sufficient information to understand the import of the approval.

An “adverse determination” means a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a benefit, where the action is based on a determination of an individual’s eligibility, a determination that a benefit is not a covered benefit, the imposition of an exclusion or limitation, or a determination that a benefit is experimental, investigational or not medically necessary or appropriate. An adverse determination includes retroactive rescission of coverage (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions).

(b) Categories of Claims, “Applicable Periods,” and Extensions

(1) Other Claims

The “applicable period” for a benefit claim not described in subsections (2) to (6) below is 90 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to 90 days, but the Plan Administrator or its delegate must notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(2) “Urgent” Health Care Claims

Urgent health care claims are requests for verification or approval of coverage for health care or treatment where, if the request were not handled expeditiously the delay could jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of the Claimant’s medical condition, would subject the Claimant to *severe pain* that cannot be adequately managed without the care or treatment that is the subject of the claim. The “applicable period” for an urgent care claim is

no longer than the period necessary to decide the matter (that is, “as soon as possible”), but in no event longer than 72 hours. Whether a claim involves “urgent care” (as defined in federal regulations) will be determined by the Claimant’s attending physician, and the Plan will defer to the judgment of the Claimant’s physician.

If the Plan cannot render a decision within this timeframe because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator or its delegate must notify the Claimant within 24 hours of the specific information needed to complete the claim. The Claimant must be given at least 48 hours to provide the required information. Within 48 hours after the earlier of (1) the Plan’s receiving the required information or (2) the expiration of the period afforded to the Claimant to provide the information, the Plan Administrator or its delegate must notify the Claimant of the Plan’s benefit determination. The Claimant may agree to extend these deadlines.

An appeal of an adverse determination regarding an urgent care claim (where the claim is still an urgent care claim) must be decided as soon as possible, but no later than 72 hours after the Plan receives the request for review or appeal. Other requirements apply to the processing of appeals by non-grandfathered healthcare coverage subject to the Patient Protection and Affordable Care Act of 2010. See below.

(3) “Pre-Service” Health Care Claims

A pre-service health care claim is any request for approval of health care coverage for a service or item that under the terms of the Plan requires advance approval. The “applicable period” for a pre-service claim is 15 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must

notify the Claimant within the timeframe of the reason for the extension and the date the Plan expects to render its decision.

If the Claimant has not followed the Plan's procedures for filing a pre-service claim, the Plan must notify the Claimant within 5 days of the proper procedures to be followed in order to complete the claim. Further, if the Plan cannot render a decision within 15 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim; the Claimant must be given at least 45 days from receipt of the notice to provide the required information; and the Plan has 15 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

(4) "Concurrent" Health Care Claims

A concurrent health care claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of health care treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care must be made sufficiently in advance of any reduction or termination in treatment to allow the Covered Person to appeal the adverse determination. If a course of treatment involves urgent care, a request by the Claimant to extend the course of treatment must be decided as soon as possible, but not later than 24 hours after receipt of the request by the Plan, provided that the request is made at least 24 hours prior to the expiration of treatment.

Expiration of an approved course of treatment is not an adverse determination under these rules. However, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed. Notice must be provided in a reasonable time before the treatments will

stop; however, the Plan is not required to allow the Claimant the 180 days to appeal the Plan's decision, before the Plan may terminate the treatment. Coverage must continue during the pendency of an appeal of an adverse determination involving a concurrent care claim to the extent required by, and in accordance with, applicable federal law.

(5) "Post-Service" Health Care Claim

A post-service health care claim is a claim that is not an urgent care, pre-service or concurrent care claim. The "applicable period" for a post-service claim is 30 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan cannot render a decision within 30 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim. The Claimant must be given at least 45 days from receipt of the notice to provide the required information. The Plan has 30 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

(6) Disability Benefit Claim

The "applicable period" for a disability benefit claim is 45 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to two (2) thirty-day extensions, but the Plan Administrator or its delegate will notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(7) Special Rule for Retroactive Health Care Coverage Rescissions

Where health care coverage subject to the Patient Protection and Affordable Care Act of 2010 is rescinded retroactively (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions), in addition to any other notice that may be required by these provisions the Plan will supply written notice of the rescission to each affected participant not fewer than 30 days in advance of the date the Plan takes action to actually rescind the coverage.

(c) Form and Content of Notice of Adverse Determination on Claims

If a claim is denied in whole or in part, notice of such adverse determination must be provided to the Claimant. Notice must be written or electronic; oral notice is permitted with respect to urgent care claims, but only if written or electronic confirmation is furnished to the Claimant within three (3) days after the oral notice is provided.

The notice must include the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- if applicable, a description of any additional information needed for the Claimant to perfect the claim and an explanation of why such information is needed;
- a description of the Plan's review procedures, including the Claimant's right to bring a civil action under Section 502(a) of ERISA;
- (for health care and disability claims) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement

that it will be provided without charge upon request;

- (for health care and disability claims) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

(d) Right to Request Review

Any person who has had a claim for benefits denied in whole or in part by the Plan Administrator or its delegate, or is otherwise adversely affected by action of the Plan Administrator or its delegate, will have the right to request review by the Plan Administrator. Such request must be in writing, and must be made within 180 days (for health care and disability benefit claims) or 60 days (for other claims) after such person is advised of the Plan Administrator's (or its delegate's) action. If written request for review is not made within such 180-day (or 60-day, as the case may be) period, the Claimant will forfeit his or her right to review. The Claimant or a duly authorized representative of the Claimant may review all pertinent documents and submit issues and comments in writing. The Plan Administrator may prescribe a reasonable procedure under which a Claimant may designate an authorized representative.

(e) Review of Claim

The Plan Administrator or its delegate will then review the claim. The person or entity that reviews the claim must be a named fiduciary under the Plan, and (in the case of reviews of health care or disability claims) may not be the same person, or a person subordinate to the

person, who initially decided the claim. If in the case of a health care or disability claim the adverse determination was based on medical judgment, the person handling the appeal must consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional may not be the same professional who was consulted with respect to the initial action on the claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and will issue a written or electronically disseminated decision reaffirming, modifying or setting aside its former action. The decision on appeal must be made within 72 hours for a claim involving urgent health care, 30 days for a pre-service health care claim, 45 days for a disability claim, or 60 days for a post-service health care claim or claim for a benefit other than a health care or disability benefit; the time period begins to run on the date the appeal is received by the Plan. The Claimant may agree to extend these deadlines.

The decision on review may be delayed for up to 45 days (in the case of a disability benefit claim) or 60 days (in the case of a claim other than for a disability benefit) where special circumstances require the delay, and such delay is permitted by federal regulations. The Plan Administrator or its delegate will provide notice of the extension, and the reason therefore, to the Claimant prior to the end of the initial review period.

A copy of the decision will be furnished to the Claimant. The decision will set forth:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement that the Claimant is entitled to receive without charge reasonable access to any document (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit

determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) in the case of a group health Plan or disability Plan, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;

- a statement of any voluntary appeals procedures and the Claimant's right to receive information about the procedures as well as the Claimant's right to bring a civil action under Section 502(a) of ERISA;

- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;

- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and

- 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." (However, this latter statement is not required if there is no alternative dispute resolution process (e.g., arbitration).)

The decision will be final and binding upon the Claimant and all other persons involved, except to the extent otherwise provided under applicable law.

(f) Additional Rules Applicable to Disability Claims

The following additional rules will apply to any claim or review of a denied claim for disability benefits submitted on or after April 2, 2018 (or a later effective date prescribed by Department of Labor Regulations).

- All written notices will be provided in a culturally and linguistically appropriate manner, and will include the following:

- a statement that a copy of all documents, records and other information relevant to the claim is available to the Claimant, free of charge, upon request;

- a discussion of the Plan's decision, including (for example) an explanation of the basis for disagreeing with or not following the views of any disability determination regarding the Claimant by the Social Security Administration, health care professionals, or vocational professionals;

- if the denial is based on medical necessity, experimental treatment, or other similar exclusions or limitations, an explanation of the scientific or clinical judgment used in the decisions, or a statement that an explanation will be provided free of charge upon request; and

- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the denial, or a statement that they do not exist.

- The claim will be decided in a way that ensures the independence and impartiality of Plan decision makers involved in the review process, including claims processors or medical experts, and avoids any conflicts of

interest as set forth in Section 2560.503-1 of the Department of Labor regulations.

- No deference will be afforded to the initial adverse determination, and the review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

- In deciding an appeal that is based in whole or in part on a medical judgment, the Plan decision maker will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination.

- Any health care professional consulted in making a medical judgment will be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual.

- Any new or additional evidence considered, relied on, or generated by the Plan or decision maker in connection with a review of the denied claim will be disclosed to the Claimant as soon as possible, and in all cases before the Plan can issue an adverse benefit determination.

