NORTHERN VIRGINIA REGIONAL PARK AUTHORITY
EMPLOYEE BENEFITS PLAN

Summary Plan Description
(Effective as of January 1, 2019)

A. INTRODUCTION

This document with the various Certificate of Insurance Booklet(s) referenced herein which describe the Benefits provided, constitutes a Summary Plan Description ("**SPD**") which summarizes and explains the important provisions of the Northern Virginia Regional Park Authority Employee Benefits Plan (the "**Plan**") as amended and restated as of January 1, 2019.

This Plan also contains a cafeteria plan component that is designed to comply with Section 125 of the Internal Revenue Code. It includes a premium conversion feature that allows you to use salary reductions to pay your share of the cost of participating in the Medical, Dental, Vision, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account Benefits under the Plan.

Northern Virginia Regional Park Authority (the "**Employer**") is the Plan sponsor.

Complete details of the Plan are found in the official Plan document and the Certificate of Insurance Booklet(s) relating to the benefit options offered under the Plan. The Plan document, Certificate of Insurance Booklet(s) and any written administrative procedures pertaining to the Plan may be reviewed by Plan Participants and/or their legal representatives during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator. If there is a conflict between this SPD and the Plan document, the Plan document will control. Also, with respect to benefits provided by an insurance company if there is a conflict between the applicable Certificate of Insurance Booklet(s) and either the Plan document or this SPD, the provisions of the SPD will control. Copies of the Certificate of Insurance Booklet(s) are available to Plan Participants upon request and some Certificate of Insurance Booklet(s) are also available online.

The Plan is not a contract of employment and does not guarantee continued employment. The benefits under the Plan are provided at the sole discretion of the Employer. The Employer makes no promises to continue Plan benefits in the future, and rights to future benefits will never vest. In addition, the Employer reserves the right, in its sole discretion, to amend, modify or terminate the Plan, in whole or in part, at any time, as necessary to comply with requirements of applicable law.

It is recommended that you read this SPD carefully so you can understand the Plan's operation and the benefits it offers. Capitalized terms used in this SPD will have the same meaning provided in the "Definitions" section of the Plan document. If you have any questions after reading this SPD or would like additional information, please contact the Plan Administrator at the address specified in Section B: *Basic Facts*.

Please note that as an entity that meets the requirements of a governmental entity, these employee benefits are exempt from ERISA and this SPD is being provided as informational only and does not constitute any rights for the participants under ERISA.

B. BASIC FACTS

Plan Name: Northern Virginia Regional Park Authority Employee Benefits Plan

Renewal Plan Year: January 1st – December 31st

Plan Sponsor/Employer: Northern Virginia Regional Park Authority
5400 Ox Road
Fairfax Station, VA 22039
703-352-5900

Sponsor's Employer Identification Number: 54-0715585

Plan Administrator: Northern Virginia Regional Park Authority
5400 Ox Road
Fairfax Station, VA 22039
703-352-5900

Plan Administrator: County of Fairfax, Virginia (self-funded medical plan only)
HR Benefits Division
12000 Government Center Park, Suite 2
Fairfax, VA 22035
703-324-3311

Service of Legal Process: Northern Virginia Regional Park Authority
5400 Ox Road
Fairfax Station, VA 22039
703-352-5900

Service of Legal Process: County of Fairfax, Virginia (self-funded medical plan only)
HR Benefits Division
12000 Government Center Park, Suite 2
Fairfax, VA 22035
703-324-3311

Plan Type: The Plan is an employee welfare benefit plan.

Type of Administration: This plan has self-funded and fully-insured benefits (provided by contracts with an Insurance Carrier). Benefits are provided under a group insurance contract entered into between the Employer and the Insurance Carriers. The Insurance Carriers listed in Appendix A (not the Employer) are responsible for paying benefits. Note that the Employer

and the Insurance Carriers share responsibility for administering the plan.

C. OVERVIEW OF PLAN BENEFITS

1. Employer Paid and Employer Subsidized Benefits

(a) The Plan provides Eligible Employees certain "Employer Paid Benefits," the cost of which is fully paid by the Employer. The Employer Paid Benefits include the following:

Life Insurance Benefits
Accidental Death and Dismemberment Benefits
Long Term Disability Benefits
Employee Assistance Program
Short Term Disability Benefits

(b) The Plan provides Eligible Employees certain "Employer Subsidized Benefits," the cost of which is partially paid by the Employer and the remainder of which is paid for by the Employee. The Employer Subsidized Benefits include the following:

Medical Benefits

2. Optional Benefits

The Plan also provides an Eligible Employee the opportunity to elect certain "Optional Benefits" for himself or herself and his or her Eligible Dependents. The Optional Benefits include the following:

Dental Benefits
Supplemental Life Insurance Benefits
Supplemental Accidental Death and Dismemberment Benefits
Health Care Flexible Spending Account Plan
Dependent Care Flexible Spending Account Plan
Vision Benefits

During each open enrollment period prior to the beginning of the Renewal Plan Year, you will receive information regarding the required Participant contributions for the Employer Subsidized Benefits and Optional Benefits.

3. Required Premium Payments and the Pre-Tax Advantage

Insurance premiums for Employees and their Dependents are paid in part by the Plan Sponsor out of its general assets, and in part by Employee pre-tax payroll deductions. The Employer will determine and periodically communicate your share of the cost of the Benefits provided through each component benefit program, and it may change that determination at any time.

