SDSU FOUNDATION HEALTH VEBA PLAN FOR POST RETIREMENT HEALTH CARE BENEFITS

1. INTRODUCTION

San Diego State University Foundation (SDSU Foundation) maintains this SDSU Foundation Health VEBA Plan for Post Retirement Health Care Benefits (the Plan). The Plan, together with the SDSU Foundation Health VEBA Trust for Post Retirement Health Care Benefits (the Trust) constitutes a voluntary employees' beneficiary association that the Internal Revenue Service determined is exempt from Federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(9) of the Internal Revenue Code. SDSU Foundation maintains employee health and dental plans for active employees. These plans are administered by SDSU Foundation and the specific benefits and insurance coverages offered under these plans changes from time to time. This Plan extends these benefits to retirees under the conditions described in this document. Any health benefits extended to retirees under these plans through this Plan and the terms of those retiree benefits, including the documents outlining the retiree benefits and benefit limitations, are incorporated and made a part of this Plan by reference.

This document and the insurance booklet from the Insurer make up the Plan's summary plan description (SPD) effective as of *January 1, 2021*. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information. Keep your health plan documents in a safe place for future reference. This plan does not provide any benefits that are not contained in your health coverage policy and this Plan should be interpreted to be consistent with your health coverage policy. If there is a conflict between your health coverage policy and this Plan that would result in benefits payable that are not payable under the health coverage policy, the policy terms will control and the benefit will not be payable.

Reservation Of Right To Change This Policy

SDSU Foundation reserves the right to modify coverage, add or eliminate plan options, add or eliminate insurance carriers or providers, modify employer/employee/retiree contributions, cancel, modify or reduce this coverage, or to make any changes to this policy at any time. Additionally, SDSU Foundation may authorize the deletion of any group or program named in this policy, or the addition of any new group or program.

2. Eligibility

Upon retirement, an employee must meet all of the criteria described in one of three employee groups in order to be eligible for the employer's premium contributions available to that group. All eligible retirees have the same choice of health and dental insurance providers offered to active employees in California, however, some plan differences may exist, depending upon the products made available by the insurance carriers. The insurance carriers provide specific products for Medicare Eligible Retirees. For Medicare eligible retirees, plan benefits will be coordinated with Medicare using the Medicare "carve-out" approach. For plans where the Medicare "carve-out" approach is not an option, retirees eligible for Medicare are required to participate in the programs designed to integrate benefits with Medicare. Medicare Eligible Retirees inside California may choose not to participate in a SDSU Foundation sponsored health plan and, instead, may participate in an individually obtained Medicare Supplement Plan, such as those offered through the American Association of Retired Persons (AARP). The Plan will pay for the cost of an individual Medicare Supplement Plan up to the amount which would have been contributed to a SDSU Foundation sponsored plan. Medicare Eligible Retirees that reside outside of California can be reimbursed for a portion of their premium for individual coverage that they secure outside of California and the Plan will provide details about this option to those Medicare Eligible Retirees before the start of each year. Once the choice to terminate participation in a SDSU Foundation sponsored health plan has been made, the retiree may not elect to later re-enroll in a SDSU Foundation sponsored plan unless reenrollment follows a change in other coverage for the retiree or the retiree's spouse (such as a loss of coverage under another group health plan or upon becoming eligible for Medicare). The election to reenroll must be made within 31 days of the change in other coverage.

Eligibility under any of the Eligible Groups first requires that the employee is a "Benefit Eligible Employee" at the time of retirement. To be a Benefit Eligible Retiree, the individual must retire from employment from a designated SDSU Research Foundation entity (Central Staff, SDSU Research Advancement, SDSU Technology Transfer Office, KPBS, SDSU Global Campus, University Relations and Advancement, SDSU Athletics, or an organization that is the recognized predecessor or successor of such an entity) that holds funding and is administered through the SDSU Research Foundation and must be eligible for SDSU Foundation group health coverage at the time of retirement. Prior to January 1, 2014, exempt and non-exempt employees who were designated as

"Regular Salaried" employees were Benefit Eligible Employees. After January 1, 2014, Benefit Eligible Employees are employees who are full-time, working on average 30 or more hours per week as defined by SDSU Research Foundation and the group health plan coverage.