- Any new or additional rationale relied on by the Plan or decision maker in connection with the review of the denied claim will be disclosed to the Claimant as soon as

possible and in all cases before the Plan can issue an adverse benefit determination.

5.8 Additional Requirements for Non-Grandfathered Health Care Coverage Subject to the Patient Protection and Affordable Care Act of 2010

For health care claims under non-grandfathered health care coverage subject to the Patient Protection and Affordable Care Act of 2010, the following additional rules apply.

(a) Additional Requirements for Notice of Initial Adverse Determination and Notice of Final Action on Internal Appeal

Any notice of initial adverse determination or notice of final action on an internal review of an adverse determination must include the following additional information:

- the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and the treatment code and their corresponding meanings (the Plan will supply this information related to the diagnosis and treatment codes as soon as practicable following such a request, and will not consider such request to be a request for an internal appeal or, as applicable, external review);
- the standard, if any, used in denying the claim in whole or in part (i.e., a discussion of an applied “medical necessity” standard);
- a description of the available internal and external appeals procedures, including information about how to initiate an appeal; and
- the availability of—and contact information for—any applicable office of health insurance consumer assistance or ombudsman

established under the Act to assist individuals with the internal claims and appeals and external review procedures.

The notices described above must be supplied in a “culturally and linguistically appropriate” manner, pursuant to and to the extent required by applicable federal regulations.

(b) Additional Requirements Related to Access to Information Pending Decision on Appeal

In connection with any appeal of an adverse determination, the Claimant or a duly authorized representative of the Claimant will have the right to examine the Claimant’s claim file, and to present evidence and testimony as part of the review process. The Claimant will receive, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with its review of an appeal of an adverse determination, and any new or additional rationale the Plan intends to rely upon in deciding the internal appeal, sufficiently in advance of the final decision on the internal appeal to allow the Claimant an opportunity to respond prior to the decision.

(c) Additional Requirements Related to External Review of Final Action on Internal Appeal

Different external review rules apply depending on whether the relevant health care coverage is subject to a state insurance law external review requirement that meets standards specified in federal regulations, or whether the coverage is not subject to such a state law.

Where the relevant health care coverage is subject to a state standard that complies with applicable federal regulations (or is deemed to comply during any transition period under such regulations), such state standard will apply to the insurer (where the coverage is insured) or the Plan (where the coverage is self-insured). Where the relevant health care coverage is not subject to a state standard, or subject to a state standard that does not meet federal regulatory requirements (taking into account any period of

deemed compliance during a transition period provided for under federal regulations), then the following rules apply to the Plan to the extent and as of the date required by applicable federal regulations:

(1) A Claimant may file a request for external review within 4 months of receipt of notice of an adverse determination (to the extent permitted by applicable law, however, the Plan may require the Claimant to exhaust any reasonable internal appeal process); for this purpose, and to the extent permitted by applicable federal regulations, an “adverse determination” means an adverse determination as defined elsewhere in these provisions, but only to the extent it involves medical judgment or a retroactive rescission of coverage.

(2) Within 5 business days following receipt of the request for external review, the Plan will determine whether:

- the Claimant was covered under Plan and applicable health care coverage when the health care item or service was requested (or provided, where the review is a for a post-service claim);
- the adverse determination was not due to ineligibility of the Claimant;
- the Claimant exhausted any required internal appeal process; and
- the Claimant has provided all information required.

(3) The Plan will issue notice to the Claimant within one business day after the Plan’s preliminary review of the request for external review. If the Claimant is not eligible for external review, the notice must include reasons for ineligibility and contact information for the Employee Benefit Security Administration. If the request for external review is not complete, the notice must describe information that is needed and allow the claimant to complete or perfect his request

within the four-month filing period described above or 48 hours, whichever is later.

(4) If the request for external review is appropriate, the Plan will refer the appeal to an Independent Review Organization (IRO), with which the Plan has contracted in accordance with applicable federal regulations. The IRO will conduct its review and supply appropriate notices in accordance with applicable federal standards. If the IRO reverses the Plan’s decision, the Plan will provide coverage or payment upon receipt of notice of the IRO’s decision, without delay and without regard to the Plan’s intention to seek judicial review.

(5) The Plan will make available, to the extent required by and in accordance with applicable federal law, an expedited external review process where a Claimant receives an adverse determination or final internal adverse determination and where completion of an expedited internal appeal or standard external review would seriously jeopardize the life or health of the Claimant.

(d) No Conflicts of Interest

The Plan will adjudicate claims in a manner ensuring the independence and impartiality of those involved in decision-making. For example, the Plan may not hire, promote, provide incentives to or terminate the employment of individuals based on their support of a denial of benefits or on the number of claims denied.

5.9 Expenses

Unless specified otherwise in a Component Document, the Employer will pay all reasonable expenses that are necessary to operate and administer the Plan.

5.10 Bonding and Insurance

To the extent required by law, every fiduciary of the Plan and every person handling Plan funds will be bonded. The Plan Administrator will take such steps as are necessary to assure

compliance with applicable bonding requirements. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

5.11 Nondiscrimination Rules

The Plan will comply with all applicable nondiscrimination rules under the Code and any other applicable law. Should the Plan be subject to nondiscrimination testing under the Code or any other applicable law, the Plan Administrator may make any decisions or elections, whether voluntary or required by law, necessary to facilitate such testing. Any elections required to be in writing (e.g., the designation of separate testing plans, where disaggregation or aggregation of Component Programs or portions of Component Programs is permitted or required) will be stated from time to time in Appendices to the Plan, to the extent required by applicable law.

5.12 Qualified Medical Child Support Orders

The Plan will honor the terms of a Qualified Medical Child Support Order with respect to Component Programs that are subject to such Order. Qualified Medical Child Support Orders are typically issued in or after divorce proceedings, and may create or recognize the right of a child to be covered under this Plan (specifically, to be covered under a Component Plan providing health benefits).

Medical child support orders will be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and will be approved or denied. The Plan Administrator (or such other person or entity specified in the applicable Component Documents) will, promptly after receiving a medical child support order, notify the participant and each child designated in the order. The notification will contain information that permits the child to designate a representative for receipt of copies of notices

that are sent to the child with respect to a medical child support order.

Within forty (40) business days after receipt of the order (or, in the case a national medical support notice, the date of the notice) the Plan Administrator (or such other person or entity specified in the applicable Component Documents) will determine whether the order is a "qualified" medical child support order. Upon determination of whether a medical child support order is or is not qualified, the Plan Administrator (or such other person or entity specified in the applicable Component Documents) will send a written copy of the determination to the participant and each child (or, where an official of the state agency issuing the order is substituted for the name of the child, notify such official).

If the Plan Administrator (or such other person or entity specified in the applicable Component Documents) determines that the medical child support order is qualified, the participant, the child or his representative must furnish to the Plan Administrator or its designee any required enrollment information. In the case of a national medical support notice, the Plan Administrator or its designee will: (i) notify the state agency issuing the notice whether coverage is available to the child under the Plan and, if so, whether such child is covered under the Plan and either the effective date of such coverage or any steps to be taken by the child's custodial parent or an official of the state agency that issued the notice to effectuate such coverage, and (ii) provide the custodial parent (or, where an official of the state agency issuing the order is substituted for the name of the child, notify such official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

The participant is responsible for notifying the Plan Administrator of the necessary enrollment information within the timeframe(s) specified in the applicable Component Program, but generally, in no more than forty-five (45) days immediately following the date the determination was made that the order is a Qualified Medical Child Support Order. In the

case of a national medical support notice, if there are multiple coverage options available to the child under the Plan the state agency issuing the notice will select an option, but if it fails to do so within twenty (20) days after the Plan Administrator's (or designee's) notice described in the preceding paragraph, the child will be enrolled under the Plan's default option (if any).

Unless the Qualified Medical Child Support Order provides otherwise, the participant will be responsible to make any required contribution to pay for such coverage. In no event will coverage provided under a Qualified Medical Child Support Order become effective for a child prior to the date the Order is received by the Plan.

If the Plan Administrator or its designee determines that the medical child support order is not "qualified," a written determination to that effect will be furnished to the participant and the child or the child's representative. The participant or the child (or the child's representative) may appeal the determination to the Plan Administrator or its designee. Any request for review of a determination must be filed with the Plan Administrator or its designee within sixty (60) days after the Plan Administrator or its designee issues its original determination.

For purposes of this Section, a "Qualified Medical Child Support Order" is an order issued by a court having proper jurisdiction, or issued under an administrative process established under state law that has the force and effect of law under applicable state law and which creates or recognizes the existence of a child's rights to, or assigns to such child the right to, receive health benefits for which a Dependent is eligible under this Plan, provided such order clearly specifies: (i) the name and last known mailing address of the Employee, and the name and mailing address of each child covered by the order (to the extent provided in the order, the name and mailing address of an official of the state agency issuing the order may be substituted for the name and mailing address of the child); (ii) a reasonable description of the type of coverage to be provided by the Plan to each

child, or the manner in which coverage is to be determined; (iii) the time period to which such order applies; and (iv) meets other legal requirements. A national medical support notice that meets (or, pursuant to federal regulations, is deemed to meet) the foregoing requirements will be considered a Qualified Medical Child Support Order.

