

**SUMMARY PLAN DESCRIPTION**

**FOR**

**VANTIVA**

**HEALTH & WELLNESS BENEFITS**

Revised January 1, 2024

# SUMMARY PLAN DESCRIPTION FOR VANTIVA HEALTH & WELLNESS BENEFITS

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# **SUMMARY PLAN DESCRIPTION FOR VANTIVA HEALTH & WELLNESS BENEFITS**

The welfare benefit programs summarized in this Summary Plan Description (Summary) are provided pursuant to the Vantiva Employee Benefit Plan (Employee Benefit Plan). This Summary Plan Description was prepared for eligible Employees and Dependents and describes the medical, prescription drug, dental, vision, employee assistance, and flexible benefit plan benefits available.

**Caution:** This Summary contains information which should help you understand your rights and benefits under the Plan; however, it is merely an overview of important provisions and features and does not describe all provisions, potential situations, possible benefits or requirements of the Plan, or determine your rights and benefits under the Plan, if any. Further, the terms used in this Summary have technical meanings defined in the Plan. The Definitions Section at the end of the Summary includes definitions for many of the terms used in the Summary. In some cases, the definitions provided here have been summarized or simplified.

This Summary does not create any right to employment and your status remains that of an at-will employee.

For the self-funded benefits described in this Summary, the Employee Benefit Plan document governs your rights. The Plan documents consist of the Employee Benefit Plan and the documents incorporated by reference.

For the insured benefits described in this Summary, the Plan document, the applicable insurance policy and the insurance certificates are the only governing legal documents of the Plan. This Summary does not modify the Plan or serve as an agreed interpretation of any provision of the Plan. You should not rely on this Summary as creating any legal rights. If you have a question about eligibility, cost, or when coverage begins or ends, you should refer to this Summary. If you have a question about covered or excluded benefits, you should refer to the applicable insurance policy and certificate.

Vantiva has appointed an Administrative Committee which acts on behalf of Vantiva. The Administrative Committee, in turn, has delegated certain administrative responsibilities to specific Employees. In addition, the Plan Administrator has delegated some of its responsibilities under the Plan to the Claims Administrator or Insurance Company, as specified in this Summary. The Plan Administrator or its designee(s) has full discretion and final authority to determine eligibility for benefits under the Plan and to interpret provisions of the Plan.

If you have any questions regarding the Plan or any action of the Administrative Committee, you should contact the Plan Administrator in writing at the Benefits Department at Vantiva USA Shared Services Inc., 4855 Peachtree Industrial Blvd., Suite 200, Norcross, GA 30092, USA.

# I. ELIGIBILITY, ENROLLMENT, AND CHANGING YOUR COVERAGE

## ELIGIBILITY

### Your Eligibility

If you are a Non-Represented Full-Time or Wholly Eligible Part-Time Employee, you are eligible to participate in the Medical, Dental, Vision and Flexible Benefit Plans after 30 days of Continuous Service. To be eligible, you must be at work on the day after you complete the 30 days. If the 31<sup>st</sup> day occurs on a Saturday, Sunday or scheduled Holiday, your coverage will begin on that day, as long as you were at work on your last scheduled workday. In certain cases (e.g., for purposes of the Medical, Vision, and Dental Plans), if you are not at work on the 31<sup>st</sup> day due to a health-status related factor (as defined in HIPAA), your absence may also count toward your completion of the 30-day waiting period.

You are not eligible to participate in the Medical, Dental, and Vision Plans if you are classified as any of the following (unless you otherwise meet the special eligibility rules relating to Vantiva's compliance with Patient Protection and Affordable Care Act's (PPACA's) requirements):

- Partially Eligible Part-Time Employee
- Summer student
- Intern
- Temporary (full-time, part-time, summer or other)
- Casual (full-time, part-time, supplemental or other)
- Non-resident alien with no U.S.-source income
- Person who is seconded or otherwise assigned to a Participating Employer in the United States under the terms of the Vantiva International Assignment Policy, or any other training or exchange program, unless such policy or program specifically provides that such persons are eligible to participate in the applicable plan.
- Person who is seconded or assigned outside the United States, unless a written agreement documents that such person is eligible to participate in the applicable plan.
- Person who performs services for a Participating Employer pursuant to an agreement with a third party, an independent contractor agreement, leasing agreement, consulting agreement, vendor agreement, or any other person employed under contract, unless such agreement or contract specifically provides that such person is eligible to participate in the applicable plan.

- An Employee who is covered by a collective bargaining agreement is eligible to participate in the applicable plan only if the collective bargaining agreement allows it.

Please note that the Employee Assistance Program (EAP) has different eligibility rules, so please refer to the EAP Section of this Summary for those particular eligibility rules.

### **Your Dependents' Eligibility**

You may cover the following Dependents as long as they meet the eligibility requirements for the applicable component plan:

- Your spouse.
- Your Child(ren).
- Your Domestic Partner and Your Domestic Partner's Child(ren), if you are a Non-Represented Employee.

Coverage for your Dependents will begin on the later of when your coverage begins or when the Dependents become eligible for coverage. Although coverage stops automatically when your Dependent is no longer eligible, premium payments will continue until you notify the Vantiva Benefits Solution Center.

You may be enrolled as an Employee or as a Dependent, but not both, if you and your spouse or Domestic Partner are Non-Represented Employees and are eligible for coverage. Your Children may be enrolled as Dependents of either spouse, but not both.

If you are a Non-Represented Employee and your spouse or Domestic Partner is an Employee on Layoff, your options for coverage include:

- You may elect family coverage or individual coverage under the Medical Plan)

An individual can be covered as either as an employee or a dependent but not both.

### **Request for Eligibility Determination**

If you believe that you are eligible to participate in the Plan under its terms, or if you believe that your participation should be on different terms than what has been offered to you, you should contact Vantiva Benefits Solution Center at (800) 284-7876.

If the Vantiva Benefits Solution Center informs you that you are not eligible to participate in the Plan, and you disagree with this response, you or your authorized representative may file a written eligibility determination request under this procedure at the following address. You must file your eligibility determination request within 30 days of the date the Vantiva Benefits Solution Center responds to your request.

Address your eligibility determination request to:

Vantiva USA Shared Services Inc.  
c/o: U.S. Benefits Manager  
4855 Peachtree Industrial Blvd., Suite 200  
Norcross, GA 30092, USA

The U.S. Benefits Manager will review your eligibility determination request and will respond to you in writing as soon as administratively practicable. The U.S. Benefits Manager has authority over all questions of eligibility and any decisions by the U.S. Benefits Manager as to an individual's eligibility to participate in the Plan will be final and binding.

## **COST OF COVERAGE**

You and Vantiva share the cost of your medical, dental, and vision coverage. The actual dollar amount of your contribution is determined by the medical plan and coverage level you elect. Detailed information about the specific dollar amount of contributions will be provided to you when you are hired and during each Open Enrollment period. In most cases, contributions will be deducted from your paycheck on a pre-tax basis. However, if you elect coverage for your Domestic Partner or his or her qualifying Children, federal tax laws require that their premiums be paid on an after-tax basis and imputed income taxes will apply.

Vantiva pays for your EAP benefits. However, you are solely responsible for paying for any HCFSA or Dependent Care Account benefits you elect.

## **ENROLLING IN COVERAGE**

Within the first 30 days of your employment, you will be provided with information about how to enroll. You must complete your initial enrollment before your 30<sup>th</sup> day of service. If you do not enroll within the 30 days, you must wait for the next annual Open Enrollment period to enroll for the following year, unless you have an event that allows you to make a mid-year election.

During the annual Open Enrollment period each fall, all Employees have the opportunity to change benefit elections. Elections made during annual Open Enrollment will be effective the following January 1, unless otherwise stated. If you choose not to make any changes during Open Enrollment, your Medical, Dental, and Vision Plan elections will stay the same as the election you made for the previous Plan Year unless Vantiva requires a positive enrollment for the new Plan Year as communicated during Open Enrollment. However, your HCFSA and Dependent Care Account elections will not carry over from year to year. Each year, you will be required to make a new election for the HCFSA and Dependent Care Account during Open Enrollment.

### **Mid-Year Election Changes**

To make a mid-year change, you must notify the Vantiva Benefits Solution Center within 30 days of the event that triggered the change, or within 60 days of the loss of Medicaid or

Children's Health Insurance Program (CHIP) coverage. You will be required to provide documentation of the change within 30 days of the change date the election is made.

If your cost of coverage increases or decreases because of your mid-year election, your compensation will be adjusted based on the cost of the new coverage. The change in your compensation will become effective on the first day of your next scheduled pay period after the new election and required documentation are filed.