Eligible Groups

(i) Group 1 (Benefit Eligible Employees as of June 30, 1991) Eligible Group 1 employees are employees who meet all of the following criteria at the time of retirement:

1. Employed by SDSU Foundation as of June 30, 1991 as a Benefit Eligible Employee with 10 years of continuous service in this capacity.

2. Attained age 50 if employed by SDSU Foundation and covered by PERS on June 30, 1982, or have attained age 55 if a Regular Salaried employee of SDSU Foundation after June 30, 1982. The age requirement is waived if the employee is retiring due to permanent total disability and is approved for benefits under the "Group Long Term Disability Benefits Plan for Regular Salaried Employees of San Diego State University Foundation."

(ii) Group 2 (Benefit Eligible Employees Hired on or After July 1, 1991) Eligible Group 2 employees are employees who meet all of the following criteria at the time of retirement:

1. Employed by SDSU Foundation on or after July 1, 1991 as a Benefit Eligible Employee with 15 years of continuous service in this capacity.

2. Attained age 60. The age requirement is waived if the employee is retiring due to permanent total disability and is approved for benefits under the "Group Long Term Disability Benefits Plan for Regular Salaried Employees of San Diego State University Foundation."

(iii) Group 3 (Employees Retired Before July 1, 1991) Eligible Group 3 employees include those former SDSU Foundation employees who meet all of the following criteria at the time of retirement:

1. Retired prior to July 1, 1991.

2. Receiving benefits as of July 1, 1991, under SDSU Foundation's "Health Insurance at Retirement Policy" (approved by the Board of Directors on May 14, 1984).

(b) Medicare. For Medicare eligible retirees, plan benefits will be coordinated with Medicare using the Medicare "carve-out" approach. For plans where the Medicare "carve-out" approach is not an option, retirees eligible for Medicare are required to participate in the programs designed to integrate benefits with Medicare. Upon reaching the age of Medicare eligibility or becoming eligible for Medicare due to disability, retirees must enroll in both Parts A and B of Medicare and must convert to SDSU Foundation provided health insurance (or insurance outside of California) that interfaces with both Parts A and B of Medicare.

Retirees eligible for Medicare inside California may choose not to participate in a SDSU Foundation sponsored health plan and, instead, may participate in an individually obtained Medicare Supplement Plan, such as those offered through the American Association of Retired Persons (AARP). The Plan will pay for the cost of an individual Medicare Supplement Plan up to the amount which would have been contributed to a SDSU Foundation sponsored plan. Once the choice to terminate participation in a SDSU Foundation sponsored health plan (including participation that pays for the cost of an individual Medicare Supplement Plan) has been made, the retiree may not elect to later re-enroll in a SDSU Foundation sponsored plan unless reenrollment follows a change in other coverage for the retiree or the retiree's spouse (such as a loss of coverage under another group health plan or upon becoming eligible for Medicare).

Retirees eligible for Medicare who reside outside California are eligible for reimbursement through this Plan if they enroll in both Parts A and B of Medicare and enroll in coverage outside of California that interfaces with Medicare Parts A and B as a supplement, "carve-out", or other integration. The amount of reimbursement is limited to the amount that would have been reimbursed inside of California.

(c) Dependent Coverage. Dependent coverage is available for legally married spouses who are married to the employee on the date of the employee's retirement. Effective January 1, 2003, coverage is also available to a retiree's same sex or opposite sex domestic partner who meets the definition of domestic partner and is able to certify the partnership as described in the Domestic Partner Guide and who is a domestic partner of the employee on the date of the employee's retirement. Dependent coverage is not provided for children or any other dependents.

(d) Retirement. To be eligible for this coverage, an employee must be retired. An employee is retired if the employee is receiving benefits under the "SDSU Foundation Defined Contribution Retirement Plan" offered through TIAA-CREF, be retired under SDSU Foundation's long term disability provisions, or the employee terminates employment on or after the date that they would be initially eligible under this Plan. Continued eligibility for health and dental insurance coverage is contingent upon the employee remaining retired or disabled. If a covered retiree is reemployed, that retiree becomes ineligible for benefit paid under this Plan during the period of reemployment and any coverage will be paid either through the active group coverage or by the retiree during such period. If the person is rehired after qualifying for coverage under this Plan, but is subsequently rehired, that person will be immediately eligible to rejoin the Plan upon a subsequent retirement.