ARTICLE VI RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF

6.1 Applicability

The provisions of this Article VI apply to the extent the reimbursement and subrogation terms of an applicable Component Document do not supply greater rights to the Plan. If the reimbursement and subrogation terms of an applicable Component Document supply greater rights, the terms of such Component Document will apply. For purposes of this Article, a Component Document is "applicable" if benefits under the Component Document are the subject of a reimbursement or subrogation claim by this Plan. For purposes of this Article, a law will not be considered an "applicable law" if it is preempted by ERISA.

6.2 Corrective Payments

To the extent permitted by applicable law, whenever payments that should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any Other Plans (as defined under Section 6.9), this Plan will have the right to pay to any persons making such other payments any amounts they determine to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan will be fully discharged from liability.

6.3 Reimbursement

To the extent permitted by applicable law, whenever this Plan makes payments that together with the payments the Covered Person has received or is entitled to receive from any Other Plan or Person (as defined under Section 6.9), exceed the maximum amount necessary to satisfy the intent of this provision; or exceed, under the terms of this Plan, the benefits properly payable to or on behalf of the Covered Person, Plan, provider, or person to or for or with respect to whom the payments were made, this Plan will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator in its sole discretion will determine:

- (a) The Covered Person;
- (b) If the Covered Person is an eligible Dependent or former eligible Dependent, the Covered Person or former Covered Person with respect to whom the Covered Person is or was an eligible Dependent;
- (c) Any Other Plan, provider, or person to or for or with respect to whom such payments were made;
- (d) Any insurance company or Other Plan or Person that should have made the payment; and
- (e) Any other organizations.

Alternatively, the Plan Administrator or its designee may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the future, under this Plan to one or more of the Covered Person, Plans, persons, providers, insurance companies, or other organizations as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Person or by a health care provider who treated the Covered Person, and the Plan Administrator or its designee later determines that the claim

was for an expense not covered under this Plan, the Plan is entitled to recover the payment from the Covered Person or the provider, or to recover part of the payment from the Covered Person and part from the provider, or set-off the amount of the payment from amounts the Plan may owe in the future to the Covered Person or the provider, or both. This same rule applies if the Plan makes payment to a Covered Person or a provider of an expense that is a Covered Expense, but the amount so paid exceeds the amount the Plan requires be paid.

These reimbursement provisions also apply where this Plan makes payments of covered expenses incurred for treatment of an injury or sickness for which any Other Plan or Person is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the injury or sickness. If the Other Plan or Person makes payment to or on behalf of a Covered Person as compensation for the injury or sickness, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from the Covered Person (or anyone who received such payment on behalf of the Covered Person), from the payment made by the Other Plan or Covered Person, in an amount equal to the lesser of (i) the benefits paid by this Plan for treatment of the injury or sickness, or (ii) the amount of the payment made by the Other Plan or Covered Person. This provision will not apply where the Other Plan is a medical plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Person's covered expenses.

These reimbursement provisions will not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Covered Person (or, in the Plan's sole discretion) any other person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Person and any other person, such as the Covered Person's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to

obtain full reimbursement, to seek reimbursement from any person (such as the Covered Person's legal counsel) other than the Covered Person (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Person) where the Plan can be made whole entirely from amounts actually received by the Covered Person (or the Person, such as a parent or legal guardian, who received such amounts on behalf of the Covered Person). This same rule will apply to the Plan's rights to set-off as described above.

In addition, where another Plan or Person pays compensation to or on behalf of a Covered Person for an injury or sickness for which another Plan or Person is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise covered expenses for treatment of the injury or sickness, a special rule applies. In such a case, such otherwise covered expenses that were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, will be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Person, over the covered expenses which the Plan has already paid for treatment of the injury or sickness.

This Plan will not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Covered Person in connection with any recovery from any Other Plan or Person unless this Plan agrees in writing to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether in a settlement agreement or otherwise, will not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable covered expenses pursuant to these provisions.

6.4 Subrogation

To the extent permitted by applicable law, the Plan will be subrogated, to the extent of benefits paid or payable by this Plan, to any monies (*i.e.*, "first dollar" monies) paid or payable by any

Other Plan or Person by reason of the injury or sickness which occasioned or would occasion the payment of benefits by this Plan, whether or not those monies are sufficient to make whole the Covered Person to whom or on whose behalf this Plan made its payments or to whom or on whose behalf this Plan's payments are payable. The Plan will not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Covered Person in connection with any efforts to recover monies from any Other Plan, unless this Plan agrees in writing to pay a portion of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether under a settlement agreement or otherwise, will not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.

These subrogation provisions will not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from the Covered Person (or, in the Plan's sole discretion) any other Person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among the Covered Person and any other Person, such as the Covered Person's legal counsel.

This Plan will also be subrogated to the extent of benefits paid under this Plan to any claim a Covered Person may have against any Other Plan or Person for the injury or sickness that occasioned the payment of benefits under this Plan. Upon written notification to the Covered Person, this Plan may (but will not be required to) collect the claim directly from the Other Plan or Person in any manner this Plan chooses without the Covered Person's consent. This Plan will apply any monies collected from the Other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining will be paid to the Covered Person as soon as administratively practical. The Plan

Administrator may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

6.5 Implementation

The Plan Administrator will determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue. The Plan Administrator may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (1) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (2) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

6.6 Subrogation/Reimbursement Agreement

To the extent permitted by applicable law, except as otherwise provided herein (*e.g.*, the coordination rules regarding automobile insurance), if a Covered Person incurs an injury or sickness under circumstances where compensation may be payable to the Covered Person by some Other Plan or Person (as defined in this Article), the Plan may agree to pay benefits for that injury or sickness to the extent otherwise payable under the Plan, provided the Covered Person or someone legally qualified and authorized to act for the Covered Person in writing:

(a) Consents to the Plan's subrogation of any recovery or right of recovery the Covered Person has with respect to the injury or sickness;

(b) Promises not to take any action that would prejudice the Plan's subrogation rights;

(c) Promises to reimburse the Plan for any such benefits payments to the extent that the Covered Person receives a recovery from another Plan or Person, irrespective of how the

recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Covered Person whole. This reimbursement must be made within 30 days after the Covered Person (or anyone on his or her behalf) receives the payment; and

(d) Promises to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all documents the Plan may need for this purpose.

In the event the Covered Person fails to, or refuses to, execute whatever assignment, form or document requested by the Plan Administrator or its designee, the Plan will be relieved of any and all legal, equitable or contractual obligation for any benefits or Covered Expense incurred by the Covered Person and each member of the Covered Person's family, including claims then incurred but unpaid.

Nothing in this Reimbursement Agreement provision will be construed to prevent application of the provisions of the Reimbursement provisions above, regarding the Plan's exclusion of otherwise Covered Expenses which have not been paid at the time the Covered Person receives compensation for the injury or sickness that gave rise to the expenses.

6.7 Constructive Trust

In the event the Plan, pursuant to these reimbursement and subrogation provisions, is entitled under such provisions to be reimbursed for benefits it has paid for treatment of a Covered Person's sickness or injury, and where the Covered Person or someone (including an individual, estate or trust) on behalf of the Covered Person receives or is entitled to receive compensation for such sickness or injury from some other source, the Plan will have a constructive trust on such compensation to the extent of the benefits paid by this Plan. Such constructive trust will be imposed upon the person or entity then in possession of such compensation.

6.8 Right To Receive And Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this Plan or any Other Plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Administrator deems to be necessary for such purposes, with respect to any person claiming benefits under this Plan. Any person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision.

6.9 Special Definitions

For purposes of this Article VI, the following special definitions will apply:

(a) "Covered Person" means a Covered Person as defined in Article I, or a participating coverage continuation beneficiary who meets the eligibility requirements for coverage as specified in this Plan and is properly enrolled under the Plan.

(b) "Other Plan" includes, but is not limited to, any of the following providing payments on account of an injury or sickness:

(i) Any group, blanket or franchise health insurance, or coverage similar to same;

(ii) A group contractual prepayment or indemnity Plan, or coverage similar to same;

(iii) A Health Maintenance Organization (HMO), whether group practice or individual practice association;

(iv) A labor-management trusted Plan or a union welfare Plan;

(v) An Employer or multiemployer Plan or Employee welfare benefit Plan;

(vi) A governmental medical benefit program;

(vii) Insurance required or provided by statute;

(viii) Automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance);

(ix) Settlement or judgment proceeds (regardless of the manner in which such proceeds are characterized).