The Employer will make its contributions in an amount that (in the Employer's sole discretion) is at least sufficient to fund the Benefits or a portion of the Benefits that are not otherwise funded by your contributions. The Employer will pay its contribution and your contributions to an Insurance Carrier on behalf of you or your eligible Dependents from the Employer's general assets. Your contributions toward the cost of a particular Benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

If you elect coverage for which your contributions will be paid on a "pre-tax" basis, your gross earnings will be reduced by the amount you are required to pay for the benefits you selected. You will be taxed for federal income tax purposes only on the remaining amount of your gross earnings and not on the amounts used to pay for these benefits. The pre-tax contributions made for the benefits are not subject to Social Security taxes. Therefore, your Social Security benefits may be reduced if you elect these benefits, rather than taxable compensation. Generally, the reduction is a small one. However, the impact varies from case to case and cannot be predicted by the Employer. In return for this pre-tax advantage, the law provides that your election must be *irrevocable* for the year. You may make mid-year changes only in response to and consistent with certain events as described in Section K. Any amounts not expended for benefits during the year will be forfeited.

D. ELIGIBILITY AND PARTICIPATION

1. Eligible Employees

To determine whether you and your dependents are eligible to participate in a component benefit program, please read the eligibility information contained within the attachments for the applicable component benefit programs. A summary of this information is set forth below.

Plan	Who is eligible	When Participation Begins
Fully Insured Medical Dental Vision	FT/PT Employees working 30 or more hours per week	1st of the month following the first day of employment
Fully Insured Medical Self-funded Medical Dental Vision Employee Assistance Plan Life Insurance Supplemental Life Insurance Accidental Death and Dismemberment Supplemental Accidental Death and Dismemberment Long Term Disability Short Term Disability	FT Employees working 40 or more hours per week	1st of the month following the first day of employment

Whether you are entitled to participate in a specific Benefit shall be determined in accordance with the rules and regulations of such Benefit. Any restrictions, limitations, and additional requirements relating to your entitlement to a Benefit that are not set forth in the Plan are described in the Certificate of Insurance Booklet(s) for the specific Benefit.

2. Eligible Dependents

You may also elect to enroll your eligible Dependents with respect to medical coverage, dental coverage, vision coverage and supplemental life insurance coverage. The determination of who is a "Dependent" will be determined in accordance with the rules and regulations of such Benefit.

In regard to the Medical, Dental and Vision Benefits, your "Eligible Dependents" are defined as (i) your lawful Spouse including same sex determined under Federal law; and (ii) your child who is 26 years old or younger (in which case coverage will extend to the last day of the calendar month in which such child attains age 26). For purposes of this definition, the term "child" shall mean the Participant's biological child, step child, legally adopted child or foster child.

In regard to the Supplemental Life Insurance Benefit and Supplemental Benefit, your "Eligible Dependents" are defined as (i) your lawful Spouse including same sex determined under Federal law and (ii) your child who is 19 years old or younger, or 25 years old or younger and a full-time student in an accredited institute of higher education (in which case coverage will extend to the date on which such child attains age 19, 25, or is no longer a full-time student). For purposes of this definition, the term "child" shall mean the Participant's biological child, step child, legally adopted child or foster child.

Individuals covered under a Qualified Medical Child Support Order issued against you are also eligible for group health benefits as described under the Order (see Section F.9).

3. Termination of Participation

Generally your coverage for Benefits under the Plan ends either on the day your employment terminates or at the end of the month following the day your employment terminates for any reason including death or, if earlier, when you cease to be an eligible Employee. Coverage also ceases upon your election subject to the rules in Section K or if you fail to make required contributions.

Benefit	When Participation Ends
Medical Dental Vision Employee Assistance Plan Life Insurance Supplemental Life Insurance Supplemental Accidental Death and Dismemberment	Last day of the month of termination

Short Term Disability Long Term Disability Health Care Flexible Spending Account Dependent Care Flexible Spending Account	Date of termination

Coverage you have elected for your Eligible Dependents under any Benefit ceases when your coverage ceases or, if earlier, when such individual ceases to be your Eligible Dependent. If you are required to make contributions for certain coverage that you have elected for yourself and your Eligible Dependent(s), then such coverage will cease if you fail to make the required contributions. Further, all health and welfare benefit coverage provided under this Plan will cease on the date the Plan is terminated.

Although coverage may otherwise cease, you may elect COBRA continuation coverage for group health benefits as provided in Section F.1. You may also be able to convert some of the group insurance coverage to personal coverage. Please consult the applicable Certificate of Insurance Booklet(s).

4. Rehires and Leaves of Absence

If you are an Eligible Employee who has terminated employment with the Employer and who is later rehired within a period of 13 weeks, you will be reinstated into the same Medical Benefit in effect before your termination date (or the most comparable Benefit thereto where that same Medical Benefit is no longer available), but must satisfy the eligibility period described in Section D.1 upon rehire in order to be eligible to participate in all other Employer Paid Benefits, Employer Subsidized Benefits and Optional Benefits. If you are an Eligible Employee who has terminated employment with the Employer and who is later rehired after a period of 13 weeks, you must satisfy the eligibility period described in Section D.1 upon rehire in order to be eligible to participate in all Employer Paid Benefits, Employer Subsidized Benefits and Optional Benefits.

If you are an Eligible Employee who is eligible and approved for a FMLA Leave, you will continue to receive all Employer Paid, Employer Subsidized and Optional Benefits during the period of such leave, up to a maximum of 12 weeks within a 12-month period. You will still be responsible to continue to pay your portion of the premiums within a 60 day grace period date provided by the Employer. If payments are not received timely, all Benefits can be terminated. If you choose not to continue benefits while on an approved FMLA Leave, then upon your return to work, you will be reinstated in all Benefits immediately following your return to work. Additionally, if your leave period lasts for longer than 12 weeks, you will be permitted to continue coverage under COBRA. Then, if you return to active employment, you will be reinstated in all Benefits immediately.

If you are an Eligible Employee on a leave of absence for military service, you will be covered for Benefits as determined in accordance with USERRA.

To the extent that another law, regulation or ordinance that is not described herein requires the Plan to provide you with more favorable or beneficial family leave or military leave benefits, then the Plan and the Employer will comply with such laws, regulations or ordinances,

and will provide you with such additional benefits. For more information about the Employer's leave policies, please contact the Northern Virginia Regional Park Authority Human Resources Department.