### **CHANGE IN STATUS**

Mid-year changes are allowed for a variety of reasons. You may revoke or change your election for the rest of the Plan Year if the revocation and/or new election are both as a result of and consistent with a change in status. A change in status includes:

- **Marital Status.** A change in your legal marital status, including death of your spouse, marriage, divorce, legal separation or annulment
- **Dependents.** A change in the number of your Dependents through birth, adoption, placement for adoption or death of your spouse or Dependent
- **Employment Status.** You or your spouse experiences a change in employment (or employment status) which affects benefits eligibility, including:
  - You or your spouse begin or end employment
  - You or your spouse have a reduction or increase in hours of employment due to a:
    - Change from part-time to full-time or full-time to part-time,
    - Strike or lockout, or
    - Beginning or ending an unpaid leave of absence
- **Change in Dependent Status.** Your Dependent becomes eligible or ineligible for coverage
- **Change in Residence.** You, your spouse and/or Domestic Partner or your Dependent changes a place of residence or work
- **Change in Coverage under Another Employer Plan.** You may make a prospective election change that is a result of and corresponds with a change under another employer's plan in one of two situations: one, if the other plan allows an election change that also is allowed under the change in status rules of this Plan, or two, if the other plan allows Participants to make an election for less than or more than a calendar year. In addition, you may make a prospective election change to add health coverage if you or your spouse or Domestic Partner or Dependent loses coverage under any group health coverage that is sponsored by a governmental or educational institution.

- **Qualified Medical Child Support Order (QMCSO).** If a QMCSO is in place that affects your Child or dependent foster Child, you may change your coverage election to either:
  - Cover the Child, if the order requires coverage for the Child under your health coverage, or
  - Cancel coverage for the Child if the order requires your spouse, former spouse or other individual to provide health coverage for the Child and that coverage is provided

The Claims Administrator will provide the Child, Custodial Parent or legal guardian with information about how to obtain benefits and submit claims.

- **Nondiscrimination Requirements.** If the Plan Administrator determines that any part of the Plan may not satisfy any applicable nondiscrimination requirement imposed by the Code, the Plan Administrator will cancel or revise the elections of key Employees to satisfy the Code’s nondiscrimination requirements.

**The following change in status events are applicable to only certain of the benefits described in this Summary.**

- **Change in Cost. (not applicable to EAP or HCFSA)** Your cost of coverage under the Medical Plan or HMO alternative, Dental, Vision, or Dependent care Account significantly increases or significantly decreases during the Plan Year. You may:
  - Revoke your existing coverage elections and elect coverage for the remainder of the year under another option that provides similar coverage,
  - Drop your coverage if there is no other benefit option providing similar coverage, or
  - Elect an option with a significant decrease in cost
- **Addition or Improvement of Coverage Options. (applicable to Medical, Dental, and Vision Plans only)** If a coverage option is added under the Medical Plan or an HMO alternative (or if coverage under an existing option is significantly improved) during the Plan Year, you may revoke your election and elect coverage under the new or improved option for the rest of the year.
- **Medicare or Medicaid. (applicable to Medical Plan and HCFSA only)** You may cancel or reduce coverage for the affected person for the remainder of the year, if you, your spouse or Domestic Partner or your Dependent becomes entitled to Medicare or Medicaid benefits (other than coverage under the program only for distribution of pediatric vaccines). If coverage is lost under Medicare or Medicaid, you may change your, your spouse’s or Domestic Partner’s or your Dependent’s election to begin or increase coverage for the affected person for the remainder of the year.

- **Significant Reduction with Loss of Coverage. (applicable to Medical Plan only)** If your coverage under the Medical Plan or HMO alternative is significantly reduced and results in a “loss of coverage,” you may:
  - Revoke your existing coverage election and elect to receive coverage for the remainder of the year under another option that provides similar coverage, or
  - Drop your coverage if there is no similar option available under the Plan

A “loss of coverage” means:

- A complete loss of coverage, including the elimination of the option, an HMO no longer being available in the area where you reside or you losing all coverage under the option because of a lifetime or annual coverage limitation, or
  - Any other fundamental loss of coverage as determined by the Plan Administrator
- **Significant Reduction without Loss of Coverage. (applicable to Medical Plan only)** If your coverage under the Medical Plan or HMO alternative is significantly reduced (e.g., a significant increase in the Deductible, Copay or out-of-pocket cost sharing limit under a group health plan coverage option) but there is not a loss of coverage, you may revoke your coverage election and elect coverage for the remainder of the year under another option that provides similar coverage. Your coverage under the Medical Plan or HMO alternative is “significantly reduced” only if there is an overall reduction in coverage.

### **SPECIAL ENROLLMENT (APPLICABLE TO MEDICAL PLAN ONLY)**

Certain status changes create a Special Enrollment. You may be eligible for special mid-year election changes if you or your Dependents lose other coverage or if you gain a new Dependent. No eligible Dependent (spouse, Domestic Partner or Child) may be enrolled unless you already are a Participant in the Medical Plan (or an HMO alternative) or are enrolling yourself at the same time. You and your eligible Dependent must be enrolled in the same Medical Plan or HMO.

Descriptions of Special Enrollment situations follow.

**Loss of Other Coverage.** If you are eligible for coverage under the Medical Plan and you previously declined coverage for yourself and/or your Dependents because you and/or your Dependents had coverage under another group health plan or other health insurance, you may enroll yourself and/or your Dependent in the Medical Plan (or an HMO alternative) when you lose the other coverage, if:

- The persons being enrolled had other health coverage when coverage under the Medical Plan (and HMO alternatives) was declined, or if both you and your Dependents are being enrolled, at least one of you had other health coverage when coverage under the Medical Plan (and HMO alternatives) was declined,

- The other health coverage was lost because of any of the following:
  - The COBRA continuation period ended,
  - Eligibility under the other coverage was lost (such as losing eligibility due to legal separation, divorce, death of your spouse or a parent or termination of employment), or
  - Employer contributions for the other coverage ended

To qualify, the other coverage cannot be lost because you did not pay premiums on a timely basis, or because of an event that resulted in your coverage ending for cause, including, but not limited to, submission of a fraudulent claim or misrepresentation,

- The persons to be enrolled are otherwise eligible for coverage under the Medical Plan, and
- You provide documentation of the date the other coverage was lost

If you meet the requirements above, coverage will be effective as of the date you submit the written application and any necessary documentation to the Vantiva Benefits Solution Center.

***Children’s Health Insurance Program (CHIP) and Medicaid.*** You may enroll yourself and/or your Dependents in the Medical Plan (or an HMO alternative) for either of the following reasons:

- You and/or your Dependent loses Medicaid or CHIP coverage because of a loss in eligibility for that coverage, or
- You and/or your Dependent becomes eligible for premium assistance under Medicaid or CHIP

To be enrolled:

- The person(s) added must be eligible for coverage under the Medical Plan,
- You must provide documentation of the date coverage was lost or you became eligible for premium assistance, and
- You must submit a completed enrollment form to the Vantiva Benefits Solution Center within 60 days of the loss of Medicaid or CHIP coverage or the date you are eligible for premium assistance

***Acquire a New Dependent.*** If you are enrolled in the Medical Plan (or an HMO alternative) or if you are eligible for coverage and you waived coverage, you may enroll yourself, your spouse or Domestic Partner, any new Dependent Children you gain by birth, marriage, adoption or

placement for adoption, or any new qualifying Children of your Domestic Partner, as long as any of the following occur:

- You gain a new Dependent child or spouse through marriage,
- You gain a new Dependent Child through birth, adoption or placement for adoption, or
- Your Domestic Partner satisfies the eligibility requirements

Coverage for a newborn, newly adopted or newly placed Child will be effective as of the date of birth, adoption or placement for adoption. Coverage for others will be effective on the date you submit the completed enrollment form and documentation.

## II. VANTIVA MEDICAL PLAN (PPO PLUS HSA)

The Vantiva PPO PLUS HSA Plan (“Medical Plan” or “Plan”) offer you and your Dependents medical and Prescription Drug coverage that includes a choice of using In-Network Providers or Out-of-Network Providers; however, the Plan is designed to pay a higher benefit when you receive services from In-Network Providers.

In some Geographical Areas, Health Maintenance Organizations (HMOs) are available to provide your medical care. Normally, HMOs provide treatment that is similar to the treatment you are reimbursed for under the Medical Plan, but some benefits may be different. If Vantiva has an arrangement with a qualified HMO that provides service in your area, you will be offered the choice of an HMO in addition to the Medical Plan. You will receive information about an HMO if one is available to you.

### COVERAGE LEVELS

During enrollment, you must choose one of the following levels of coverage under the Medical Plan:

- No Coverage.
- Coverage for yourself only.
- Coverage for yourself and spouse (or Domestic Partner) or Coverage for yourself and your Children.
- Coverage for yourself and your family (spouse or Domestic Partner plus Children).

### HOW MEDICAL COVERAGE WORKS

Before you look at the medical plan in greater detail, you should be familiar with the terms in this section.

#### **Deductible**

If you have coverage for yourself only, you must meet the individual Deductible for the plan in which you are enrolled.

#### *PPO Plus HSA Plan*

If you have family coverage under the PPO Plus HSA Plan, the individual Deductible does not apply. The sum of the amounts applied for all family members must meet the family Deductible limit.