The term "Other Plan" does not include any individual health insurance policies or contracts, or public medical assistance programs such as Medicaid, except as otherwise provided herein. The term "Other Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

(c) "Person" means any individual, association, partnership, corporation or any other organization.

**ARTICLE VII
AMENDMENT AND
TERMINATION**

7.1 Amendment or Termination

The Employer establishes this Plan with the intention that it will be maintained indefinitely; however, the Employer reserves the right at any time and from time to time to amend any or all of the provisions of the Plan, or terminate the Plan and/or Employer contributions thereunder, in whole or in part, for any reason and without consent of any person and without liability to any person for such amendment or termination, provided that the payment of claims that are

incurred at the time of any such amendment or termination will not be adversely affected.

Any amendment of the Plan will be made in writing and will be approved by the Employer and executed by a duly-authorized representative of the Employer, provided that an amendment of any of the Appendices may be made by the Plan Administrator or its authorized representative. Because the Plan can only be amended by a written instrument, no person may rely on any oral statements or representations by any other person that attempt or purport to alter the provisions of the Plan or the benefits described in this Summary or any other written Plan document. Nothing in this Plan will be construed to require continuation of this Plan with respect to existing or future Covered Persons or beneficiaries.

Any insurer providing benefits under this Plan under the terms of a Component Document may amend such Component Document as and to the extent provided therein.

Where a change to a Component Document affects the information described in one or more Appendix, then the Appendix may be updated in accordance with the change to the Component Document without resorting to the formalities of a formal amendment. For example, if a Component Document is amended or replaced with a similar document (e.g., a group insurance contract is replaced by a similar contract issued by the same or different insurer), or where the claims administrator for a particular Component Program is changed, the Employer may, without resorting to the formalities of a formal amendment, replace the Appendices attached hereto with Appendices reflecting the updated information regarding the Component Document or its issuer.

7.2 Exclusive Purpose of Providing Benefits to Covered Persons

The Employer establishes this Plan for the exclusive benefit of Covered Persons. No Plan amendment or termination will be made which would cause or permit benefits to be provided other than for the exclusive benefit of such

individuals, unless such amendment is made to comply with federal or local law.

7.3 Surplus Assets After Plan Termination

If a benefit is terminated and surplus assets attributable to that benefit remain after all liabilities regarding such benefit have been paid, such surplus will revert to the Employer to the extent permitted by applicable law, unless otherwise specified in the Component Documents for such benefit.

ARTICLE VIII GENERAL PROVISIONS

8.1 Plan Interpretation

This Plan document, including the attached Appendices and Component Documents incorporated herein by reference, sets forth the provisions of this Plan. This Plan will be read in its entirety and not severed except as provided in Section 8.8. The provisions of this document will control over the provisions of any Component Document, except to the extent this document expressly provides to the contrary.

8.2 Participation by Affiliated Employers

The Employer may permit any of its Affiliated Employers to participate in one or more benefits under the Plan. An Affiliated Employer will be deemed to have adopted the Plan and become an “Employer” hereunder by making contributions under the Plan.

8.3 Non-Alienation of Benefits

Except as provided in Section 5.12 (Qualified Medical Child Support Orders) or as set below, no benefit, right or interest of any person hereunder will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

Without limiting the preceding paragraph, a Covered Person may not assign to any party, including without limitation to a provider of healthcare services/items, such person's right to benefits under this Plan, nor may the Covered Person assign any administrative, statutory, or legal rights or causes of action he or she may have under ERISA, including, but not limited to, any right to make a claim for Plan benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights will be void and unenforceable under all circumstances.

A Covered Person, however, may authorize the Plan to pay any healthcare benefits to a participating or non-participating provider of benefits under a Component Program. When a Covered Person authorizes the payment of benefits to a participating or non-participating provider, the Covered Person authorizes the payment of the entire amount of the benefits due on that claim. A Covered Person may not interpret or rely upon this discrete authorization or permission to pay any healthcare or other benefits to a participating or non-participating provider as the authority to assign any other rights under this Plan to any party, including, but not limited to, a provider of healthcare services/items.

8.4 No Additional Rights

No person will have any rights under the Plan, except as, and only to the extent, expressly provided for in the Plan. Neither the establishment or amendment of the Plan or the creation of any fund or account, or the payment of benefits, nor any action of the Employer or the Plan Administrator will be held or construed to confer upon any person any right to be considered or continued as an Employee, or, upon dismissal, any right or interest in any account or fund other than as herein provided. The Employer expressly reserves the right to discharge any Employee at any time.

8.5 Representations

The Employer does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in this Plan. A Covered Person should consult with professional tax advisors to determine the tax consequences of participation.

8.6 Notice

All notices, statements, reports and other communications from the Employer to any Employee or other person required or permitted under the Plan will be deemed to have been duly given when delivered (including facsimile transmission, email, telex, and telegrams) to, or when mailed by first-class mail, postage prepaid and addressed to, such Employee, or other person at the address last appearing on the Employer's records.

8.7 Masculine and Feminine, Singular and Plural

Whenever used herein, a pronoun will include the opposite gender and the singular will include the plural, and the plural will include the singular, whenever the context will plainly so require.

8.8 Severability

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

8.9 Governing Law

This Plan will be construed in accordance with applicable federal law and to the extent otherwise applicable, the laws of the State of Tennessee.

8.10 Disclosure to Covered Persons

To the extent required by law, each Covered Person will be advised of the general provisions

of the Plan and, upon written request addressed to the Plan Administrator, will be furnished any information requested regarding the Covered Person's status, rights and privileges under the Plan as may be required by law.

8.11 Accounting Period

The accounting period for the Plan will be the Plan Year.

8.12 Facility of Payment

In the event any benefit under this Plan will be payable to a person who is under legal disability or is in any way incapacitated so as to be unable to manage his or her financial affairs, the Plan Administrator may direct payment of such benefit to a duly appointed guardian, committee or other legal representative of such person, or in the absence of a guardian or legal representative, to a custodian for such person under a Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such person's benefit. Any payment made in good faith pursuant to this provision will fully discharge the Employer and the Plan of any liability to the extent of such payment.

8.13 Correction of Errors

In the event an incorrect amount is paid to or on behalf of a Covered Person or beneficiary, any remaining payments may be adjusted to correct the error. The Plan Administrator may take such other action it deems necessary and equitable to correct any such error.

8.14 Workers' Compensation

This Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance or program; provided, however, the Plan Administrator in its sole discretion reserves the right to coordinate the receipt of workers' compensation benefits with any self-insured benefits available under this Plan and may determine that such workers' compensation benefits shall offset or otherwise reduce the benefits available under this Plan.

8.15 Managed Care Directories

To the extent any Component Document hereunder provides health benefits under one or more managed care networks, a directory of network providers may be furnished or made available to each Eligible Employee in writing or electronically. However, upon written request, each Eligible Employee will receive, at no cost, a written directory of network providers, which may be provided in a separate document.

8.16 Time for Bringing Actions Against the Plan

Notwithstanding any provision in this Plan document or the terms of a Component Document to the contrary, no legal action may be brought to recover from or with respect to this Plan (i) prior to the date the claimant has exhausted all administrative remedies under this Plan and applicable Component Documents, or (ii) after the date that is eighteen (18) months following the date the claimant has received a final decision on appeal with respect to such claim.

8.17 Newborns' and Mothers' Health Protection Act

With respect to Component Programs that would separately be considered group health plans, the Plan will comply with the Newborns' and Mothers' Health Protection Act. Group health plans and health insurance issuers offering group insurance coverage 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 normal 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 the above periods. In any case, such 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 the above periods.

8.18 CHIPRA Special Enrollment Rights

CHIPRA provides you with a 60-day special enrollment right to enroll in a Component Benefit that is a group health plan under the following two circumstances: (1) your coverage or coverage of your dependent under Medicaid or a state-sponsored children's health insurance program ("CHIP") terminates due to loss of eligibility; and (2) you or your dependent becomes eligible for state financial assistance under Medicaid or CHIP to help pay for coverage under the Employer's group health plan(s).

8.19 Mental Health Parity

Any financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket expenses) and any treatment limitations (such as frequency of treatment, medical necessity determinations, number of visits and days of coverage) applied to mental health and substance abuse coverage under a Component Program that is a health plan may not be more restrictive than the limitations applied to comparable medical and surgical coverage under the health plan. More information is available in the Component Documents.

8.20 Women's Health and Cancer Rights

The health benefits available through the Plan will comply with the Women's Health and Cancer Rights Act of 1998, which requires the provision of coverage for breast reconstruction in connection with mastectomy as follows, subject to plan deductibles and coinsurance, if any:

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

8.21 Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act prohibits using genetic information to discriminate with respect to health benefits. The health plans and insurers are prohibited from (1) restricting enrollment or adjusting premiums based on genetic information; and (2) requiring or requesting genetic information or genetic testing prior to or in connection with enrollment.