E. GROUP HEALTH BENEFITS

1. Medical Benefit (including prescription drugs and vision benefits)

The Employer provides *fully-insured* and *self-funded* medical and prescription drug coverages and contracts between designated providers (as listed in Appendix A) and the Employer. The coverages provide for medical, prescription drugs and vision benefits for Participants and their Eligible Dependents as described in the Certificate of Insurance Booklet(s) and insurance contracts between the Employer and the provider. The Eligible Employee may elect from among the coverage options and benefit levels set forth in the Certificate of Insurance Booklet(s) that is distributed to Participants. The Medical Benefit is more fully described in the Certificate of Insurance Booklet(s) and contracts.

The Employer and the Participant each pay a portion of the premiums for the Medical Benefit. You make these contributions on a pre-tax basis under the Flexible Benefits Plan by agreeing to reduce your pay by the amount of your required contribution. Your pay will be reduced on a bi-weekly basis for your contribution.

2. Dental Benefit

The Employer provides *fully-insured* stand-alone dental coverage for Participants and their Eligible Dependents as described in the Certificate of Insurance Booklet(s) and in the insurance contract between the Employer and a designated provider (as listed in Appendix A). The Eligible Employee may elect from among the coverage options and benefit levels set forth in the Certificate of Insurance Booklet(s) that is distributed to Participants. The Dental Benefit is more fully described in that Certificate of Insurance Booklet(s) and contract.

The Participant is responsible to pay for the premiums for the Dental Benefit. You make these contributions on a pre-tax basis under the Flexible Benefits Plan by agreeing to reduce your pay for the amount of your required contribution. Your pay will be reduced on a bi-weekly basis for your contribution.

3. Vision Benefit

The Employer provides *fully-insured* stand-alone vision coverage for Participants and their Eligible Dependents as described in the Certificate of Insurance Booklet(s) and in the insurance contract between the Employer and a designated provider (as listed in Appendix A). The Vision Benefit is more fully described in that Certificate of Insurance Booklet(s) and contract.

The Participant is responsible to pay the entire cost for the Vision Benefit. You make these contributions on a pre-tax basis under the Flexible Benefits Plan by agreeing to reduce your

pay for the amount of your required contribution. Your pay will be reduced on a bi-weekly basis for your contribution.

4. Health Care Flexible Spending Account

You may elect to reduce your compensation on a pre-tax basis and have such amounts credited to a Health Care Flexible Spending Account under the Flexible Benefits Plan. Your contributions are made on a pre-tax basis so you avoid federal income and Social Security/Medicare taxes on the amount you set aside. State taxation may also apply depending on the income laws of the state where you reside. The amount you contribute can then be used to reimburse you for otherwise unreimbursed qualified health care expenses that you, your Spouse (as defined under federal law) and your Dependents (who qualify as dependents under Internal Revenue Code section 106) incurred during the Plan Year (January 1st – December 31st) and while you are a Participant with respect to such Health Care Flexible Spending Account.

You decide how much to contribute to your account based on how much you expect to spend on qualified health care expenses during the Plan Year up to a maximum amount of $2,650. If you don't expect to have any qualified health care expenses in the Renewal Plan Year and, you may not want to contribute anything because amounts not used for eligible expenses during the Renewal Plan Year are forfeited with the exception of a permitted Carry Over. The Plan permits you to Carry Over an amount (up to a maximum of $500) from the Plan Year to be used to reimburse expenses incurred in the following Plan Year. This amount is in addition to the maximum yearly maximum of $2,650.

You may use your Health Care Flexible Spending Account to pay health-related expenses for yourself, your Spouse and your Dependents regardless of the insurance coverage you have, whether through the Employer or another source. As long as the expense is not reimbursed through any other source, you may submit the expense for reimbursement. The following are examples of eligible expenses:

- Health care plan deductibles, co-payments, and other out-of-pocket expenses which are not excludable. ("Exclusions" below.)
- Medical expenses which generally are not covered until deductibles are met, such as doctors' office visits and prescription drugs.
- Medical/dental expenses not covered under your health care plan but considered to be health care expenses under Section 213(d) of the Internal Revenue Code: e.g., vision exams and prescription eye wear; hearing exams and hearing aids; orthodontia, etc.
- Certain over the counter medicines with a physician referral purchased for medical care such as antacids, allergy medicines, pain relievers and cold medicines.

Exclusions: There are certain expenses which may not be reimbursed by your Account. These include:

- Expenses reimbursed through any other policy or plan, including any health insurance plan for your spouse or dependent child, Medicare, or any other Federal or state program;

- Expenses specifically prohibited by the IRS, including medical insurance premiums paid by your spouse at his/her Employer or by you;

- Expenses incurred before you became eligible to participate;

- Expenses which are incurred in another calendar year;

- Expenses for which you claim a deduction or credit for federal income tax purposes;

- Expenses for cosmetic surgery or similar procedures unless necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury from an accident or trauma, or disfiguring disease; and

- Items that are merely beneficial to your general health such as dietary supplements and vitamins.

Your pre-elected contributions will be deducted in equal amounts throughout the year from your pay as long as you are eligible to participate. The amounts are then deposited in your Account. No single installment may exceed your gross pay for the pay period. Newly hired Employees will normally have contributions deducted in equal installments during the remainder of the year unless otherwise noted.

Information regarding the procedures for reimbursement and the documentation required will be provided to you. Claims for expenses not considered eligible under IRS rules will be disallowed. You will be reimbursed for eligible expenses up to the amount you elected for the year regardless of the amount of your contributions as of such date. If you have any questions regarding the procedures for reimbursement, please contact your Plan Administrator.

In order for an expense to be reimbursable for a particular Plan Year, the expense must be for services that were rendered in that Plan Year. It is important to remember that what determines whether an expense is reimbursable is when you incur the expense and not when you receive the bill for those services. Claims for eligible expenses incurred during a Plan Year must be submitted by March 31st following the end of such Plan Year.