For example, if the In-Network Deductible is \$1,600 for an individual and \$3,200 for a family, if you cover yourself plus two Dependents under the PPO Plus HSA Plan and you incur covered costs of \$2,000, but your Dependents have incurred no covered costs for the calendar year, your In-Network Deductible will not be met until you (or your Dependents) incur an additional \$600 of covered costs. For Cigna participants, only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network deductibles.

Note: Behavioral health care and substance abuse services apply to the Deductible.

Deductibles cross apply. This means that any services or supplies you receive from an In-Network Provider that require a Deductible will apply to your In-Network and Out-of-Network Deductibles, and any services or supplies you receive from an Out-of-Network Provider that require a Deductible will apply to your In-Network and Out-of-Network Deductibles.

Deductibles you met with a prior insurance carrier do not carry over to the Medical Plan. In addition, Deductibles you met under the Medical Plan in the last quarter of a previous Plan Year do not carry over to the following Plan Year.

### **Coinsurance and Copays**

Coinsurance and Copays are your share of the medical costs after the Medical Plan pay. Coinsurance is a percentage of the eligible expenses you pay. For example, when the Medical Plan pays 80% and you pay 20%, the 20% you pay is coinsurance and counts toward your Out-of-Pocket Maximum.

A Copay is a flat-dollar amount that you pay under the medical plan. For example, if a \$25 Copay is required for an office visit with a primary care Physician (PCP), then the Plan pays the remaining eligible charges.

### **Out-Of-Pocket Maximum**

The Medical Plan limits your annual out-of-pocket costs through an Out-of-Pocket Maximum. After the annual limit is reached, the Medical Plan pay 100% for Covered Medical Expenses for the rest of the calendar year for both In-Network and Out-of-Network Provider charges.

Under the PPO Plus HSA Plan, if you have family coverage, out-of-pocket costs for all family members are combined to satisfy the family maximum. Once the family maximum is met, the PPO Plus HSA Plan pays 100% of Covered Medical Expenses for you and each Enrolled Dependent for the rest of the calendar year.

The following expenses apply to your Out-of-Pocket Maximum: your annual individual and family Deductibles and coinsurance.

The following expenses for Anthem do not apply to your Out-of-Pocket Maximum: flat dollar Copays DO apply to OOP, charges that are more than Reasonable and Customary allowances, non-Covered Services (including, but not limited to, charges for use of an Emergency Room for

non-Emergency Care), and services that are not Medically Necessary. For Cigna participants, all copays and benefit deductibles contribute towards your out-of-pocket maximum.

Note: Behavioral health care and substance abuse services apply to the Out-of-Pocket Maximum.

Out-of-Pocket Maximums cross apply. This means that any services or supplies you receive from an In-Network Provider that normally would apply against your Out-of-Pocket Maximum will count toward your In-Network and Out-of-Network Out-of-Pocket Maximums, and any services or supplies you receive from an Out-of-Network Provider that normally would apply against your Out-of-Pocket Maximum will apply to your Out-of-Network and In-Network Out-of-Pocket Maximums.

**Lifetime Maximum**

There is no lifetime maximum benefit limit under the Medical Plan.

**BENEFITS UNDER THE MEDICAL PLAN**

**The Claims Administrator**

Each Medical Plan has a Claims Administrator. Benefits under the Medical Plan are provided through these Claims Administrators.

Claims Administrator	
<b>Anthem</b> Vantiva PPO PLUS HSA Plans (outside Memphis)	
• Pre-Certification	(866) 454-3592
• Administration	(866) 542-4469 / (866) 452-1276
• Web site	<a href="http://www.anthem.com">www.anthem.com</a>
• Network option	National BlueCard option
• Transplant Coordinator	(866) 513-6934
<b>CIGNA</b> Vantiva PPO PLUS HSA Plans (Memphis Location)	
• Telephone	(800) 244-6224
<b>Prescriptions – CVS/Caremark</b>	
• Claims Administration	(866) 475-0056
• CVSHealth Member Services	(800) 552-8159
• Prescription Drug Web site	<a href="http://www.caremark.com">www.caremark.com</a>
• Specialty Prescription Drug Program	CVS Specialty Pharmacy (800) 237-2767 or <a href="http://www.cvscaremarkspecialtyrx.com">www.cvscaremarkspecialtyrx.com</a>  SGM (Specialty) CALL FOR MD’s (866) 814-5506

• Mail Order Service	CVS/Caremark (866) 475-0056
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### Selecting A Provider

Benefits under the Medical Plan are provided through the Medical Plan Claims Administrators and feature a network of Physicians, Specialists and Hospitals called In-Network Providers. Each local network is carefully structured to include a full range of general medical services (such as ambulatory surgery, intensive care, cardiology, oncology and obstetrics/gynecology) as well as a broad range of specialties (such as burn care, Hospice program, organ transplants and trauma care).

Information about how to find an In-Network Provider can be found in the supporting literature provided by your plan’s Claims Administrator or at its Web site. When searching online, be certain to select the correct network option for your plan’s Claims Administrator.

## OBTAINING COVERED SERVICES

Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend, or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service, and does not guarantee payment by the Medical Plan. During its review of your claim, the Claims Administrator will determine whether services or supplies are Medically Necessary and will determine if a service or referral is Medically Necessary.

### Identification Card

When you receive care from a Provider, you must show your Identification Card. Possession of an Identification Card does not give you a right to receive benefits from the Medical Plan.

To be entitled to services or benefits, you must be covered at the time the service is received. If you receive services or other benefits and you are not entitled to them under the Medical Plan, you will be responsible for the actual cost of those services or benefits.

The amount payable for Covered Services varies depending on whether you receive your care from an In-Network Provider or an Out-of-Network Provider. Benefits paid for Covered Services are based on the Maximum Allowable Amount for a service. Plan payment for Covered Services will be limited by any Copay and/or Deductible that you are required to pay.

### In-Network Services And Benefits

When you receive care from an In-Network Provider, benefits will be considered In-Network Services. If the type of Provider you need is not included in the network, contact the Claims Administrator, who may approve an Out-of-Network Provider for that service as an Authorized Service.

You will not be required to file any claims when you receive services from In-Network Providers. In-Network Providers will seek compensation for Covered Services from the Medical Plan and not from you, except for approved Copays and/or Deductibles.

### Out-Of-Network Services and Benefits

A service which is not obtained from an In-Network Provider or not as an Authorized Service will be considered an Out-of-Network Service. The exception is Emergency Care. All Out-of-Network benefits are based on Reasonable Charges. In addition, certain services are not covered unless they are obtained from an In-Network Provider.

You are responsible for filing claims and paying any higher cost sharing amount required under the Medical Plan for services provided by an Out-of-Network Provider. If you use an Out-of-Network Provider, in addition to any Copay or Deductible, you are responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount. Out-of-Network Providers will bill you for that difference.

If there is no In-Network Provider who is qualified to perform the treatment you require, contact the Claims Administrator before receiving the service or treatment, and the Claims Administrator may approve an Out-of-Network Provider for that service as an Authorized Service.

## **PRE-CERTIFICATION**

Pre-certification is required for Inpatient Hospital, Residential Treatment, Skilled Nursing Facility, Home Health Care, Hospice care and private duty nursing care. Pre-certification is not required for Covered Services; however, it is recommended so that you and your Provider have an understanding of the charges that will be covered by the Medical Plan before services are provided and expenses are Incurred.

If you use an In-Network Hospital or Specialist, that Provider can initiate the pre-certification process. If you choose to use a Provider who is not part of the network, you should contact your Claims Administrator for pre-certification.

## **COVERED AND NON-COVERED SERVICES**

The applicable Claims Administrator (e.g., Anthem or Cigna) has prepared summaries describing the benefits covered and excluded under each of the PPO Plus Options. Please refer to the applicable summary for information regarding each option.

## **EXCLUSIONS AND LIMITATIONS**

The applicable Claims Administrator has prepared summaries describing the benefits covered and excluded under each of the PPO Plus Options. Please refer to the applicable summary for information regarding each option.

## PRESCRIPTION DRUG PROGRAM

The Medical Plan includes a Prescription Drug Program for you and your Enrolled Dependents. Under the Prescription Drug Program, you have two options for purchasing Prescription Drugs — retail and mail order.

At retail, you may obtain up to a 30-day supply of your medication or a 90-day supply of your maintenance medication. The 90-day supply must be filled through CVS/Caremark mail order or at a CVS or Target retail pharmacy location.

To be covered by the Medical Plan, Prescription Drugs must be Medically Necessary and not Experimental/Investigative, unless it is stated differently in this document. The Plan may establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan or utilization guidelines.

### Formulary

A Formulary is an extensive list of FDA-approved, Brand Name and Generic Drugs that are proven to be effective. Hospitals and health plans have been using prescription formularies for many years as an effective way to manage costs. The Formulary is reviewed from time to time and may change. Just because a drug or related item is on the Formulary does not mean it is covered.