8.22 Indemnity of Employees

To the extent any Employee or committee of Employees has been appointed to serve as the Plan Administrator, the Employer shall indemnify and hold each such individual harmless from any and all liabilities or expenses of any kind incurred by such individual in carrying out their administrative responsibilities under the Plan, except to the extent such liabilities or expenses result from the gross negligence or willful misconduct of the individual.

ARTICLE IX HIPAA PRIVACY PROTECTIONS

9.1 Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon the portion of this Plan providing health benefits, and certain other entities, certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to Covered Persons remains confidential, subject to limited exceptions in which PHI may be disclosed. "Protected Health Information" means health information (including oral information) that:

- (a) is created or received by health care providers, health plans, or health care clearinghouses;
- (b) relates to an individual's past, present or future physical or mental health condition, 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

(c) identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

9.2 Applicability and Effective Date

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy Regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan. The rules only apply to the portions of the Plan that provide medical care (e.g., medical, dental and vision care), and only to the extent such benefits are not “excepted benefits” under the HIPAA Privacy Regulations. The Plan Administrator may make a “hybrid entity designation” under which it has identified portions of the Plan that engage in functions covered by the HIPAA privacy rules, and the portions that do not. To the extent permitted by law, where the Plan includes one or more fully insured health care Component Program(s), and one or more self-insured health care benefit Component Program(s), the mere fact that fully insured and self-insured health care benefits are bundled under this Plan will not be construed to subject any fully insured medical benefit (absent the Employer’s acquisition of PHI with respect to the fully insured health care benefit) under this Plan to the same HIPAA privacy requirements that apply to the self-insured health care benefit Component Program(s).

9.3 Disclosure of PHI

Provided that the Plan (or the Employer on behalf of the Plan) provides to Covered Persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose PHI (relating to a Covered Person) to the Employer, as further described below, without the consent or authorization of the Covered Person. In no event may the Plan disclose PHI to the Employer, without the consent or authorization

of the Covered Person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Employer.

The Plan may disclose PHI to the Employer, without the consent or authorization of the Covered Person, subject to the Employer’s obligations described below in Section 9.4 for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of PHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information to the Employer, without the consent or authorization of the Covered Person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. “Summary health information” is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information to the Employer without the consent or authorization of the Covered Person.

9.4 Obligations of Employer Regarding Receipt and Use of PHI

As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

(a) not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Person to whom the PHI relates;

(b) ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;

(c) not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the Covered Person to whom the PHI relates;

(d) report to the Plan any improper uses or disclosures of the PHI;

(e) provide Covered Persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);

(f) make available to appropriate federal authorities the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan; and

(g) return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

9.5 Use And Disclosure Of PHI By The Employer; Dispute Resolution

When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to members of the Employer's designated HIPAA team, including the Employer's human resources/benefits department, payroll department and the Employer's chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the Covered Person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the

Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in section above titled, "Disclosure of PHI." The Employer may also disclose PHI relating to a Covered Person, without the consent or authorization of the Covered Person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the Covered Person, to law enforcement, public health, and judicial agencies in certain circumstances. PHI pertaining to a minor Covered Person may, to the extent permitted by local law, be disclosed to the Covered Person's parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the Covered Person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a Covered Person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the Plan Administrator for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which should have already been received (an additional copy is available from the Plan Administrator). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.

ARTICLE X HIPAA SECURITY PROTECTIONS

10.1 Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes

upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information (“PHI”) that is *electronic* Protected Health Information (“ePHI”) pertaining to covered persons remains confidential, subject to limited exceptions in which ePHI may be disclosed.

“Protected Health Information” means health information that:

(a) is created or received by health care providers, health plans, or health care clearinghouses;

(b) relates to an individual’s past, present or future physical or mental health condition, 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

(c) identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

“Electronic Protected Health Information” is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103.

10.2 Applicability and Effective Date

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Security regulations contained in 45 C.F.R. § 160.101 *et seq.* apply to the Plan. To the extent permitted by law, where the Plan includes one or more fully insured health care Component Program(s), and one or more self-insured health care benefit Component Program(s), the mere fact that fully insured and self-insured health care benefits are bundled under this Plan will not be construed to subject any fully insured medical benefit (absent the Employer’s acquisition of PHI with respect to the fully insured health care benefit) under this Plan to the same HIPAA privacy requirements

that apply to the self-insured health care benefit Component Program(s).

10.3 Disclosure of ePHI

Provided that the Plan (or the Employer on behalf of the Plan) provides to covered persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose ePHI (relating to a covered person) to the Employer, as further described below, without the consent or authorization of the covered person. In no event may the Plan disclose ePHI to the Employer without the consent or authorization of the covered person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (although the Plan may disclose summary ePHI or enrollment-related ePHI to the Employer, without authorization, as further described below).

The Plan may disclose ePHI to the Employer, without the consent or authorization of the covered person, subject to the Employer’s obligations described below (in the section titled, *Employer Obligations with Respect to ePHI Obtained from the Plan*) for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of ePHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing ePHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited electronic summary health information to the Employer, without the consent or authorization of the covered person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. “Summary health information” is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least

18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose electronic enrollment and disenrollment information to the Employer without the consent or authorization of the covered person.

10.4 Obligations of Employer Regarding Receipt and Use of ePHI

As a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation, between the ePHI and persons who have no legitimate need to access such ePHI, as required by 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware.

ARTICLE XI COVERAGE CONTINUATION RIGHTS

11.1 Background

Eligible Employees and Dependents have the opportunity to continue their health coverage (e.g., medical, dental and vision, as the case may be) in certain instances where coverage would otherwise terminate. Such continuation coverage is as described in the Consolidated

Omnibus Budget Reconciliation Act of 1985 (COBRA), and is therefore sometimes referred to as “COBRA Continuation Coverage.”

11.2 Entitlement And Qualifying Events

Under COBRA, a covered Employee or covered Dependent may elect to continue health coverage if that coverage would otherwise terminate due to a “qualifying event.” Qualifying events are:

(a) A covered Employee’s termination of employment, for reasons other than gross misconduct, or reduction in work hours;

(b) Death of the covered Employee;

(c) Divorce or legal separation of the covered Employee and his spouse;

(d) A covered eligible child’s ceasing to satisfy the Plan’s definition of eligible child; or

(e) A covered Employee’s entitlement to Medicare.

11.3 COBRA Qualified Beneficiaries

A Qualified Beneficiary is an individual who is entitled to COBRA Continuation Coverage. In addition to those individuals covered under the Plan immediately preceding a qualifying event, a child born to a Qualified Beneficiary who is a former covered Employee or who is adopted by or placed for adoption with such a former covered Employee, during the Employee’s period of Continuation Coverage, is also a Qualified Beneficiary.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event for certain retirees. If a proceeding in bankruptcy is filed by the Employer, and that bankruptcy results in the loss of coverage (if any) of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse,

surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

11.4 Maximum Coverage Continuation Periods

Generally, coverage under COBRA may continue for up to:

(a) Eighteen (18) months for an Employee or Dependent whose coverage would cease because of the Employee's termination of employment or reduction in work hours; or

(b) Twenty-nine (29) months (i.e. 18 plus 11) for a disabled individual who:

(1) becomes entitled to the 18 months of continued coverage available after an Employee's termination of employment or reduction in work hours;

(2) is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA Continuation Coverage; and

(3) notifies the Plan of that disability determination within 60 days after the person receives it and while still purchasing the first 18 months of COBRA Continuation Coverage.

Please note that a COBRA Qualified Beneficiary is eligible for this additional 11 months of coverage, even if not disabled, if he is entitled to COBRA Continuation Coverage due to the same qualifying event that entitles a disabled person to the additional 11 months of coverage.

(c) Thirty-six (36) months, for a divorced or widowed spouse, or a child who has ceased to be a "Dependent" under the terms of the Plan.

(d) Where due to a reduction in hours during a stability period (for example,

from full-time to part-time or per diem status) an Employee's eligibility for coverage will terminate at the end of such or a subsequent stability period, the Employer's obligation to notify the plan administrator of the occurrence of the reduction in hours begins on the date of the loss of coverage, and the end of the maximum COBRA coverage period is measured from the date of the loss of coverage rather than from the earlier reduction in hours. The terms "measurement period" and "stability period" shall have the meanings as defined in the Employer's *Policy Document for Full-Time Employee Determinations Under the Patient Protection and Affordable Care Act ("PPACA Policy")*. The foregoing policy, if adopted by the Employer, will be applied on a uniform and consistent basis among all similarly situated Employees.