- Once you have made your Health Care Flexible Spending Account election, you may not change the amount of your Health Care Flexible Spending Account contributions until the next Renewal Plan Year unless a revocation or change is permitted as provided under Section K.

- Any amount (in excess of $500) remaining in your Account after all eligible claims for that Plan Year will be forfeited. You cannot receive any of your deposits back if you do not use the full amount you have contributed into another Renewal Plan Year. For these reasons, it is important to estimate your anticipated expenses carefully before you commit a portion of your pay to the Plan.

If you terminate employment with the Employer for any reason, your Health Care Flexible Spending Account can only be used to pay expenses incurred prior to your termination unless you have a right to, and elect, continuation coverage. All claims, however, must be submitted by March 31st following the end of the Renewal Plan Year and your termination date.

If you die, your surviving Spouse or Dependents may continue to use any balance in your Health Care Flexible Spending Account to obtain reimbursements for covered expenses that were incurred prior to your death. These claims must be submitted by March 31st following the end of the Plan Year following your date of death.

If coverage under the Health Care Flexible Spending Account would cease, you, your spouse and/or dependents may also have a right to elect continuation coverage. See "Your Rights under COBRA" in Section F.1, and in particular, the Medical and Health Care Reimbursement Rule at the end thereof.

F. LEGAL RIGHTS WITH RESPECT TO GROUP HEALTH BENEFITS

1. Your Rights under COBRA

You have a right to choose continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") for yourself, your covered Spouse and dependent children if you lose group health plan coverage (medical, dental and health care flexible spending account) under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). (A child who is born to or placed for adoption with a Participant during a period of COBRA coverage is also considered a covered dependent child.).

If you are the Spouse of a Participant you have the right to choose COBRA continuation coverage for yourself and your covered dependent children if you lose group health plan coverage under the Plan for any of the following four reasons, known as "qualifying events":

- The death of the Participant;
- A termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- Your divorce or legal separation from the Participant; or

- Entitlement of the Participant to Medicare

A covered "dependent child" of a Participant has the right to continue coverage under COBRA if Health Coverage under the Plan ends because of any of the following five qualifying events:

- Death of the Participant;
- Termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment with the Employer;
- Divorce or legal separation of the Participant and Spouse;
- Entitlement of the Participant to benefits under Medicare; or
- Ineligibility for coverage as a dependent child under this Plan

You or a family member or legal representative must inform the Human Resources Department within 60 days of the date of a divorce, legal separation, or loss of dependent child status under this Plan. If the Human Resources Department is not notified within 60 days, you will lose the right to continue coverage. **You must provide notice in writing to the Northern Virginia Regional Park Authority Human Resources Department.** The notice must state the nature of the event, the date of the event, the covered individuals who are affected, and the identity of the person providing the notice and his or her relationship to the affected individual(s). The Plan Administrator may require copies of documents evidencing the event, such as the court order evidencing divorce or legal separation.

When the Human Resources Department is notified on a timely basis that a qualifying event has occurred, you will be notified that you have the right to choose COBRA continuation coverage. You have 60 days from the later of the date you are notified about COBRA or the date of loss of your coverage to inform the Human Resources Department that you want to continue your coverage by completing and submitting the required forms. If you do not choose COBRA continuation coverage, your group health coverage under this Plan will END.

Generally, if you choose to continue your coverage, you may be charged up to 102% of the full cost to the Plan for your coverage. You will be required to pay your first premium payment within 45 days from the date you choose to continue your coverage. If you lose health coverage under the Plan due to a reduction in the hours of the Participant's employment or the termination of the Participant's employment, you may continue your coverage for 18 months. However, the 18-month coverage period for covered Spouses, and dependent children may be extended to 36 months if another event (death, divorce or legal separation, Medicare entitlement, or ineligibility for Dependent coverage) occurs during the initial 18-month period. For all other qualifying events, you may continue your coverage for 36 months. You or a family member or legal representative must inform the Human Resources Department in writing if you believe that you, your covered Spouse or covered dependent children are entitled to extend the period of continuation coverage. The notice must meet the requirements set forth above.

If you are eligible for 18 months of COBRA continuation coverage, coverage may be extended for up to an additional 11 months if you (or a covered Spouse or child is) are determined to be disabled under the rules for Social Security benefits within 60 days of the date of your termination of employment or reduction in hours of employment. You may be charged up to 150% of the cost of the coverage for the 19th through the 29th month of coverage. To extend coverage, you must notify the Human Resources Department in writing at the mailing address or email address set forth above of a determination of disability within 60 days after the later of the date the determination is made or the date coverage would be lost as a result of the qualifying event and before the end of the first 18 months of COBRA coverage. The notice must state the identity of the covered individual determined to be disabled, the date the disability was determined to have commenced, and the identity of the person providing the notice and his or her relationship to the disabled individual. The notice must be accompanied by a copy of the Social Security disability determination.

Your COBRA continuation coverage may end earlier for any of the following reasons:

- The Employer no longer provides group health benefits coverage to any of its Employees;
- The premium for your continuation coverage is not timely paid;
- You become covered under another group health plan that does not contain any exclusion or limitation with respect to a pre-existing condition that you have and that would apply to deny you coverage;
- You become entitled to Medicare; or
- Coverage is extended for up to 29 months due to a disability and there has been a final determination that the disabled individual is no longer disabled. You must notify the Human Resources Department within 30 days of the date of any final determination that disability has ended.

Health Care Flexible Spending Account Rule. If you, your covered Spouse or Dependent loses coverage under the Health Care Flexible Spending Account as a result of one of the qualifying events specified above, the right to elect continuation coverage applies only to continued coverage for the remainder of the Renewal Plan Year and only if the amount that could be received for the remainder of such year exceeds the amount required to be paid for such coverage for the remainder of the year.

2. Your Rights under WHCRA

The Plan, as required by the Women's Health Cancer Rights Act of 1998 ("WHCRA"), provides the following benefits for a Plan Participant or beneficiary who is receiving health care benefits in connection with a mastectomy:

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

Coverage for these benefits or services will be provided in consultation with the Participant's or beneficiary's attending physician.