3. Premium Contributions

The premium contribution is based on the years of service for which amounts were prefunded through contributions into the VEBA. The source from which an eligible employee's benefits are paid (the employing entity during the Benefit Eligible Employee's employment) must pre-fund the contingent liability for an employee's post retirement health and dental insurance benefits in order for the employee to be eligible. Funds are held in trust by the SDSU Foundation Health VEBA Trust for Post Retirement Health Care Benefits.

(a) Years of Service. Credit for years of service under this policy is given for the period of time an employee is a Benefit Eligible Employee. Service credit is not counted for other SDSU Foundation employment

such as employment as a temporary, casual, overload, project, or student employee. Credit is not given for employment with San Diego State University. In the event that a Benefit Eligible Employee terminates employment and is rehired again as a Benefit Eligible Employee within a period of twelve months, prior eligible service will be counted towards the employee's years of service. If the break in service is longer than twelve months, prior service will not be counted even if the employee is re-employed into an eligible class. Time spent on an approved leave of absence will be counted towards the employee's years of service.

(b) Premium Contribution Rate for Group 1 (Benefit Eligible Employees as of June 30, 1991). SDSU Foundation's premium contribution for Group 1 will be based upon the cost of the least expensive comprehensive plan for which the retiree is eligible. The amount of the contribution will also be determined by the years of service the employee has earned on the date of retirement, in accordance with the schedule shown below. The minimum retiree contribution for individual coverage is the amount an active employee pays for individual coverage. The minimum retiree contribution for spousal or domestic partner coverage is the amount paid by an active employee to cover one dependent. The percent stated in the chart below specifies the percent of the remaining premium which will be paid by SDSU Foundation.

Years of Service Credit	Percent SDSU Foundation Contribution for Retiree/Spousal/Domestic Partner *
0-9 years	Not eligible
10	50%
11	55%
12	60%
13	65%
14	70%
15	75%
16	80%
17	85%
18	90%
19	95%
20	100%

*At a minimum, retirees must pay the same premium contribution as is paid by active employees. The percentages shown in the above chart apply to the remaining portion of the premium, after the minimum contribution has been made.

(c) Premium Contribution Rate for Group 2 (Benefit Eligible Employees Hired on or After July 1, 1991). SDSU Foundation's premium contribution for Group 2 will be based upon the cost of the least expensive comprehensive plan for which the retiree is eligible. The amount of the contribution will also be determined by the years of service the employee has earned on the date of retirement, in accordance with the schedules shown below. The minimum retiree contribution for individual coverage is the amount an active employee pays for individual coverage. The minimum retiree contribution for spousal or domestic partner coverage is the amount an active employee pays to cover one dependent. The percent stated in the chart below specifies the percent of the remaining premium which will be paid by SDSU Foundation.

Years of Service	% SDSUF Contribution For Retiree*	% SDSUF Contribution For Spouse or Domestic Partner*
0-14 years	Not eligible	Not eligible
15	75%	37.5%
16	80%	40.0%
17	85%	42.5%
18	90%	45.0%
19	95%	47.5%
20	100%	50.0%

*At a minimum, retirees must pay the same premium contribution as is paid by active employees. The percentages shown in the above chart apply to the remaining portion of the premium after the minimum contribution has been made.

(d) Premium Contribution Rate for Group 3 (Employees Retired Before July 1, 1991). For Group 3, SDSU Foundation will pay the same percentage of the premium it pays for active employees. For example, if SDSU Foundation pays 100% of the cost of coverage for active employees, it will pay 100% of the cost of coverage fora retired

employee. Retirees will be required to make the same contribution for spousal or domestic partner coverage, if any, that is paid by active employees to cover one dependent.

(e) Reimbursements Outside of California. The amount that will be reimbursed for Medicare Eligible Retirees who are covered outside of California will be established each year and may vary based on the geographic location of the retiree. A notice will be provided 90 days before the beginning each year that will describe the reimbursement rights. In any event, the amount that may be reimbursed is limited to the amount which would have been paid if the retiree resided inside of California.