To access the Formulary used by the Prescription Drug Program:

- Log in to the CVSHealth member portal at [www.caremark.com](http://www.caremark.com)

### Prior Authorization

Prior Authorization may be required to fill a prescription for certain Prescription Drugs or to receive the prescribed quantity of a particular drug. When you fill a prescription, the In-Network pharmacist's computer system alerts the pharmacist of the Prior Authorization requirement. Your physician will need to contact CVS/Caremark at phone: 800-294-5979 or fax 866-303-1654 to provide the necessary clinical information in order for the claim to be allowed to be processed.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the *Claim Filing and Appeals* section. To see if your drug requires a Prior Authorization, give CVSHealth Member Services a call or visit the member portal at [www.caremark.com](http://www.caremark.com).

### Covered Prescription Drug Benefits

The following are covered under the Prescription Drug Program:

- Prescription Legend Drugs

- Injectable insulin and syringes used for administration of insulin
- Contraceptive drugs when obtained through an eligible Pharmacy
- Certain supplies and equipment obtained by Mail Service or from an In-Network Pharmacy are covered with a Copay. Contact the CVS/Caremark Claims Administrator to determine which supplies are covered.

If certain supplies, equipment or appliances are not obtained by Mail Service or from an In-Network Pharmacy, they are covered as Medical Supplies, Durable Medical Equipment and Appliances instead of under Prescription Drug Benefits.

- Brand Name drugs – If an employee requests a brand name drug when a physician indicates that a generic is acceptable the employee will pay a differential in addition to the copay amount.
- Injectables
- Over-the-counter (OTC) Proton Pump Inhibitors such as Prilosec OTC, omeprazole 20mg OTC, Prevacid24HR, lansoprazole 15mg OTC, and Zegerid OTC.
- Over-the-counter (OTC) Non-sedating antihistamines such as Alavert (D), Allegra (D), Claritin (D), Zyrtec (D) including their generic; and in all forms and all in-store brands.

#### **Not Covered Prescription Drug Benefits**

Non-Covered Services include the following:

- Immunization agents
- Biological sera
- Drugs prescribed as a result of war or acts of war
- Drugs furnished by or paid under any plan or law of any government agency or organization, or under any workers' compensation law
- Drugs, devices and products or Prescription Legend Drugs with over-the-counter equivalents Drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device or product
- Off label use, except as otherwise prohibited by law or as approved by the Claims Administrator
- Drugs in quantities that are more than the quantity prescribed, or for any refill dispensed more than one year after the date of the original Prescription Order

- Charges for the administration of any drug
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including, but not limited to, samples provided by a Physician. This does not apply to drugs used in conjunction with a Diagnostic Service with chemotherapy performed in the office; they are Covered Services or drugs eligible for coverage under the Medical Supplies benefit.
- Any drug which is primarily for weight loss, except certain drugs for the treatment of morbid obesity may be Covered Services based on Medical Necessity
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for
  - Injectable insulin,
  - Sugar test tablets, test tape and acetone test tablets, and
  - Benedict’s solution or equivalent
  - OTC Proton Pump Inhibitors
  - OTC Non-sedating antihistamines
- Drugs in quantities which are more than the limits established by the Plan, or which exceed any age limits set by the Claims Administrator
- Any drug which is primarily for cosmetic purposes (including, but not limited to, preserving, changing or improving your appearance, such as changing the appearance or texture of your skin)
- Contraceptive devices, oral immunizations and biologicals are payable as Medical Supplies based on where the service is performed or the item is obtained (even though they are federal Prescription Legend Drugs). If these items are over-the-counter drugs, devices or products, they are not Covered Services except for contraceptive devices covered under the PPACA.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause
- Fertility drugs
- Any New FDA Approved Drug Product or Technology (including, but not limited to, medications, Medical Supplies or devices) for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The

Medical Plan and Specialty Prescription Drug Program may waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

### **Specialty Prescription Drug Program**

The Specialty Prescription Drug Program is administered by CVS Specialty Pharmacy. It is a full-service, specialty Pharmacy that manages and monitors high-cost specialty drugs. If you take specialty medications for conditions such as hemophilia, hepatitis, cancer, multiple sclerosis or rheumatoid arthritis, the Specialty Prescription Drug Program offers a support program, including a team of nurses, pharmacists and care coordinators, to help you achieve the best possible outcomes from your treatments. Specialty medications are limited to a 30-day supply and must be obtained through the CVS Specialty Pharmacy.

For a full listing of high-cost specialty drugs covered under the Specialty Prescription Drug Program, please contact CVS Specialty Pharmacy at (800) 237-2767 or the Web site at [www.cvscaremarkspecialtyrx.com](http://www.cvscaremarkspecialtyrx.com).

### **Preventive Prescriptions**

As part of PPACA, commonly referred to as “Health Care Reform,” some preventive medications are covered at 100 percent, with no Copay or Coinsurance required. These products may be eligible for coverage as PPACA preventive medications through CVS/Caremark at no cost to you, subject to a prescription and you meeting certain criteria (e.g., age requirements). Please contact CVSHealth to see if a preventive drug is required to be covered by PPACA in your particular situation.

### **How To Obtain Prescription Drug Benefits**

How you obtain your benefits depends upon whether you go to an In-Network or an Out-of-Network Pharmacy or you use the Mail Order Service.

***In-Network Pharmacy*** – When you fill a prescription at an In-Network Pharmacy, present your written Prescription Order from your Physician and your Identification Card to the pharmacist. The Pharmacy will file your claim for you, and you will be charged your Deductible and/or Copay at the point of purchase.

#### **Finding In-Network Pharmacies**

For a complete listing of network pharmacies in your area:

- Call (800) 552-8159
- Visit [www.caremark.com](http://www.caremark.com)

If you do not present your Identification Card, you will have to pay the full cost of the prescription. In this case, ask your pharmacist for an itemized receipt and submit it to the Claims Administrator with a written request for refund.

***Out-of-Network Pharmacy*** – For the Vantiva PPO PLUS HSA Plan, Out-of-Network Pharmacy claims are not covered, so you are responsible for paying the entire amount charged by the Pharmacy.

**Mail Order Service** – The Claims Administrator provides Mail Order Service. For information about how to use the Mail Order Service, contact your Claims Administrator.

When filling a prescription through the Mail Order Service, complete an Order and Patient Profile Form. You will need to complete the patient profile information only once.

You may mail written prescriptions you receive from your Physician, or you may have your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to pay the applicable Mail Order Service Deductible and/or Copay amounts when you request a prescription or refill.

### **Payment of Benefits**

The amount of benefits paid is based upon whether you receive the Covered Services from an In-Network Pharmacy, an Out-of-Network Pharmacy or the Mail Service Program. It is also based upon whether you obtain a Generic or Brand Name Prescription Legend Drug and whether Formulary Prescription Legend Drugs were dispensed.

If you choose a Brand Name Drug and a Generic equivalent is available, you pay the Brand Name Drug Copay plus the difference in cost between the Brand Name Drug and the Generic Drug. Where no Generic Drug is available, you are only responsible for the applicable Formulary or Non-Formulary Drug Copay.

**For the PPO PLUS HSA**, prescriptions are Covered Medical Expenses that are generally included in the Deductible.

However, in order to support the goal of ongoing good health, certain prescriptions are considered preventive and would be covered at 100% (\$0 Copayment) even before the Deductible is met. In order to determine if a drug is covered on this list, please go to [www.caremark.com](http://www.caremark.com), or call CVSHealth Member Services at 800.552.8159. Such preventive medications are only covered at no cost to the member with a prescription from the prescriber.

No payment will be made by the Plan for any Covered Service unless the negotiated rate is more than any Deductible and/or Copay that is your responsibility. Your Copay(s) and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the Plan from drug manufacturers or similar vendors. For Covered Services provided by an In-Network Pharmacy or through Mail Service, you are responsible for all Deductibles and/or Copay amounts. For Covered Services provided by an Out-of-Network Pharmacy, you are responsible for the applicable amount(s).

### **Appealing a Prescription Drug Claim Determination**

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be

initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to Caremark, Inc., Attn: Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084, or faxed to: 866-443-1172. A decision regarding your appeal will be sent to you within 15 days of receipt of your written request.

Please refer to the Claims and Appeals Procedure section of this Summary for more information.

## **MEDICARE**

Any benefits covered under both the Medical Plan and Medicare will be paid according to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions and federal law.

**Under most circumstances, Covered Persons under the Medical Plan will not be eligible for Medicare.** Federal law will determine whether the Medical Plan or Medicare will be the primary payor for each Covered Person who is eligible for Medicare. If Medicare is primary for a Covered Person, the benefits under this Plan will not duplicate any Medicare benefit a Covered Person is entitled to, including Parts B and/or D. When Medicare is the primary payor, all amounts payable by Medicare for services provided to Covered Persons will be reimbursed by or on behalf of the Covered Person to the Plan, if the Plan has made payment for the services.

If the Covered Person has not enrolled in Medicare Part B, the Medical Plan will calculate benefits as if the Covered Person had enrolled. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part D, the Plan will pay primary.