Coverage for the mastectomy-related services or benefits required under the WHCRA are subject to the same deductibles and coinsurance or co-payment provisions that apply with respect to other medical or surgical benefits provided by your health care medical contract. Contact the Plan Administrator for more information.

3. Your Rights under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights relating to group health benefits. These provisions generally apply to your medical and dental coverage as well as your health care flexible spending account coverage (referred to jointly as "medical coverage" below) except in relation to the provision of benefits that are "excepted" from the scope of the HIPAA portability rules under applicable law.

a. Special Enrollment Rights. HIPAA amended the Code, the Public Health Service Act to provide special enrollment rights to certain individuals who earlier declined group health coverage and later wish to elect enrollment for themselves, one or more Eligible Dependents, or both themselves and their Dependents. Group health plans and any insurer offering group health coverage must provide special enrollment periods to certain individuals eligible for group health coverage.

An Employee who is eligible, but not enrolled for medical coverage under the terms of the Plan (or his or her Dependent if the Dependent is eligible but not enrolled for coverage) is permitted to enroll for medical coverage under the Plan if:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time the Plan's medical benefits were previously offered to the Employee or individual;
- The Employee stated in writing at the time he or she declined coverage that the reason for declining medical coverage under the Plan during enrollment was due to coverage under another group health plan or health insurance coverage;
- The coverage of the Employee or Dependent who has lost the coverage was (i) under COBRA continuation coverage and the COBRA coverage

was exhausted, or (ii) was not covered under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated; and

- The Employee requests enrollment within 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contribution (as described in (ii) above).

b. Nondiscrimination Based on Health Factor. The Plan generally may not establish any rule for eligibility to enroll in the plan (including continued eligibility) that discriminates against an Employee or Dependent because of a Health Factor or charge higher premiums on account of a Health Factor. Health Factors include with respect to an individual (i) health status; (ii) medical condition (including both physical and mental illnesses); (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information; (vii) evidence of insurability (includes conditions arising out of acts of domestic violence and activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities); or (viii) disability.

c. Privacy Rules. HIPAA requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the privacy notice, which was last distributed to you upon enrollment. You can obtain a copy of the privacy notice from the Human Resources Department. Notices for the insured benefits are also available from the insurers.

This Plan, and the Employer, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please contact the Privacy Officer or Privacy Official within the Human Resources Department.

4. Your Rights under CHIPRA

You and your Dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the Renewal Plan Year under two circumstances:

- You or your Dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy. This law does not apply in relation to the provision of benefits that are "excepted" from the scope of the HIPAA portability rules under applicable law.

5. Your Rights under the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA")

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).

6. Your Rights Under Michelle's Law

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the Plan. Coverage will be continued until: (1) one year from the start of the medically necessary leave of absence, or (2) date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

7. Your Rights Under the Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to

substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

8. Your Rights Under the Genetic Information Non-Discrimination Act ("GINA")

GINA broadly prohibits covered employers from discriminating against an Employee, individual, or member because of the Employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual. GINA also prohibits employers from requesting, requiring, or purchasing an Employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

9. Qualified Medical Child Support Orders ("QMCSOs")

The Plan is required to provide health benefits in accordance with the applicable provisions of any "qualified medical child support order" ("QMCSO"). In general, the term qualified medical child support order means a "medical child support order" which requires the Plan to provide a child of a Participant with health coverage under the Plan where the child would not otherwise be covered; for example, if the child would lose coverage as a result of a parent's divorce. A medical child support order is a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction. It also includes a National Medical Support Notice that meets the requirements of the regulations of the Department of Labor set forth at 29 CFR § 2590.609-2. Under a QMCSO, the Plan can be ordered to enroll the child in any available health care expense coverage option and deduct the applicable cost from the Participant's wages. Accordingly, the Plan Administrator has the right to make any necessary changes to the Participant's medical coverage elections in order to provide the child(ren) with the coverage required by the QMCSO, and to authorize on the Participant's behalf the payment of any additional premium costs from the Participant's wages. The Plan Administrator has established procedures for qualifying medical support orders. Participants and beneficiaries may obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

10. Special Rules Regarding Military Leaves

An Employee on leave will be entitled to coverage no less favorable than as required under the Uniformed Services Employment and Reemployment Right Act ("USERRA") provided, however, that coverage pursuant to the terms of USERRA and COBRA coverage will run concurrently.

G. DISABILITY

1. Short Term Disability

The Employer provides *fully-insured* short term disability coverage for Eligible Employees. The Short Term Disability Benefit provides short term disability insurance to eligible Participants through a designated provider (as listed in Appendix A), as described in the Certificate of Insurance Booklet(s) and in the insurance contract between the Employer and the provider. The Short Term Disability Benefit is more fully described in that Certificate of Insurance Booklet(s) and contract.

The Employer pays your entire cost of the coverage.

While receiving Short Term Disability Benefits, Employees may be eligible to continue Health Benefits, as pursuant to your Rights under FMLA.

2. Long Term Disability

The Employer provides *fully-insured* long term disability coverage for Eligible Employees. The Long Term Disability Benefit provides long term disability insurance to eligible Participants through a designated provider (as listed in Appendix A), as described in the Certificate of Insurance Booklet(s) and in the insurance contract between the Employer and the provider. The Long Term Disability Benefit is more fully described in that Certificate of Insurance Booklet(s) and contract.

The Employer pays your entire cost of the coverage.

While receiving Long Term Disability Benefits, Employees may be eligible to continue Health Benefits, as pursuant to your Rights under COBRA (See, "Your Rights under COBRA" in Section F.1 above).