Special COBRA rules apply to COBRA continuation coverage under the health flexible spending account ("FSA"). Notwithstanding the foregoing, the duration for which a qualified beneficiary may purchase COBRA coverage under a health FSA depends on a number of factors. In most cases COBRA coverage is not available beyond the end of the 12-month FSA coverage period in which the qualifying event occurred. In addition, if at the time of the qualifying event the Eligible Employee has received health FSA benefit payments (during the 12-month coverage period) in an amount *exceeding* his or her contributions to the health FSA for that coverage period, then the qualified beneficiary is not eligible for COBRA coverage at all under the health FSA.

However, if the maximum amount of benefits available to the Eligible Employee under the health FSA exceeds two times his or her salary reduction contribution for the year or, if greater, the salary reduction contribution plus \$500, COBRA coverage can continue for 18 months (for qualifying events that are a termination of employment (for reasons other than death) or reduction in work hours) or 36 months (for other qualifying events). If a qualified beneficiary is disabled (within the meaning of the Social Security Act) at the time of a qualifying event that is a termination of employment (for reasons

other than death or gross misconduct) or reduction in hours, or is so disabled during the first 60 days of COBRA coverage following such a qualifying event, COBRA coverage for that beneficiary—and any other qualified beneficiary affected by the same qualifying event can continue for up to 29 months. Where there are multiple qualifying events the 18- or 29-month limit may be extended to 36 months.

If a qualified beneficiary is eligible for and chooses COBRA coverage he or she is eligible for reimbursement, for covered claims incurred after the qualifying event but during the same 12-month coverage period in which the qualifying event occurred, in an amount up to the maximum amount of reimbursement selected by the Eligible Employee on his or her health FSA benefit election form for that 12-month coverage period, *minus* the amount of reimbursements made to the Eligible Employee for the 12-month coverage period up to the date of the qualifying event. If COBRA coverage can continue into subsequent 12-month coverage periods (under the rules in the preceding paragraph), the qualified beneficiary must make an election—prior to the beginning of the 12-month coverage period—concerning the benefits he or she wants to have available for that new 12-month coverage period.

11.5 Special Second Election Period for Certain Trade-Displaced Individuals Who Did Not Elect COBRA Coverage

Special COBRA rights apply to Employees who lose health coverage as a result of termination or reduction of hours and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance” under a federal law called the Trade Act. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the Employee begins receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the

requirement to exhaust unemployment benefits) or begins receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after the Employee’s group health plan coverage ended.

11.6 Multiple Qualifying Events

If a Dependent is eligible to choose and chooses to continue coverage under these provisions after an Employee’s termination of employment or reduction in work hours, and then another COBRA qualifying event (other than termination of employment or reduction in work hours) occurs during the original COBRA Continuation Coverage period, that Dependent may continue coverage for up to 36 months, measured from the date of the initial qualifying event. However, for an event to operate as a *second* qualifying event, it must be an event that would have triggered a loss of coverage had it been the *initial* qualifying event. In no case will any period of COBRA Continuation Coverage exceed 36 months. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent, in writing, to the appropriate person described in Section 11.9. Please note that for the Employee’s Medicare entitlement to be considered a second qualifying event for eligible Dependents, the Plan must provide that Medicare entitlement causes a loss of coverage for Dependents.

11.7 Special Continuation of Coverage Period for Medicare Entitlement

When an individual becomes entitled to Medicare and then, within 18 months thereafter, experiences a qualifying event that is loss of coverage due to termination of employment or reduction in work hours, the COBRA Continuation Coverage period for the Dependent spouse or Dependent children may continue for up to 36 months from the date of the Medicare entitlement.

11.8 Early Termination Of COBRA Coverage

Once a COBRA Qualified Beneficiary elects to continue coverage, coverage may continue for the period described above, unless:

(a) In the case of a person entitled to 29 months of COBRA Continuation Coverage (due to his or another person's disability), the Social Security Administration determines that he (or such other person) is no longer disabled, in which case the extended Continuation Coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination;

(b) If the person becomes entitled to Medicare, after the date he elects Continuation Coverage;

(c) The person fails to make a required monthly payment within the 30 day grace period pursuant to this provision;

(d) The person becomes covered - after the date he elects Continuation Coverage - under another employer group health plan (because of employment or otherwise) and that coverage contains no exclusion or limitation with respect to any pre-existing condition;

(e) The person becomes covered - after the date he elects Continuation Coverage - under another group health plan (because of employment or otherwise) that contains an exclusion or limitation with respect to a pre-existing condition which is nullified, waived or does not apply because of the Health Insurance Portability and Accountability Act (HIPAA) rules; or

(f) The Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

11.9 Notification Of A Qualifying Event

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the

Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of the Employee's employment or reduction of hours of employment, his death, the employer's commencement of a proceeding in bankruptcy with respect to a retiree (if applicable), or his enrollment in Medicare (Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events (of course, where the Plan Administrator is the Employer, there's no need for the Employer to notify itself of these events).

A COBRA Qualified Beneficiary must notify the Plan Administrator within 60 days of a divorce or legal separation, of a child ceasing to meet the Plan's definition of "Dependent", or of the Social Security Administration's determination of disability. In addition, if the person is a disabled individual who obtained 29 months of COBRA Continuation Coverage, he must notify the Plan Administrator of any determination by the Social Security Administration that he is no longer disabled. Notification to the Plan Administrator must be made within 30 days of the date such determination is made.

Notice for the qualifying events described above must be sent, in writing (describing the qualifying event and the date it occurred) to the Plan Administrator or designated COBRA administrator.

11.10 Benefits That May Continue

If a COBRA Qualified Beneficiary elects COBRA Continuation Coverage, the coverage will be identical to the health coverage then being provided under the Plan to Eligible Employees or, if in the case of a Dependent, to covered Dependents of Eligible Employees. COBRA Qualified Beneficiaries do not have to prove insurability to choose continuation coverage, but are required to pay for it.

11.11 Application And Payment Procedures

After a COBRA qualifying event (and the provision of any notice required by COBRA

Qualified Beneficiary, as described in Section 11.9), the Plan Administrator will send or cause to be sent a more detailed notice and an application for continued coverage. To continue coverage under COBRA, a COBRA Qualified Beneficiary must complete and return the application to the Plan Administrator or its designee within 60 days from the later of the date the application is sent or the date coverage would otherwise terminate.

Payment for the period from the date coverage would otherwise terminate through the 45th day after COBRA Continuation Coverage is elected must be made by that 45th day (for example, if a person elects COBRA Continuation Coverage on the 30th day of the 60-day election period, he must make his first payment by the 45th day after he elected COBRA Continuation Coverage (or the 75th day following the start of an election period), and the payment must be for the period of COBRA Continuation Coverage from the date he would otherwise lose coverage to that 75th day). Thereafter, payments must be made within thirty (30) days after the monthly premium due date to be considered timely. The Plan will terminate coverage as of the qualifying event, but will reinstate it retroactively to the date of the qualifying event if a timely election for COBRA Continuation Coverage, and timely initial payment, are made.

The monthly cost of COBRA Continuation Coverage will be set for 12-month periods, and will not exceed 102% of the cost of coverage under the Plan for similarly situated Covered Persons. However, if a person qualifies for periods of extended coverage due to a disability (whether his or another Qualified Beneficiary's), the monthly COBRA premium during the period of extended coverage may be 150% of the cost of coverage under the Plan for similarly situated Covered Persons, depending on whether the disabled person continued coverage during the extended coverage period.

Please note that the terms of the Component Documents might set forth slightly different procedures for applying and paying for COBRA Continuation Coverage, or providing notice of certain qualifying events, or for other rights and

obligations regarding COBRA Continuation Coverage. In that case the terms of the Component Document will control over this Article XI, to the extent the terms of the Component Document are consistent with applicable law.

11.12 Questions and More Information

A Covered Person may contact the Plan Administrator or COBRA administrator if he or she has any questions concerning COBRA continuation rights. Covered Person may also obtain information about their rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), and other laws affecting group health plans, by contacting the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Each Covered Person must keep the Plan Administrator informed of any changes in the addresses of family members. A copy of any notices sent to the Plan Administrator should be retained by the Covered Person.

ARTICLE XII STATEMENT OF ERISA RIGHTS

12.1 Covered Persons' Rights

As an Eligible Employee covered under the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered Eligible Employees will be entitled to:

(a) Receive Information About Your Plan and Benefits:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest

annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

(2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

(b) Continue Group Health Plan Coverage:

Continue health care coverage for yourself, covered spouse or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered Dependents may have to pay for such coverage. Review this document and the Component Documents for the rules governing your COBRA continuation coverage rights.