## **WORKERS' COMPENSATION**

The benefits under the Plan are not designed to duplicate any benefit Covered Persons are eligible for under the workers' compensation Law. All amounts paid or payable by workers' compensation for services provided to a Covered Persons will be reimbursed to the Medical Plan by, or on behalf of, the Covered Persons. It is understood that coverage under the Medical Plan is not in lieu of, and will not affect, any requirements for coverage under workers' compensation.

## **OTHER GOVERNMENT PROGRAMS**

Except to the extent that applicable law would require the Plan to be the primary payor, the benefits under the Plan will not duplicate any benefits a Covered Person is entitled to under any other governmental program. If the Plan has duplicated the benefits, all amounts payable

under government programs for services to Covered Persons will be paid to the Plan by or on behalf of the Covered Persons.

## **EXTENSION OF BENEFITS**

### **If You Are On Family Or Medical Leave under the Family and Medical Leave Act (FMLA)**

During an FMLA leave, you may continue coverage under the Medical Plan or alternative HMO by paying the required premiums.

### **If You Are On Medical Leave (Non-FMLA)**

During a Medical leave, you may continue participation for you and your eligible Dependents for up to six months (including any portion of the Medical Leave covered by the FMLA) by paying the same premium that active Employees pay for the level of coverage you have elected. At the end of the sixth month of Medical Leave, your coverage under the Medical Plan may end. Contact the Benefits Team at [Vantiva.benefits@Vantiva.com](mailto:Vantiva.benefits@Vantiva.com) or the Vantiva Benefits Solution Center by visiting [www.myVantivabenefits.com](http://www.myVantivabenefits.com) or by calling (800) 284-7876 for additional information about coverage during a Medical Leave.

### **If You Are On Approved Leave Of Absence**

During an Approved Absence other than an FMLA Leave or extended Medical Leave (e.g. beyond FMLA), you may continue coverage under the Medical Plan for up to six months by paying the required premiums. The cost for continued coverage may be different than the cost an active Employee pays. Your premium amount will be communicated to you when your absence begins. Coverage will not be continued beyond the end of an Approved Absence or under any circumstances for longer than six months.

### **Paying Your Premium While On Leave**

#### ***PAID LEAVE***

Your premiums will continue to be deducted from your pay on a pre-tax basis when you are on a paid leave where you continue to be paid directly through Vantiva. If your pay is not enough to cover your premiums, any shortage may be taken from your pay when you return to work. If your pay is provided through a third-party carrier (such as for short-term or long-term disability) you will be billed by BenefitPlan Manager (BPM) for the premiums you owe. You will be expected to make these payments to BPM. throughout your leave of absence.

#### ***UNPAID LEAVE***

If you are on an unpaid leave and continue your coverage, you will receive information about when and how premium payments should be made. Contact the Vantiva Benefits Solution Center at (800) 284-7876 if you have questions.

### **Important Information About Extension Of Benefits**

In each of the situations described above in this section, you must elect continued coverage by completing the election forms in a timely manner; otherwise you may lose your opportunity to continue your coverage. The election forms will be provided to you.

Included with the election form(s) will be information about the cost of coverage under each option. If you choose an option that requires contributions by you, you must make your payments in a timely manner as directed in the information provided, or your coverage will end.

### **If You Are on Layoff**

If you are laid off, the Human Resources Department at your work location will provide information about the medical benefits, if any, that can be continued while on layoff.

## **WHEN COVERAGE ENDS**

Coverage under the Medical Plan or an HMO alternative ends for you and/or your Enrolled Dependent(s) on the last day of the month during which:

- Your employment terminates,
- You retire or die,
- Your employment status changes and you are no longer eligible for coverage,
- You transfer to an employer not covered by the Medical Plan,
- You fail to make any required contribution toward the cost of coverage, or
- You become covered by a collective bargaining agreement that does not provide for participation in the Medical Plan or an alternative HMO.

Coverage under the Medical Plan ends if you elect an HMO alternative. Coverage under an HMO alternative ends if you elect a different HMO or one of the Medical Plan.

Coverage under the Medical Plan also ends if this Plan is discontinued by Vantiva. Coverage under an elected HMO ends if Vantiva discontinues its relationship with that HMO.

Coverage for an Enrolled Dependent ends when he or she is no longer an eligible Dependent.

Refer to the *COBRA* section of this Summary to determine whether or not you are eligible for COBRA continuation if one of these events occurs.

### **III.VANTIVA DENTAL PLAN**

The Vantiva Dental Plan (Dental Plan) encourages preventive and diagnostic dental care by paying a higher percentage of the claim for preventive and diagnostic care.

#### **COVERAGE LEVELS**

During enrollment, you must choose one of the following levels of coverage under the Dental Plan:

- No Coverage.
- Coverage for yourself only.
- Coverage for yourself and one eligible Dependent.
- Coverage for yourself and two or more eligible Dependents.

#### **DENTAL BENEFITS**

Please refer to the summary MetLife has prepared that describes the benefits covered and excluded under the Dental Plan.

#### **YOUR ANNUAL DEDUCTIBLE**

The Yearly Individual Deductible is the amount that you and each of dependent must pay for covered services to which such Deductible applies each year before the Plan will be benefits for such covered benefits. The Individual Deductible is \$50 per year. The family Deductible is \$150 per year. We apply amounts used to satisfy Yearly individual deductibles to the Yearly Family Deductible. Once the Yearly Family Deductible is satisfied, no further Yearly Individual Deductibles are required to be met. As with the Health Plan, at least one person in your family must meet the individual Deductible before the family deductible applies. The Deductible does not apply to Preventive Services & Supplies or Diagnostic Services & Supplies.

#### **MAXIMUM BENEFIT**

There is a maximum benefit of \$2,000 per individual per calendar year for Restorative & Prosthetic Care and Prosthetic Services & Supplies. In addition, there is a lifetime maximum benefit of \$3,000 per individual for Orthodontic Service & Supplies. There is no maximum applied to Preventive Services & Supplies, Diagnostic Services & Supplies or Oral Surgery & Supplies.

## DELTA DENTAL PREFERRED PROVIDER PROGRAM

The Preferred Provider Program (PPO) consists of a national network of carefully selected general and specialty Dentists. Dentists and specialists in the Network must meet rigorous credentialing standards. All participating Dentists have agreed to provide services at fees that are typically below the Reasonable Charges in their communities. Although benefits for eligible expenses are payable at the same percentages inside or outside of the Network (for example, 80% for oral surgery), you are likely to pay less when you use a PPO Network Dentist because they charge less.

**You are not required to use a PPO Network Dentist.** Each time you need care, you can visit any licensed Dentist, either inside or outside the PPO Network. However, your out-of-pocket costs are likely to be lower when you use participating PPO Network Dentists.

Visit [www.deltadentalins.com](http://www.deltadentalins.com) for a directory of participating Network Dentists in your area.

## FILING A CLAIM FOR BENEFITS

Delta Dental of California is the Claims Administrator for the Dental Plan. In most cases, the Dentist will file your claim electronically and you are not required to file a claim form. However, if your Dentist does not file the claim for you, you will need to submit a completed Dental Expense Claim Form or, if you used the Predetermination of Benefits feature of the Dental Plan, an outline of benefit payment marked to show that the work has been completed. The form must be completed by both the patient and the Dentist. Dental Expense Claim Forms are available from the Vantiva Benefits Solution Center by visiting [www.myVantivabenefits.com](http://www.myVantivabenefits.com) or by calling the Claims Administrator at the toll free number (888) 335-8227. You can also download and print a claim form from Delta Dental's website at [www.deltadentalins.com](http://www.deltadentalins.com). You can also call Delta Dental for more information or to verify coverage.

Please refer to the Claims and Appeals Procedure section of this Summary for more information.

## EXTENSION OF BENEFITS

### **If You Are On Family Or Medical Leave under the Family and Medical Leave Act (FMLA)**

During an FMLA leave, you may continue coverage while you are covered under the Dental Plan by paying the required premiums.

### **If You Are On Medical Leave (Non-FMLA)**

During a Medical leave, you may continue participation for you and your eligible Dependents for up to six months (including any portion of the Medical Leave covered by the FMLA) by paying the same premium that active Employees pay for the level of coverage you have elected. At the end of the sixth month of Medical Leave, your coverage under the Dental Plan may end. Contact the Benefits Team at [Vantiva.benefits@Vantiva.com](mailto:Vantiva.benefits@Vantiva.com) or the Vantiva Benefits Solution

Center by visiting [www.myVantivabenefits.com](http://www.myVantivabenefits.com) or by calling (800) 284-7876 for additional information about coverage during a Medical Leave.

### **If You Are On Approved Leave Of Absence**

During an Approved Absence other than an FMLA Leave or extended Medical Leave (e.g. beyond FMLA), you may continue coverage under the Dental Plan by paying the required premiums. The cost for continued coverage may be different than the cost an active Employee pays. Your premium amount will be communicated to you when your absence begins. Coverage will not be continued beyond the end of an Approved Absence or under any circumstances for longer than six months.