H. LIFE INSURANCE COVERAGE

1. Employer Provided Life Insurance

If you are an Eligible Employee, you will be covered under a *fully-insured* group term life insurance policy. The Life Insurance Benefit provides life insurance including accidental death and dismemberment benefits (in an amount that varies depending on your status with the Employer) for you through a designated provider (as listed in Appendix A), as described in the Certificate of Insurance Booklet(s) and in the insurance contract between the Employer and the provider. The Life Insurance Benefit is more fully described in that Certificate of Insurance Booklet(s) and contract. The Employer pays your entire cost of the coverage. However, for amounts of life insurance over $50,000, you will be subject to imputed income based on the IRS guidelines.

2. Supplemental Life Insurance

You may also elect a *fully-insured* optional supplemental life insurance coverage for yourself and your Eligible Dependents. The Supplemental Life Insurance Benefit provides life insurance including accidental death and dismemberment benefits in excess of the Life Insurance Benefit provided for you and provides coverage for your Eligible Dependents as described in the Certificate of Insurance Booklet(s) and in the contract between the Employer and a designated provider (as listed in Appendix A). You will be responsible for the total cost of this benefit. You make these contributions on a post-tax basis and pay will be reduced on a bi-weekly basis for your contribution.

3. Accidental Death and Dismemberment

You will be covered under a *fully-insured* group accidental death and dismemberment insurance policy if you are an Eligible Employee. The Accidental Death and Dismemberment Benefit provides you with accidental death and dismemberment insurance through a designated provider (as listed in Appendix A), as described in the Certificate of Insurance Booklet(s) and in the insurance contract between the Company and the provider. The Accidental Death and Dismemberment Benefit is more fully described in that Certificate of Insurance Booklet(s) and contract. The Company pays your entire cost of the coverage.

I. EMPLOYEE ASSISTANCE PROGRAM

If you are an Eligible Employee, you will be covered under a *fully-insured* Employee Assistance Plan. The Employer pays your entire cost of the coverage. The Employee Assistance Plan provides counseling and referral services for you through a designated provider (as listed in Appendix A), as described in the Certificate of Insurance Booklet(s) and in the insurance contract between the Employer and the provider. The Employee Assistance Plan is more fully described in that Certificate of Insurance Booklet(s) and contract.

J. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

You may use your Dependent Care Flexible Spending Account to pay dependent care expenses for children under age 13, or certain other Dependents, incurred so that you can work, provided you can claim a deduction for these individuals on your federal income tax return. The Plan can be used to cover expenses for babysitters and eligible day care centers (to be eligible, a day care center must meet all applicable state and local regulations, provide care for more than six non-resident people, and receive a fee for such services, whether or not for profit).

Dependent care expenses are covered only if (i) the Dependent (your child, grandchild, sibling or stepsibling or their descendant) lives with you (for more than one-half of the year), is under age 13 and provides less than one-half of his or her support; or (ii) the individual is your Spouse who is physically or mentally incapable of self-care and lives with you (for more than one-half of the year); or (iii) the Dependent, regardless of age, is physically or mentally incapable of self-care, lives with you (for more than one-half of the year) and has gross income

less than the exemption amount and you provide over one-half of his or her support. If services are provided outside your home, an incapacitated Spouse or Dependent that is age 13 or over must regularly spend at least eight hours a day in your household.

Your deposits for dependent care expenses are limited to a maximum of $5,000 a year (or $2,500, if you are married and you file a separate Federal income tax return). Reimbursement for dependent care is limited to employment-related expenses as defined by the Internal Revenue Code which are excludable from your income. The following limitations for Dependent Care Flexible Spending accounts apply:

(1) Both you and your Spouse (unless your Spouse is a full-time student or is disabled) must work in order for dependent care expenses to be excludable from your income for Federal income tax purposes.

(2) Dependent care expenses are not excludable to the extent they exceed the lesser of

- Your earned income; or
- The earned income of your Spouse.

For example, if you earn more than your Spouse and your Spouse earns $3,000 per year working part-time, $3,000 is the maximum you can exclude for dependent care costs (assuming you have allocated at least that amount to your Account).

If your Spouse is either a full-time student or disabled, even if he or she does not earn income, you may exclude up to $250 a month if dependent care expenses apply to one Dependent or $500 a month if the expenses apply to two or more Dependents. However, months during which a student-Spouse is not attending classes may not be counted.

(3) Your Dependent Care Account may not be used to exclude payments to anyone who can be claimed as a Dependent on your or your Spouse's tax return, or to your own child or stepchild under age 19. For example, you cannot exclude payments you make to your 17-year-old daughter for babysitting your three-year-old son.

(4) There are certain other expenses which may not be reimbursed. These include:

- Expenses reimbursed through any other policy or plan;
- Expenses incurred before you became eligible to participate;
- Expenses which are incurred in another Plan Year;
- Expenses for which you claim a deduction or credit for federal income tax purposes; and

- Expenses that the IRS would not permit to be claimed as a deduction or credit for federal income tax purposes.

Note: For many people, making contributions to their Dependent Care Flexible Spending Account will be more tax-effective to cover dependent care expenses than taking a dependent care tax credit. Others may find that it is more tax-effective to take a dependent care tax credit on their Federal income tax return at the end of the year. Employees who use the Dependent Care Flexible Spending Account (or who take a tax credit) will be required to provide the name and taxpayer ID number of each provider on their tax return. **For specific advice about your personal situation, you should consult your own tax advisor.**

Your pre-elected contributions will be deducted in equal amounts throughout the year from your pay as long as you are eligible to participate. The amounts are then deposited in your Account. No single installment may exceed your gross pay for the pay period. Newly hired Employees will normally have contributions deducted in equal installments during the remainder of the year unless otherwise noted.

Information regarding the procedures for reimbursement and the documentation required will be provided to you. Claims for expenses not considered eligible under IRS rules will be disallowed. You will be reimbursed up to the balance in your Account and any excess amount will be carried over to the next reimbursement period (pay period) when additional funds are deposited into the account.