4. PLAN INFORMATION

Name of Plan: SDSU Foundation Health VEBA Plan for Post Retirement Health Care Benefits

Offerings and Insurance Carriers: Current group health coverage offerings of the SDSU Foundation

Plan Administrator: SDSU Foundation

Agent for Service of Legal Process on the Plan:

SDSU Foundation
5250 Campanile Drive
San Diego, CA 92182-1945

Plan Sponsor's Employer Identification Number: EIN # 95-6042721

VEBA Trust EIN #: 33-0712822

Plan Number: 504

Plan Year: January 1 –December 31

Effective Date: August 1, 1982

5. FUNDING AND ADMINISTRATION

(a) Funding. The Plan is fully insured. Plan benefits are payable pursuant to contracts with the Insurers. Claims for benefits are sent to

Insurers and the Insurers are responsible for paying benefits. The SDSU Foundation is not responsible for paying benefits under the Plan. Premium contributions are paid in part by the SDSU Foundation Health VEBA Trust and in part by retirees through contributions. In the event that SDSU Foundation pays any part of a premium contribution, the payment will come directly through SDSU Foundation's general assets. Any refund, rebate, dividend, experience adjustment, or other similar payment under the group insurance contract will be allocated, if consistent with the fiduciary obligations imposed by ERISA and permitted by law, to reimburse the SDSU Foundation for its payments first and then to the SDSU Foundation Health VEBA Trust.

(b) Type of Administration. Because the Plan's benefits are provided through an insurance contract, both the Insurer and the SDSU Foundation administer the Plan. The SDSU Foundation, as plan administrator, has the discretionary authority to interpret and administer the Plan. This includes making determinations of an individual's eligibility under the Plan. The Insurer has the authority to make benefit determinations under the Plan and is the Named Fiduciary responsible for following the Plan's claims procedures. The Plan Administrator has designated the Human Resources Office to be responsible for enrolling eligible employees and distributing information on plan benefits. All fiduciary delegations carry with them discretionary authority with respect to the delegated function.

(c) Compliance with State and Federal Laws. To the extent required by law, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, as amended, including the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998 (WHCRA), the Family and Medical Leave Act of 1993 (FMLA), the Mental Health Parity Act (MHPA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Information Technology for Economic and Clinical Health Act (HITECH), Michelle's Law, the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Affordable Care Act

(PPACA). Some protections in these laws may not apply to certain retiree benefits.

(d) Amendment or Termination. The SDSU Foundation may modify, amend or terminate the Plan at any time at its sole discretion. The right to modify, amend or terminate also applies to the insurance contract between the SDSU Foundation and the Insurer. Any modification, amendment, or termination will be communicated to participants under the Plan. There are no vested benefits under the Plan and there is no promise of employment or retiree benefits for any period of time after retirement. If any portion of this Plan is determined to be illegal or unenforceable, that provision shall be severed to the extent necessary to meet the objectives of the Plan and to comply with law.

6. PARTICIPATION

(a) Enrollment. When you retire, you will be given an opportunity to enroll in the Plan. You may need to complete insurance carrier forms and pay your share of premiums to enroll in coverage. Your coverage terminates under certain circumstances, such as failure to pay required premiums, failing to meet eligibility requirements, submitting fraudulent claims and other reasons described in your insurance booklet. Coverage for your spouse terminates when your coverage ends and for other reasons described in your insurance booklet, such as divorce. Under HIPAA, group health plans are required to provide active employees, their dependents and COBRA qualified beneficiaries with special enrollment opportunities for certain situations. Because this Plan does not cover active employees, HIPAA does not apply to this Plan.

(b) Termination for Failure to Pay. You must pay your premium to participate and your coverage will terminate if you do not pay your required premiums. You will be notified as to the due date for your premium contribution when you first become eligible and it is your responsibility to provide timely payment. If you do not pay on your due date you will be given a grace period of 60 days to pay. If you do not pay within 60 days of your due date, your coverage will immediately terminate. If you pay at least 90% of your premium cost before your grace period expires, but still have a shortfall, you will be notified of the shortfall and you will given an additional 30 days to

pay the shortfall. The Plan is under no obligation to provide notice of nonpayment prior to cancellation and any notice provided does not obligate the Plan to provide such notice in the future.