### **Paying Your Premium While On Leave**

#### ***PAID LEAVE***

Your premiums will continue to be deducted from your pay on a pre-tax basis when you are on a paid leave where you continue to be paid directly through Vantiva. If your pay is not enough to cover your premiums, any shortage may be taken from your pay when you return to work. If your pay is provided through a third-party carrier (such as for short-term or long-term disability) you will be billed by BenefitPlan Manager (BPM). for the premiums you owe. You will be expected to make these payments to BPM throughout your leave of absence.

#### ***UNPAID LEAVE***

If you are on an unpaid leave and continue your coverage, you will receive information about when and how premium payments should be made. Contact the Vantiva Benefits Solution Center at (800) 284-7876 if you have questions.

### **Important Information About Extension Of Benefits**

In each of the situations described above in this section, you must elect continued coverage by completing the election forms in a timely manner; otherwise you may lose your opportunity to continue your coverage. The election forms will be provided to you.

Included with the election form(s) will be information about the cost of coverage under each option. If you choose an option that requires contributions by you, you must make your payments in a timely manner as directed in the information provided, or your coverage will end.

### **If You Are on Layoff**

If you are laid off, the Human Resources Department at your work location will provide information about the dental benefits, if any, that can be continued while on layoff.

## WHEN COVERAGE ENDS

Coverage under the Dental Plan ends for you and/or your Enrolled Dependent(s) on the last day of the month during which:

- Your employment terminates,
- You retire or you die (except as provided above),
- Your employment status changes and you are no longer eligible for coverage,
- You transfer to an employer not covered by the Dental Plan,
- You fail to make any required contribution toward the cost of coverage,
- You become covered by a collective bargaining agreement that does not provide for participation in the Dental Plan, or
- The Dental Plan is discontinued by Vantiva.

Coverage for an Enrolled Dependent ends at the end of the month in which they are no longer an eligible Dependent.

Refer to the *COBRA* section of this Summary to determine whether or not you are eligible for COBRA continuation if one of these events occurs.

If you or your Dependents are undergoing dental treatment at the time coverage terminates, the following will be covered if treatment begins prior to your termination and continues within 90 days after coverage terminates:

- Fixed bridgework, crowns, inlays, onlays, or gold restorations, provided the preparation of the teeth took place prior to termination of coverage.
- Full or partial dentures, provided the impression was taken prior to termination of coverage.
- Endodontics, provided the tooth was opened for root canal therapy prior to termination of coverage.

These extended benefits, however, will not be paid if they are also covered under any other group insurance policy or group plan.

## IV. VANTIVA VISION PLAN

The benefits under the Vantiva Vision Plan (Vision Plan) are provided through The Guardian Life Insurance Company (Guardian) on an insured basis. The Employee pays the full cost of the Vision Plan. The following is intended to be only a summary of the benefits available under the Vision Plan. Full details are contained in the brochure distributed by Guardian.

### COVERAGE OPTIONS

During enrollment, you must choose one of the following levels of coverage for the Vision Plan:

- No Vision Plan Coverage.
- Vision Plan Coverage for yourself only.
- Vision Plan Coverage for yourself and your spouse.
- Vision Plan Coverage for yourself and two or more eligible Dependents.

### VISION PLAN BENEFITS

The Vision Plan gives you enhanced vision coverage. In most cases, you pay a fixed amount and the Vision Plan pays the remaining cost for the service, subject to specified limits. Guardian has providers nationwide. Guardian preferred providers are located in retail, neighborhood, medical and professional settings. If you do choose to go outside the network, you will receive a lower reimbursement for services.

For more details, please refer to the Guardian insurance certificate that describes the benefits covered and excluded under the Vision Plan.

### HOW TO USE THE VISION PLAN

If you have enrolled in the Vision Plan and you visit a Guardian network doctor, you will pay your copays to the doctor for the services covered under the Vision Plan (plus any charges for additional services received but not covered under the Vision Plan). You do not have to file any claims; Guardian will take care of paying the doctor directly.

If you have enrolled in the Vision Plan and you visit a doctor outside the Guardian network, you must send the itemized bill to Guardian for reimbursement. Claim forms and instructions for filing a claim are available on the Guardian website at [www.GuardianAnytime.com](http://www.GuardianAnytime.com)

#### **Benefit Claims and Appeal Procedure**

For full details regarding the benefit claims and appeal procedure for the Plan, you should consult the Guardian certificate.

The benefit claims and appeals process is fully outsourced to Guardian. Vantiva has no involvement whatsoever with decisions relating to benefit claims and appeals.

## **EXTENSION OF BENEFITS**

### **If You Are On Family Or Medical Leave under the Family and Medical Leave Act (FMLA)**

During an FMLA leave, you may continue coverage under the Vision Plan by paying the required premiums.

### **If You Are On Medical Leave (Non-FMLA)**

During a Medical leave, you may continue participation for you and your eligible Dependents for up to six months (including any portion of the Medical Leave covered by the FMLA) by paying the same premium that active Employees pay for the level of coverage you have elected. At the end of the sixth month of Medical Leave, your coverage under the Vision Plan may end. Contact the Benefits Team at [Vantiva.benefits@Vantiva.com](mailto:Vantiva.benefits@Vantiva.com) or the Vantiva Benefits Solution Center by visiting [www.myVantivabenefits.com](http://www.myVantivabenefits.com) or by calling (800) 284-7876 for additional information about coverage during a Medical Leave.

### **If You Are On Approved Leave Of Absence**

During an Approved Absence other than an FMLA Leave or extended Medical Leave (e.g. beyond FMLA), you may continue coverage under the Vision Plan by paying the required premiums. The cost for continued coverage may be different than the cost an active Employee pays. Your premium amount will be communicated to you when your absence begins. Coverage will not be continued beyond the end of an Approved Absence or under any circumstances for longer than six months.

### **Paying Your Premium While On Leave**

#### ***PAID LEAVE***

Your premiums will continue to be deducted from your pay on a pre-tax basis when you are on a paid leave where you continue to be paid directly through Vantiva. If your pay is not enough to cover your premiums, any shortage may be taken from your pay when you return to work. If your pay is provided through a third-party carrier (such as for short-term or long-term disability) you will be billed by BenefitPlan Manager (BPM) for the premiums you owe. You will be expected to make these payments to BPM throughout your leave of absence.

#### ***UNPAID LEAVE***

If you are on an unpaid leave and continue your coverage, you will receive information about when and how premium payments should be made. Contact the Vantiva Benefits Solution Center at (800) 284-7876 if you have questions.

### **Important Information About Extension Of Benefits**

In each of the situations described above in this section, you must elect continued coverage by completing the election forms in a timely manner; otherwise you may lose your opportunity to continue your coverage. The election forms will be provided to you.

Included with the election form(s) will be information about the cost of coverage under each option. If you choose an option that requires contributions by you, you must make your payments in a timely manner as directed in the information provided, or your coverage will end.

### **If You Are on Layoff**

If you are laid off, the Human Resources Department at your work location will provide information about the vision benefits, if any, that can be continued while on layoff.

## **WHEN COVERAGE ENDS**

Coverage under the Vision Plan ends for you and/or your Enrolled Dependent(s) on the last day of the month during which:

- Your employment terminates,
- You retire or you die,
- Your employment status changes and you are no longer eligible for coverage,
- You transfer to an employer not covered by the Vision Plan,
- You fail to make any required contribution toward the cost of coverage,
- You become covered by a collective bargaining agreement that does not provide for participation in the Vision Plan, or
- The Vision Plan is discontinued by Vantiva.

Coverage for an Enrolled Dependent ends at the end of the month in which they are no longer an eligible Dependent.

Refer to the *COBRA* section of this Summary to determine whether or not you are eligible for COBRA continuation if one of these events occurs.

## **V. VANTIVA EMPLOYEE ASSISTANCE PROGRAM**

The purpose of the Vantiva Employee Assistance Program (EAP) is to provide short-term counseling and access to information, resources and qualified, pre-screened referrals on personal concerns that affect your work and family life. The benefits under this EAP are not intended to replace any other benefits that may be available under the Vantiva Employee Benefit Plan.

### **ELIGIBILITY**

You (as an active Full-Time or Part-Time Employee or COBRA participant) and your Dependents become eligible to participate in the EAP on the first day of your employment with a Participating Employer. Your coverage and coverage of your eligible dependents is automatic; you do not need to take any steps to enroll.

#### **Dependents**

Dependents:

- Your spouse or domestic partner
- Your unmarried dependent children (whether or not they reside with you)
- Members of your household

Your child or the child of your spouse will be eligible to participate in the EAP in accordance with the terms of any QMCSO.

### **COST OF COVERAGE**

The Employer pays the full cost of participation in the EAP for you and your Dependents. You have no obligation to pay any premium or fees for EAP coverage or to obtain EAP services (other than during a leave of absence, as explained below); there are no premiums, Copayments, co-insurance, or deductible payments applicable to EAP services.

### **HOW THE PROGRAM WORKS**

The EAP is a confidential program that offers short-term counseling, information, resources and referrals, and self-screening tools via the telephone or the Internet. The EAP provides up to 8 counseling sessions per person per calendar year at no cost to you.