The amount you elect for a Plan Year is used to reimburse expenses incurred in that Plan Year and while you are a Participant with respect to the Dependent Care Flexible Spending Account. A Participant who has a balance in his or her Account at the end of the Plan Year may continue to receive reimbursement for eligible expenses incurred by the end of the Plan Year. Any amounts not used to reimburse eligible expenses incurred before the end of the Renewal Plan Year are forfeited.

In order for an expense to be reimbursable for a particular Plan Year, the expense must be for services that were rendered in that Plan Year. It is important to remember that what determines whether an expense is reimbursable is when you incur the expense and not when you receive the bill for those services. Claims for eligible expenses incurred during a Plan Year must be submitted by March 31st following the end of the Plan Year.

Any amount remaining in your Account after all eligible claims for that Plan Year have been reimbursed will be forfeited. You cannot receive any of your deposits back if you do not use the full amount you have contributed, and you cannot carry unused amounts forward into another Plan Year. For these reasons, it is important to estimate your anticipated expenses carefully before you commit a portion of your pay to the Plan.

K. PRE-TAX ELECTIONS

1. Mid-Year Changes to Elections

As provided above, you may elect to reduce your compensation on a pre-tax basis to pay your required contributions for elected medical, dental and vision coverage for yourself and your Eligible Dependents, and for elected amounts to be allocated to your Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account. In return for the pre-tax advantage, your election is generally binding for the year. You may change your election during the year only if you meet the circumstances set forth below. You are permitted to make election changes under the following circumstances provided you notify the Plan Administrator within 30 days of the event and timely submit your election change form.

a. Change in Status. The events that constitute a "change in status" include the following:

- Events that change your legal marital status, including marriage, death of Spouse, divorce, legal separation, and annulment.

- Events that change your number of Dependents, including birth, death, adoption, and placement for adoption. (Note: Gaining or losing a Dependent who is not a tax Dependent such as a parent will not be considered an allowable event for an election change.)

- Events that change your employment status or the employment status of your Spouse or Dependents that affect your eligibility for benefits, including a termination or commencement of employment, reduction or increase in hours, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in work site.

- You have been in an employment status under which you were reasonable expected to average at least 30 hours of service per week and there is a change in your status so that you will be reasonable expected to average less than 30 hour of service per week after the change, even if that reduction does not result you being ineligible for the group health plan and your termination from the medical benefit corresponds with intended enrollment for you and your dependents in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

- Events that cause your Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstances.

- A change in your place of residence, the place of residence of your Spouse or Dependent that affect eligibility for benefits under the plan.

General Consistency Rules: You may only make an election change pursuant to a change in status if your requested election change is consistent with that change in status. The Plan Administrator has sole discretion to determine whether a requested change is consistent with the change in status. Your election change will be consistent with the change in status only if the change is on account of and corresponds with a change in status *that affects eligibility for coverage under the Plan*. A change in status that affects eligibility under the Plan includes a change in status that results in an increase or decrease in the number of an Employee's family members or Dependents who may benefit from coverage under the Plan. *Please note, it is possible to experience a "change in status" event, but not have the change affect your eligibility to participate in the Plan's benefits or change benefit elections. In such case, you will not be able to make a change in your elections.*

Exception for COBRA Qualifying Events: If you, your Spouse or Dependent become eligible for continuation coverage under the Plan due to a COBRA qualifying event, you may elect to increase your contributions in order to pay for the continuation of coverage.

b. Judgment, Decree or Order. If there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a Qualified Medical Child Support Order, *see* Section F.9, that requires a change in accident or health coverage for your child or foster child who qualifies as your Dependent, you or the Plan Administrator may make an election change to add or drop coverage consistent with the terms and scope of the order.

c. Entitlement to Medicare or Medicaid. If you or your Spouse or Dependent becomes entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines), you may make a corresponding prospective election change to cancel or reduce coverage under the Plan. Similarly, if you or your Spouse or Dependent loses eligibility for Medicare or Medicaid, you may make a corresponding prospective election change to commence or increase coverage under the Plan.

d. Significant Cost or Coverage Changes. This applies to benefits other than the Health Care Flexible Spending Account.

- *Automatic Changes:* If there is an increase or decrease in the cost of a benefit, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective change to your premium election, to cover the change in cost.

- *Significant Cost Changes:* If the cost charged to Employees significantly increases or decreases during the Renewal Plan Year, as determined by the Plan Administrator, you may be allowed to make a new election for the option with the decreased cost or with respect to the higher cost option to revoke your election, but you must elect similar coverage if available

under the Plan. If there is an increase in the cost of Dependent care coverage, a change is permitted only if the dependent care provider is not a relative of the Employee.

- *Significant Curtailment without Loss of Coverage*: If coverage for you, your Spouse or Dependent is significantly curtailed under a benefit option during the Renewal Plan Year (without a total loss of coverage), you may revoke your election and make a new prospective election for similar coverage that is offered under the Plan. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided under the benefit option that constitutes reduced coverage generally. Thus, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

- *Significant Curtailment with Loss of Coverage*: If your coverage under a medical care provider ceases or is significantly curtailed during a Renewal Plan Year, you may revoke your election of that option and elect a new option prospectively which provides similar coverage (or, if there is no similar option, you may drop the coverage).

- *Addition or Improvement of a Benefit Option*: If the Plan adds a new benefit type or new option under an existing benefit during the Renewal Plan Year, or if coverage under an existing benefit or option is significantly improved during the Renewal Plan Year (i) Eligible Employees who are not Participants may prospectively elect the new benefit; and (ii) current Participants may revoke their existing elections of similar benefits and prospectively elect the new benefit or option.

- *Change in Coverage under Another Employer Plan*: You may make a prospective election change that is on account of and corresponds to a change made under another employer plan if such other plan is a cafeteria plan that permits election changes or has a Renewal Plan Year that is different from that of the Plan.