(c) Continuation of Coverage. If your coverage or the coverage of your spouse terminates because of certain reasons known as qualifying events (such as divorce, or certain bankruptcy proceedings), you or your spouse may be entitled to continue health care coverage for a certain period of time under a federal law called COBRA. COBRA for active employees often follows a termination of active employment, but because retiree coverage is not based on active employment, termination of employment is not a COBRA qualifying event for this Plan. Contact HR at the SDSU Foundation for more information about your rights under COBRA.

7. PLAN BENEFITS

(a) Insured Benefits. The Plan provides benefits to you and your eligible spouse (or domestic partner) while you are eligible for and covered by the Plan. For a detailed description of benefits available under the Plan, please review the insurance booklet which includes cost-sharing information, out-of-pocket maximums, limitations, provider network provisions, when new drugs are covered, preventive care services, when medical tests/devices are covered, restrictions, excluded services, Procedures for obtaining prior authorization, approvals, or utilization review decisions, etc. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information.

(b) Loss of Coverage. Benefits are no longer payable if your coverage is terminated for any reason. The Plan reserves the right to recover overpayments of benefits or benefits paid in error through the rights of subrogation and reimbursement as described more fully in your insurance booklet.

(c) Exclusions and Limitations. Please review the insurance booklet carefully for information on other situations that may affect your right to receive benefits under the Plan, such as applicable deadlines for submitting claims and any exclusions and limitations that may result in the denial of a claim or a loss or reduction of a benefit. Other situations may also lead to a reduction or limitation (e.g., timeline to

file a claim), which are described in the certificate of insurance booklet.

(d) Patient Protection/Notice of Choice of Providers. Your insurance carrier(s), plan administrator, or issuer generally allows/requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. In addition, your insurance carrier could auto designate a primary care provider until you make your own selection. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact the insurance carrier directly. Contact information can be found under the "Offerings" section. You do not need prior authorization from your insurance carrier(s), plan administrator, or issuer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, you may contact the insurance carrier(s), plan administrator, or issuer directly. Contact information can be found under the "Offerings" section.

(e) Reimbursements. If you are receiving a reimbursement for premium expenses because you are a Medicare Eligible Retiree residing outside of California and are therefore not enrolled in SDSU Foundation sponsored plan, you will only receive reimbursements for premiums paid for individual health insurance coverage that is subject to and complies with the requirements in Public Health Services (PHS) Act sections 2711 (and § 2590.715-2711(a)(2) of this part) and PHS Act section 2713 (and § 2590.715-2713(a)(1) of this part). All individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. To receive reimbursement, you will be required to certify your eligibility in writing and provide a document from a third party (for example, a health insurance issuer) showing that you were enrolled in individual

health insurance coverage for the applicable month and the amount paid for that coverage.

8. CLAIMS PROCEDURES

(a) Benefit Claims and Appeals. The Insurer is responsible for reviewing and deciding all benefit claims in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. The benefits insurance booklet or evidence of coverage for your insurance carrier provides more information about the Insurer's claims procedures, including information on how to file a claim. If your claim is a claim for eligibility, you will have the same claims procedure protections, but you will file your claim with the Plan Administrator.

(b) Claim Appeals. The Insurer may deny claims in part or in full pursuant to the terms of the Plan. If your claim is denied, you will be notified of the denial. You may appeal any denial of a claim. The Insurer will review your denied claim and will decide your appeal in accordance with its reasonable claim's procedures, as required by ERISA and other applicable law. If you do not appeal a denial by the applicable deadlines, you will lose certain rights, such as the right to file a lawsuit regarding the denial and you will not be deemed to have exhausted your internal administrative rights. You must appeal a denial to bring your claim to court. Appeals from an eligibility claims denial or reimbursement claims denial will be decided by the SDSU Foundation VEBA Oversight Committee.

9. STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts 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 Benefits Security Administration.

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

Receive a summary of the Plan's annual financial report, if the plan administrator is required by law to file a Form 5500. The plan administrator may be required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

Continue health care coverage for yourself or spouse if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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.

Genetic Information Nondiscrimination Act of 2008 (GINA)

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

Model Newborns' Act Disclosure

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

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Assistance with Your Questions

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

Plan Restated January 1, 2021