#### **Counseling**

From time to time, everyone experiences problems in daily living that can seem overwhelming. You may, for example, encounter difficult periods in a relationship, pressures at work, a marital

separation or divorce, troubled adolescents, or illness or death of someone close to you and your family members. For these situations, professional help is available by calling the EAP for assistance.

You may obtain professional assistance through the EAP in one of the following ways:

### ***SELF-REFERRAL***

You or your Dependent who desires confidential assistance for a personal problem should call the EAP Provider at (800) 846-6111 and ask to speak to an EAP Representative. You or your Dependent can call any time, 24 hours a day, seven days a week. The EAP Provider will either provide necessary assistance over the telephone or arrange for further confidential consultation in a counseling office in or near your community. All communication between you or your Dependent and the EAP Provider will be confidential, except as required by law or you consent to a disclosure.

### ***MANAGEMENT RECOMMENDATION***

Although EAP participation is always voluntary on the part of any Employee (or other eligible person) there are two general circumstances where a supervisor may become involved in the referral process for an Employee:

- When an Employee brings a personal problem to the attention of a supervisor, but work performance and attendance are within acceptable standards, a supervisor may suggest that an Employee use the EAP and may (with your permission) facilitate the initial contact with the EAP Provider.
- When there is a performance problem which requires disciplinary action, on a case-by-case basis, a supervisor may suggest that the Employee consider use of the EAP and may (with your permission) facilitate the initial contact with the EAP Provider.

Use of the EAP is strictly your decision. A decision to use the EAP will not adversely affect your employment status with a Participating Employer. At the same time, participation in the EAP in no way relieves you of the responsibility to meet acceptable work performance and attendance standards as determined by a Participating Employer. A performance problem will be addressed through the established disciplinary policies of the Participating Employer whether or not you receive assistance through the EAP.

**There is no cost to you for counseling services provided through the EAP. If your need is beyond the scope of the EAP, the EAP Provider will refer you to other resources. Fees may apply for services outside the EAP. However, some fees may be covered by a health plan in which you are enrolled.**

## **Work Life Benefits**

To assist you in balancing your work life with your family and personal responsibilities, the EAP includes a work/life consultation and referral services. The EAP can provide resources and referrals to help with work and family concerns such as:

- Becoming a Parent – preparing for pregnancy or adoption. The essentials of good parenting. Keeping kids safe. Keeping kids healthy.
- Child Care – Family child care homes, Day care centers. Options for varying schedules. Baby-sitters, nannies/au pairs. Emergency care. Sick care.
- School Age Decisions – Nursery schools, Montessori, Pre-K/Kindergarten. Before and after school programs. Public and private schools. Sectarian schools.
- Mature Transitions – Lifestyle changes. Health and wellness issues. Leisure time pursuits. Volunteer opportunities. Retirement housing options. Financial options.
- Special Needs – Testing and assessments. Intervention programs. Programs for the gifted. Schools for exceptional children. Handling birth disabilities.
- Emergency Care Services – Community resources. Nanny and baby-sitting service. Long-distance adult care giving. Home health agencies. Care for mildly ill.
- College – Pre-college planning. Junior/community colleges. Vocational/trade schools. Colleges and universities. PSAT and SAT/ACT preparation. Tutoring. Continuing education. Financial planning. Adult re-entry programs.
- Elder Care – Senior housing options. Community services and resources. Financial and estate planning. Independent living options. Residential care. Transportation services. Home health care. Care managers. Senior centers.

To talk with a consultant, you can call (800) 846-6111. You decide if you want to use the services or providers based on information provided to you by the consultants. You can also do a self-search and seek comprehensive information through the online website at [www.magellanascend.com](http://www.magellanascend.com). There is no cost to you for the referral, educational or consultative services.

## **Self-Screening**

If you or your Dependent needs help with mental health or substance abuse concerns, but are not ready to speak with a counselor, you or the Dependent can use the Magellan Self-Screening System (MSSS). The MSSS is a confidential resource that allows you to get help and information using the telephone and calling (866) 516-2485. Prompts on the EAP telephone system or website take you to the alcohol misuse or depression self-screenings.

There is no cost to you for this service.

## **Legal and Financial Consultation Services**

As part of the EAP, legal and financial consultation services are available to you and your Dependents. If you or your Dependent has a legal or financial concern, you can call (800) 846-6111 and a customer service representative will connect you to a legal or financial consultant from a nationwide network of attorneys, Certified Public Accountants (CPAs), registered investment representatives, banking professionals and former IRS agents and auditors. EAP consultants are available 24 hours a day, seven days a week to link you to legal and financial consultation services.

### ***LEGAL CONSULTATION SERVICES***

You and your Dependents are eligible for:

- One free initial face-to-face or telephonic consultation with a network lawyer for each separate legal matter per year and discounts on continuing legal services if the network lawyer is retained.
- Consultation on a full range of legal issues, such as civil/consumer, personal/family, business, real estate, will preparation and estate planning.
- One free initial face-to-face or telephonic consultation with a trained mediation professional that listens to your issues and assists with determining if mediation is the appropriate method for resolving the legal issue.

### ***FINANCIAL SERVICES***

You and your Dependents are eligible for:

- Unlimited free telephonic consultations for financial matters with a financial counselor.
- Consultation on a full range of financial services, such as budgeting, debt consolidation, lease/purchase of your next car, IRS matters, consumer credits, saving for retirement or saving for college education and identity theft or fraud-related event.
- One free initial face-to-face consultation with a local financial consultant for each separate matter per year for more complex financial planning issues.
- Free personalized reports such as pre-retirement analysis, college funding analysis, and stock option analysis through local financial consultants.

### ***ONLINE RESOURCES***

Through [www.magellanascend.com](http://www.magellanascend.com) you can obtain general information on a wide range of legal and financial topics, including many common issues and frequently asked questions. You will also have access to a legal library, mortgage and retirement calculators, over 5,000 state specific legal and financial forms, articles and ability to e-mail requests for referral services. The site also offers an interactive will preparation program free of charge.

## **EXTENSION OF BENEFITS**

### **If You Are On Family Or Medical Leave under the Family and Medical Leave Act (FMLA)**

During an FMLA leave, you may continue coverage while you are covered under the Employee Assistance Plan by paying the required premiums.

### **If You Are On Medical Leave (Non-FMLA)**

During a Medical leave, you may continue participation for you and your eligible Dependents for up to six months (including any portion of the Medical Leave covered by the FMLA) by paying the required premiums at the same rate as for active employees. At the end of the sixth month of Medical Leave, your coverage under the Employee Assistance Program may end. Contact the Benefits Team at [Vantiva.benefits@Vantiva.com](mailto:Vantiva.benefits@Vantiva.com) or the Vantiva Benefits Solution Center by visiting [www.myVantivabenefits.com](http://www.myVantivabenefits.com) or by calling (800) 284-7876 for additional information about coverage during a Medical Leave.

### **If You Are On Approved Leave Of Absence**

During an Approved Absence other than an FMLA Leave or extended Medical Leave (e.g. beyond FMLA), you may continue coverage under the Employee Assistance Plan by paying the required premiums at the same rate as active employees. Your premium amount will be communicated to you when your absence begins. Coverage will not be continued beyond the end of an Approved Absence or under any circumstances for longer than six months.

### **If You Are on Layoff**

If you are laid off, the Human Resources Department at your work location will provide information about the EAP benefits, if any, that can be continued while on layoff.

## **WHEN COVERAGE ENDS**

Your EAP coverage ends for you and/or your Enrolled Dependent(s) on the last day of the month during which:

- Your employment terminates,
- You retire or you die (except as provided above),
- Your employment status changes and you are no longer eligible for coverage,
- You transfer to an employer not covered by the Dental Plan,
- You fail to make any required contribution toward the cost of coverage,
- You become covered by a collective bargaining agreement that does not provide for participation in the Employee Assistance Program, or
- The Employee Assistance Program is discontinued by Vantiva.

Coverage for an Enrolled Dependent ends at the end of the month in which they are no longer an eligible Dependent.

Refer to the *COBRA* section of this Summary to determine whether or not you are eligible for COBRA continuation if one of these events occurs.

## **BENEFIT CLAIMS**

In most cases, you will not be required to file a claim form for EAP benefits. Services will be provided on request at no charge by telephone or through the website. If your request for services is denied, please submit a written request pursuant to the procedures described in the Claims and Appeals Procedure section of this Summary.

## VI. VANTIVA FLEXIBLE BENEFIT PLAN

The Vantiva Flexible Benefit Plan or Flex Plan provides Participants with four important benefits:

- 1) First, Participants can pay premiums for the Collected Vantiva-sponsored Medical Plan, an HMO, the Dental Plan and the Vision Plan on a pre-tax basis.
- 2) Second, the Flex Plan allows Participants to defer a portion of their compensation on a pre-tax basis to the Healthcare Flexible Spending Account (HCFSA) and request reimbursement from the Account for Eligible Medical Expenses Incurred for the Participant or his or her Dependent(s).
- 3) Third, the Flex Plan allows Participants to defer a portion of their compensation on a pre-tax basis to the Dependent Care Account and request reimbursement from the account for eligible Dependent Care Expenses.
- 4) Finally, the Flex Plan allows eligible Participants to defer a portion of their compensation on a pre-tax basis to a Health Savings Account (HSA) established and maintained outside the Flex Plan by a trustee/custodian designated by the Vantiva and also provides for pre-tax employer contributions to the HSA.