- *Loss of Coverage under Other Group Health Insurance*: You may make a prospective election change to add coverage for a Spouse or Dependent if you or your Spouse or Dependent loses coverage under a group health plan sponsored by a governmental or educational institution.

e. Special Family Medical Leave Act Requirements. An Employee who takes leave under the Family Medical Leave Act of 1993 (FMLA) may either continue participation or revoke his election of any benefit. See Section K.3 below for more details.

f. HIPAA Special Enrollment Rights. If you gain the right to enroll in medical coverage or to add coverage for a family member under the special enrollment rights of HIPAA,

see Section F.3, you may revoke an election for medical coverage during the Renewal Plan Year and make a new election.

2. New Hire Election and Annual Open Election Period

New Hire Election. If you are an Eligible Employee, you will be automatically covered under any Employer Paid Benefits. The Employer will provide enrollment forms as soon as administratively feasible after you are hired. You must complete and return the enrollment forms before the end of your Individual Election Period in order to elect Employer Subsidized and Optional Benefits for the remainder of the current Renewal Plan Year.

Annual Open Election Period. You may change your elections during the open election period prior to the beginning of each Renewal Plan Year. If you make no election, your coverage for any Employer Subsidized and Optional Benefits under the Plan will continue as previously elected with the exception of the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account where an annual election is required. The Employer may require you to complete enrollment forms from time to time.

3. Special Rules Regarding FMLA Leaves

You are required to pay for benefits continued during an unpaid FMLA Leave on a "pay-as-you-go" basis or provided the Plan Administrator so permits by advance withholding or catch-up payments upon return. Payments made during an unpaid FMLA Leave on a "pay-as-you-go" basis must be made on the same schedule and in the same manner as payments would be made if you were not on FMLA Leave, but will be made on a post-tax basis.

If you revoke your elections for medical and dental coverage during an unpaid FMLA Leave, and then return to work in the same Renewal Plan Year as an Eligible Employee, you may reinstate your election(s) which were in effect immediately before the unpaid FMLA Leave with respect to these benefits.

L. CLAIMS AND APPEALS UNDER THE PLAN

1. Overview.

Claims for benefits under the Plan should be brought in accordance with the claims procedures set forth in the Certificate of Insurance Booklet(s) for the component benefits provided under the Plan. These claims procedures are intended to comply with the Department of Labor regulations and the relevant guidance issued by the government.

2. Prohibition on Assignment.

Your rights under the Plan to be covered by the Plan's benefits, and to receive benefits and benefit payments under the Plan, are personal to you, and are not assignable in whole or in part to any person, hospital, provider or other entity; nor may the benefit of any such coverage be transferred, either before or after services covered under such benefit are rendered to you. Any

direct payments made under one of the Plan's health benefits to either an in-network or out-of-network provider shall not constitute a waiver of these terms that prohibit assignment of coverage and rights under such benefit, and any direction to pay any person, hospital, provider or entity shall not be treated as or constitute an assignment of any right under the particular Plan health benefit, or of any legal or equitable right to institute any court proceedings.

3. Statute of Limitation and Venue for Plan Claims.

Please note that no legal action may be commenced or maintained to recover benefits under component benefits of the Plan more than 24 months after the final review/appeal decision by the Claims Administrator has been rendered (or deemed rendered). Further, no legal action may be commenced or maintained to recover benefits under any component benefit of the Plan before you exhaust all claims procedures applicable to that benefit. All legal action commenced under the Plan must be brought in the federal court of proper jurisdiction in the Commonwealth of Virginia.

M. LOSS OF BENEFITS

Except as otherwise provided herein, you will lose coverage either upon your termination of employment or at the end of the month in which your termination of employment occurs. Your benefit coverages will also cease if you cease to be an Eligible Employee. As stated in the "Introduction," the Employer has reserved the right to amend or terminate the Plan and thus you will lose the right to future benefits if a benefit is eliminated or reduced or the Plan is terminated.

N. FUNCTION OF THE PLAN ADMINISTRATOR

The Plan Administrator (or its designees) shall have the exclusive authority to interpret the Plan, decide all questions of eligibility of persons to participate in the Plan, make findings of fact, correct any defect, and construe any uncertain or disputed term or provision in the Plan and this SPD, unless this function is the responsibility of an insurance Employer or carrier with respect to any fully-insured benefits. The determinations made in the exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, you, your estate, your beneficiaries, and the Employer. To the extent an insurer or other provider or a contract administrator exercises discretionary authority or discretionary responsibility over claims for benefits, it shall have the authority and discretion to construe any uncertain or disputed term or provision in its contracts, booklets, and certificates, or to determine the amount to be paid pursuant to a claim for benefits.

Additionally, the Plan Administrator has the authority and responsibility to (i) adopt such regulations, rules, procedures, and forms consistent with the Plan that are deemed necessary or desirable for the administration of the Plan; and (ii) employ individuals and firms to provide legal and actuarial advice and counsel, as necessary, to assure that the provisions of the Plan are properly interpreted and administered.

APPENDIX A
CERTIFICATE OF INSURANCE BOOKLET(S)

Medical – fully insured **Medical – self-funded**	Kaiser Permanente P.O. Box 371860 Denver, CO 80237-9998 301-468-6000 CIGNA P.O. Box 182223 Chattanooga, TN 37341 800-244-6224
Dental	Met Life P.O. Box 981282 El Paso, TX 799998-1282 800-638-5433
Employee Assistance Plan	Inova Health System 3949 Pender Drive, Suite 310 Fairfax, VA 22030 800-346-0110
Accidental Death and Dismemberment **Accidental Death and Dismemberment** **Life Insurance** **Supplemental Life Insurance** **Long Term Disability** **Short Term Disability**	Met Life P.O. Box 6100 Scranton, PA 18505-6100 800-854-6011
Health Care Flexible Spending Account **Dependent Care Flexible Spending Account**	Benefit Resources, Inc. 245 Kenneth Drive Rochester, NY 14623 866-996-5200
Vision	Avesis Third Party Administrators, Inc. Vision Claims Department P.O. Box 38300 Phoenix, AZ 85069-3800 800-828-9341