(c) Prudent Actions by Plan Fiduciaries:

In addition to creating rights for covered Eligible Employees, 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 Covered Persons. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

(d) Enforce Your Rights:

(1) If your claim for a welfare benefit is denied in whole or in part you

must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

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

(e) 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, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

PLAN DESCRIPTION APPENDIX

Plan Name:	Frontdoor Health & Welfare Benefit Plan
Plan Number:	501
Type of Plan:	Welfare benefit plan
Plan Year:	12-month period beginning January 1 and ending December 31
Plan Sponsor:	Frontdoor, Inc. 150 Peabody Place Memphis, TN 38103 901.422.9304
Plan Sponsor Tax Identification Number:	82-3871179
Affiliated Employers:	See the Affiliated Employer Appendix
Plan Administrator and Named Fiduciary:	Frontdoor, Inc. 150 Peabody Place Memphis, TN 38103 901.422.9304
Claims Administrator:	Unless otherwise described in the Component Document, the claims administrator is the insurer or third party administrator identified in Benefit Program Appendix.
Sources of Contributions:	Employee contributions and Employer contributions.
Funding Medium:	Contributions under the Plan may consist of both Employer contributions and Employee contributions. Employee contributions for coverage are paid through payroll deduction.

<p>Type of Administration:</p>	<p>Administered according to the Component Documents.</p> <p>Some benefits under the Plan are insured by one or more insurance companies. The Benefit Program Appendix describes the various benefits, whether they are insured or self-insured, and the identity of the insurance companies and/or third-party administrators.</p> <p>With respect to benefits under the Plan which are self-insured, those benefits may be administered by a third-party administrator, including an insurance company. In those cases where an insurance company has been hired to administer a self-insured plan, the insurance company does not insure or guarantee the benefits that it administers; see the Benefit Program Appendix for the identity of the third-party administrator(s).</p> <p>The Employer may maintain a stop-loss or reinsurance policy to protect the Employer against catastrophic loss under the comprehensive medical benefit program offered under this Plan. However, the stop-loss insurance merely reimburses the Employer for benefits it funds under the program, and is not to be construed as “insuring” the comprehensive medical benefits under the program.</p>
<p>Agent for Legal Process:</p>	<p>Service of legal process may be made upon the Plan Administrator.</p>

BENEFIT PROGRAM APPENDIX

(Updated effective January 1, 2022)

The terms, conditions and limitations of the benefits offered under this Plan are contained in the Component Documents listed from time to time in this Appendix, which are incorporated herein by reference.

Component Program	Insured or Self-Insured	Insurance Carrier or Administrator
Medical	Self-Insured	BCBST
Prescription Drug	Self-Insured	Express Scripts
Health Savings Accounts (HSAs)	<p>In accordance with Department of Labor (DOL) Field Assistance Bulletin 2004-1 and other DOL guidance, Health Savings Accounts are not subject to the requirements of ERISA. Accordingly, this Plan document will be interpreted and construed in accordance with the DOL guidance and any references to ERISA in this document will not apply to the Health Savings Accounts.</p> <p style="text-align: center;">Alight Smart Choice</p>	
Dental	Insured	Delta Dental of TN
Vision	Insured	EyeMed
Long Term Disability	Insured	The Hartford
Short Term Disability	Self-Insured	The Hartford
Group Term Life	Insured	The Hartford
Supplemental Term Life	Insured	The Hartford
Supplemental AD&D	Insured	The Hartford
Business Travel and Accident	Insured	Zurich American Insurance Company
Frontdoor Life Management Program	Insured	Magellan Health Services
Flexible Benefits Plan (Health FSA)	Self-Insured	Alight Smart Choice
Prepaid Legal	Insured	Metropolitan Insurance Company

ELIGIBILITY APPENDIX

(Updated effective January 1, 2022)

The various Component Programs may include eligibility rules in addition to those outlined below. Employees should review the underlying Component Documents and the Additional Coverage Details Addendum, and should contact the Plan Administrator with any questions.

Component Program(s)	Eligibility
Medical Prescription Drug	<p>Eligible Employees: All Employees classified by the Employer as full-time employees on the Employer’s books and records (generally 30 or more hours per week) are eligible for coverage.*</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the first of the month following date of hire.*</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the earlier of the date of termination of employment or the date the Employee ceases to be in an eligible class.*</p> <p><i>*Notwithstanding any provision in the Plan to the contrary, an Employee who is determined to be a full-time Employee for purposes of complying with the employer-shared responsibility rules under the PPACA will be eligible for medical coverage for the duration of the applicable stability period except as otherwise provided under the Employer’s PPACA policy and as permitted by law. Further, coverage for any such full-time Employee will commence (provided the Employee timely enrolls) no later than the first day of the stability period immediately following the measurement period during which the Employee established full-time status. Coverage for such an Employee shall terminate at the end of the last day of the last PPACA stability period with respect to which the Employee is considered a PPACA full-time Employee.</i></p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> • Legal spouse; • Same or opposite sex domestic partner; • Children of the Employee, including biological children, step-children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for children who are dependent on the Employee as the result of a physical or mental handicap. <p>Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent.</p>

Component Program(s)	Eligibility
	Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates, or (ii) the end of the month in which the person ceases to be a Dependent.
Health Savings Accounts (HSAs)	Employees participating in the high deductible health plan option are eligible to receive and make HSA contributions, subject to IRS limits.
Dental	<p>Eligible Employees: All Employees classified by the Employer as full-time employees on the Employer's books and records (generally 30 or more hours per week) are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the first of the month following date of hire.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p> <p>Eligible Dependents: Same as Medical.</p> <p>Effective Date of Dependent Coverage: Same as Medical.</p> <p>Termination Date of Dependent Coverage: Same as Medical.</p>
Vision	<p>Eligible Employees: All Employees classified by the Employer as full-time employees on the Employer's books and records (generally 30 or more hours per week) are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the first of the month following date of hire.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p> <p>Eligible Dependents: Same as Medical.</p> <p>Effective Date of Dependent Coverage: Same as Medical.</p> <p>Termination Date of Dependent Coverage: Same as Medical.</p>
Long Term Disability Short Term Disability	<p>Eligible Employees: All Employees classified by the Employer as full-time employees on the Employer's books and records (generally 30 or more hours per week) are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins the first of the month following 6 months of employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>

Component Program(s)	Eligibility
Group Life	<p>Eligible Employees: All Employees classified by the Employer as full-time employees on the Employer’s books and records (generally 30 or more hours per week) are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the first of the month following date of hire.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Voluntary Life Voluntary AD&D	<p>Eligible Employees: All Employees classified by the Employer as full-time employees on the Employer’s books and records (generally 30 or more hours per week) are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the first of the month following date of hire.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p> <p>Eligible Dependents: Same as Medical.</p> <p>Effective Date of Dependent Coverage: Same as Medical.</p> <p>Termination Date of Dependent Coverage: Same as Medical.</p>
Business Travel and Accident	<p>Eligible Employees: All Employees classified by the Employer as full-time employees on the Employer’s books and records (generally 30 or more hours per week) are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the date of hire.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>

Component Program(s)	Eligibility
Frontdoor Life Management Program	<p>Eligible Employees: All associates are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the date of hire.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p> <p>Eligible Dependents: Same as Medical.</p> <p>Effective Date of Dependent Coverage: Same as Medical.</p> <p>Termination Date of Dependent Coverage: Same as Medical.</p>
Flexible Benefits Plan (Health FSA)	<p>Eligible Employees: All Employees classified by the Employer as full-time employees on the Employer's books and records (generally 30 or more hours per week) are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the first of the month following date of hire.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Prepaid Legal	<p>Eligible Employees: All Employees classified by the Employer as full-time employees on the Employer's books and records (generally 30 or more hours per week) are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the first of the month following date of hire.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>

Please note that coverage begins only upon successful enrollment within the time period specified by the Component Documents. Coverage may also terminate due to nonpayment of premiums, elimination of coverage by the Employer, disenrollment by the Employee, or any other reason permitted under the terms of the applicable Component Documents.

Notwithstanding any other provision of this document to the contrary, to the extent an applicable state law imposes upon this Plan or any Component Document of this Plan a more generous eligibility criteria than that reflected here, such other eligibility criteria will apply to the extent, and only to the extent, required by such applicable law.

AFFILIATED EMPLOYER APPENDIX

(Updated effective January 1, 2022)

Affiliated Employers

Affiliated Employer	EIN
American Home Shield	13-2686654
Stroom, Inc	83-3944336

PLAN SPONSOR ADOPTION PAGE

The undersigned, on behalf of Frontdoor, Inc. hereby adopts the amended and restated Frontdoor Health & Welfare Benefit Plan & Summary Plan Description, in the form attached hereto, effective as of January 1, 2022.

FRONTDOOR, INC.

By: _____

Name: _____

Title: _____

Date: _____

ADDITIONAL COVERAGE DETAILS ADDENDUM

Dependent Eligibility

The term “domestic partnership” is defined as a committed relationship between two adults, of the opposite sex or same sex, in which the partners:

1. Have lived together for at least six months.
2. Are not married to anyone else nor have another Domestic Partner.
3. Are at least 18 years of age and mentally competent to consent to contract.
4. Reside together in the same residence and intend to do so indefinitely.
5. Have an exclusive mutual commitment similar to that of marriage.
6. Are each other’s sole domestic partner and intend to remain so indefinitely.
7. Are jointly responsible for each other's common welfare and share financial obligations.
8. Are not related in a way that would prohibit legal marriage in the U.S. jurisdiction in which the partnership was formed.
9. Can provide **any** of the types of documentation indicated below:
 - Designation of Domestic Partner as beneficiary for life insurance and retirement contract
 - Designation of Domestic Partner as primary beneficiary in associate's or insured's will.
 - Durable property and health care powers of attorney.
 - Joint ownership of motor vehicle.
 - Joint checking account or joint credit account.
 - Joint mortgage or lease.
10. Certify that they understand that willful falsification of the documentation required to establish that an individual is in a domestic partnership may lead to disciplinary action and the recovery of the cost of benefits received related to such falsification.

The term “domestic partnership” shall also include a domestic partnership registered under state law.

The term “legal spouse” is defined as a person of the same or opposite sex who is your husband or wife through a legally recognized marriage. This includes common-law spouses in states that recognize common-law marriage.

Under the health care plans, you cannot enroll a foster child or a grandchild unless you have legal custody of the child.

Dependent Verification

You will be required to verify your dependents’ eligibility for coverage upon their initial enrollment in the medical, dental and/or vision plans. This means that you must submit documentation to verify that covered dependents are eligible under the Frontdoor plan rules. After your dependent’s coverage becomes effective, you will be mailed a notice that will indicate the type of documentation required for each dependent as well as your deadline for providing the documentation. Common forms of documentation include marriage licenses for spouses, birth certificates for children, and affidavits for domestic partners but the requirements will vary based on your relationship to the dependent. If you do not submit the required documentation, coverage for unverified dependents will be cancelled and they will not be eligible for

COBRA continuation coverage. If your dependent coverage is cancelled, you have the right to file an appeal for reinstatement.

For more information about verification of dependent eligibility, call the Frontdoor People Support Center at **866-851-1211**.

If Two Family Members Work for Frontdoor

If you and your spouse/domestic partner both work for Frontdoor, only one of you can cover your dependents. You can choose one of the following options:

- One spouse/domestic partner can carry all family members under his or her coverage (one spouse/domestic partner elects family coverage and the other spouse elects no coverage)
- Each spouse/domestic partner can be covered as an associate, but dependent children can be covered as dependents by only one spouse/ domestic partner (one spouse/domestic partner should elect family coverage and the other spouse/ should elect associate-only coverage)

If your dependent child works for Frontdoor and is eligible for coverage as an associate, you cannot cover that child as a dependent.

COBRA

If you die, medical, dental, vision, and prescription drug coverage will automatically be continued for an additional 60 days for your covered dependents. After this 60-day continuation period, your dependents may continue their coverage for the remainder of the COBRA period by paying the monthly COBRA premium.

Retro Deductions and Arrears

If you make a retroactive election or change to your coverage – such as adding a spouse as the result of a recent marriage – you are responsible for any premium payments due as a result of the retroactive change. Retro premiums are deducted on the first possible paycheck after the retroactive election has been made. If the retro premium balance cannot be taken in full because it is greater than your per-pay-period earnings, your retro premium balance due may be converted to an arrears balance. Arrears are deducted at a rate of 50% of your standard benefit premium rate. This additional 50% is added to your standard benefit deduction until the arrears balance has been paid in full.

If you are in an active employment status but do not receive enough gross wages to cover the full cost of your benefit premiums, premium amounts not paid will accumulate as an arrears balance. Arrears are deducted at a rate of 50% of your standard benefit premium rate. This additional 50% is added to your standard benefit deduction until the arrears balance has been paid in full.

Both retro deductions and arrears deductions are taken with the same tax structure as current benefits (e.g., before- and after-tax).

Dependent Verification Appeals

Level 1 Appeals

The plans have an appeal process that is followed, in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), whenever you submit a dependent verification appeal.

A Level 1 Appeal may be filed with the Frontdoor Claims and Appeals Management Team (appeal administrator) in the following instances:

- You missed the deadline to provide documentation to verify your dependent(s') eligibility for coverage
- You failed to provide complete documentation to verify your dependent(s') eligibility during the dependent verification period

When you file a Level 1 Appeal, the Frontdoor Claims and Appeals Management Team reviews the claim and, in accordance with plan eligibility provisions and verification document requirements, either approves or denies the claim (in whole or in part). The appeal administrator will notify you in writing of this action. In some situations, the administrator may need an extension of time to process the claim (for example, if the administrator needs additional information). In these cases, you'll be notified in writing of the extension and the additional information needed.

If the Level 1 Appeal is filed within 60 days of the dependent coverage cancellation date and the dependent(s') eligibility is verified based on the documentation submitted with the appeal, coverage for the verified dependent(s) will be reinstated back to the date coverage originally ended.

If the Level 1 Appeal is filed more than 60 days after the dependent coverage cancellation date and the dependent(s') eligibility is verified based on the documentation submitted with the appeal, coverage for the verified dependent(s) will be reinstated effective as of the date the appeal was submitted to the appeal administrator.

Filing a Level 1 Appeal

To file a Level 1 Appeal with the Frontdoor Claims and Appeals Management Team, you must submit a Dependent Verification Claim Initiation Form to the address below:

Frontdoor Claims Appeals Management Team
P.O. Box 660114
Dallas, TX 75266-0114

Dependent Verification Claim Initiation Forms may be requested by calling the Frontdoor People Support Center at **866-851-1211**.

Level 2 Appeals

If a Level 1 Appeal is denied by the Frontdoor Claims and Appeals Management Team, you have 180 days from the date of the Level 1 Appeal denial to file a Level 2 Appeal with the Frontdoor Benefits Department.

If the Level 2 Appeal is filed within 180 days of the Level 1 Appeal denial and the dependent(s) eligibility is verified based on the documentation submitted with the appeal, coverage for the verified dependent(s) will be reinstated based upon the date the Level 1 Appeal was received.

If the Level 1 Appeal was received within 60 days of the original dependent coverage cancellation date, the coverage will be reinstated back to the date coverage originally ended.

If the Level 1 Appeal is received more than 60 days after the original dependent coverage cancellation date, the coverage will be reinstated back to the date the Level 1 Appeal was received.

Filing a Level 2 Appeal

To file a Level 2 Appeal with the Frontdoor Benefits Department, you must submit a written appeal letter with the required dependent verification documentation to the address below:

Frontdoor Benefits Department – Dependent Verification Appeals
150 Peabody Place
Memphis, TN 38103-3720
benefits@frontdoorhome.com

If you need additional information, please contact the Frontdoor People Support Center at **866-851-1211**

ADDENDUM FOR COVERAGE OF OVER-THE-COUNTER COVID-19 DIAGNOSTIC TEST KITS

The Plan shall provide coverage for all COVID-19-related diagnostic tests, including tests available without a physician's prescription, described in applicable federal law.¹ Such coverage shall be provided only to the extent required by and in a manner consistent with *FAQS About Affordable Care Act Implementation Part 51, Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation*, FAQs 1-6, and any subsequent federal guidance related thereto with which the Plan must comply.

Notwithstanding the foregoing, coverage shall not apply to (i) test kits that exceed the maximum number of authorized tests per 30-day (or calendar month) period, (ii) test kits exceeding the maximum cost permitted by the Plan, (iii) test kits obtained other than for personal use of a covered individual to diagnose COVID-19, (iv) test kits obtained for employment purposes, such as return-to-work or fitness-for-duty purposes, or (v) any portion of the Plan that does not provide healthcare benefits, nor to any portion that provides healthcare benefits as an "excepted benefit" as described under federal law.

This addendum shall be effective with respect to such diagnostic tests obtained on or after January 15, 2022, but not later than the last day on which the Department of Health and Human Service's Public Health Emergency Declaration related to the COVID-19 pandemic is in effect.

The Employer has the sole and exclusive power and discretion to construe and interpret all terms, provisions, conditions and limitations of this addendum, and to determine all questions arising out of or in connection with the provisions of the addendum or its administration, such construction and interpretation to be provided the most deferential standard on review.

¹ For this purpose, "applicable federal law" means Section 6001(a)(1) of the Families First Coronavirus Response Act, as amended by section 3201 of the Coronavirus Aid, Relief, and Economic Security Act. Such provisions refer to in vitro diagnostic tests for COVID-19 that are: (a) approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act; (b) tests with respect to which the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe; (c) tests developed in and authorized by a state that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID-19; or (d) are other tests that the Secretary of HHS determines appropriate in guidance.