### PRE-TAX CONTRIBUTIONS

The Internal Revenue Service defines specific rules that allow for pre-tax contributions to pay for premiums for medical, dental and vision benefit plans. These rules specify when an election for contributions can be made and under what circumstances it may be changed. They are reflected throughout the pages of this Summary.

#### Enrollment

When you enroll in the Collected Vantiva-sponsored Medical Plan, an HMO, the Dental Plan or the Vision Plan, you elect to pay premiums on a pre-tax basis through the Flex Plan. Note, however, that premiums for coverage of a qualified Domestic Partner or children of a Domestic Partner, where available, must be paid on an after-tax basis. If your coverage election under one or more of the plans changes, the amount of your pre-tax premium contribution will also change.

#### Inactive Status (for HCFSA and Dependent Care Account only)

If you become inactive after making your enrollment election but before the beginning of the new Plan Year, your election will be revoked and you will not be enrolled for the new Plan Year. If you return to active status, you may make a new enrollment election for the remainder of the Plan Year within 30 days after your return to active status.

If you become inactive after the beginning of a Plan Year and return to active status during the same Plan Year, you will need to make a new election for the remainder of the year when your return to active status. If you do not make a new election, your election will be revoked and you will not be enrolled for the remainder of the Plan Year. You may make a new enrollment election for the following Plan Year.

If you become inactive and do not return to active status during the same Plan Year, your election will be revoked. If you return to active status in a subsequent year, you may make a new enrollment election within 30 days after your return to active status.

## HEALTHCARE FLEXIBLE SPENDING ACCOUNT (HCFSA)

Under the HCFSA provision of the Flex Plan, Participants can defer a portion of their compensation on a pre-tax basis to the HCFSA and request reimbursement from the Account for Eligible Medical Expenses Incurred for the Participant or his or her Dependent(s).

### Account Deferral Election

The minimum deferral election permitted is \$100 annually and the maximum deferral is the maximum annual amount statutorily allowed. If you elect to participate in the HCFSA, your annual election will be divided by the number of pay periods in the Plan Year. This amount will be deducted from each paycheck and contributed to your HCFSA.

The Plan Administrator may cancel or revise the elections of key employees under the HCFSA if necessary to satisfy the Code's nondiscrimination requirements. You will be notified if such a change affects you.

You should plan your enrollment very carefully and sign up only for the amount of money you will spend for Eligible Medical Expenses. Never over-estimate this amount because you forfeit any unused amount at the end of the Plan Year. Any forfeited funds under this Flex Plan are used to defray the cost of administration of the Flex Plan. ***Please note that funds designated for the HCFSA cannot be used to reimburse day care expenses and funds designated for the Dependent Care Account cannot be used to reimburse Eligible Medical Expenses.***

### Eligible Medical Expenses

Reimbursement from your HCFSA may be requested for Eligible Medical Expenses that qualify under Code Section 213. Reimbursement can be claimed only for your Eligible Medical Expenses or the Eligible Medical Expenses of an individual that you can claim as a dependent for federal income tax purposes. NOTE: *Domestic Partners and the children of Domestic Partners generally will NOT qualify.*

Examples of Eligible Medical Expenses are:

- Amounts applied toward your annual deductible and your copayment after benefits have been paid under the Collected Vantiva-sponsored Medical Plan, if you are enrolled in a plan that has deductibles and/or copayments;

- Amounts not paid under the Dental Plan or Vision Plan; and
- Charges for services not covered under Collected Vantiva-sponsored Medical Plan, an HMO, the Dental Plan or the Vision Plan, such as:
  - Prescription drug copayments;
  - Hearing tests;
  - Hearing aids not required as a result of an accident;
  - Orthodontia care not covered by the Dental Plan (see notes below regarding orthodontia);
  - Health screenings not covered by the Medical Plan Wellness Benefit;
  - Lasik eye surgery;
  - Vision care (periodic examinations, eyeglasses or contact lenses), not covered by the Vision Plan;
  - Cost and maintenance of "service animals" such as Seeing Eye dogs;
  - Contact lens supplies;
  - Weight loss or smoking cessation programs that are prescribed by a Physician for health related disorders;
  - Cost of special schools for the handicapped, such as teaching lip reading or Braille;
  - Marriage or family counseling.

This is not an all-inclusive list.

With regard to reimbursement for orthodontia expenses, the IRS has regulations that allow for reimbursement over 2 or more years in accordance with your payment contract. You are required to provide a copy of the contract when filing a claim for reimbursement. Following are some examples of how it works.

- **Example 1:** You have a 3-year contract starting in January under which the total cost is \$4,500 and you pre-pay \$1,500 of the \$4,500. In this example, you can claim \$1,500 in reimbursement for the first year and \$1,500 in each of the following 2 years if you continue to participate in the HCFSAs.

- **Example 2:** You did not pre-pay any of the \$4,500, but are making monthly payments. In this example, you could receive \$125.00 monthly or \$1,500 at the end of the year.

### **Ineligible Expenses**

The following expenses are excluded from the definition of Eligible Medical Expenses:

- Charges for any individual (other than yourself) who cannot be claimed as your dependent for federal income tax purposes;
- Charges for residence in a sanitarium or “rest home”;
- Cosmetic surgery (a surgery or treatment intended to alter or improve the appearance of any portion of the body). The Claims Administrator shall have full discretion and authority in determining whether surgery is cosmetic.
- Insurance, HMO or other premiums paid for any medical, dental, or vision coverage;
- Travel (Transportation for medical-related expenses would be covered);
- Legal fees of any kind (May qualify if the fees are in connection with a medical procedure);
- Any expenses for the purchase, modification or improvement of real property or a personal vehicle, whether or not prescribed by a Physician;
- Fees or dues for health club, fitness center, spa, or any similar facility (May be eligible with a doctor’s note);
- Experimental drugs or treatments whether or not prescribed by a Physician; and
- Qualified long-term care services, as defined in Code Section 7702B(c), or coverage for any product that is advertised, marketed or offered as long-term care insurance.

### **How To Apply For Reimbursement**

On the first day of each Plan Year, your HCFSA will be credited with the annual amount of the deferral you elected. Your HCFSA will then be reduced by each reimbursement amount paid for Eligible Medical Expenses.

If you enroll in the HCFSA, you will receive a medical reimbursement debit card and instructions on how and when you can use the debit card. When you pay for Eligible Medical Expenses using your debit card, payment will be made directly from your HCFSA. **You may be required to provide acceptable documentation of the Eligible Medical Expenses to substantiate your use of the debit card.** For more information about the Flex Plan debit card, contact the Claims Administrator at (800) 473-9595.

You may also request reimbursement of Eligible Medical Expenses that are Incurred during the Plan Year by submitting the appropriate Claim Form along with the following:

- The insurance explanation of benefits (EOB) for services covered by insurance; or
- an itemized bill for services not covered by insurance with the name of the provider, amount of service and description of the services rendered.

Your claim for reimbursement must be for services Incurred within the Plan Year. Any claims Incurred after the end of the Plan Year will only be reimbursed to the extent such claims are eligible for the next Plan Year. Claims for reimbursement from the balance in your HCFSAs for the Plan Year, must be submitted no later than March 31 to be considered for reimbursement.

Claim Forms are available at [claims@naviabenefits.com](mailto:claims@naviabenefits.com). Completed Claim Forms can be mailed or faxed to the Claims Administrator using the address or fax number [claims@naviabenefits.com](mailto:claims@naviabenefits.com) found on the Claim Form. You can also submit your claims electronically at. If you have questions about submitting a claim for reimbursement, call the Claims Administrator or (800) 669-3539.

You can log on to [claims@naviabenefits.com](mailto:claims@naviabenefits.com) at any time to view account information or request a statement of your HCFSAs.

Claims are processed on a daily basis. You may elect to have your reimbursements directly deposited to your checking or savings account.

### **Deadline for Submitting Claims**

Your claim for reimbursement must be for services Incurred within the Plan Year. All claims should be submitted as they are Incurred; however claims must be submitted no later than 90 days after the end of the Plan Year for charges Incurred during the Plan Year. Claims for services Incurred during the Plan Year may be submitted for reimbursement through March 31 of the following year. *Claims received more than 90 days after the end of the Plan Year will not be reimbursed.* Note: You do not have to be a participant in the current year to file a claim for expenses Incurred in the previous year under this provision.

### **Benefit Claims and Appeal Procedure**

For full details regarding the benefit claims and appeal procedure for the Flexible Benefit Plan, please see the Claims and Appeals Procedure Section.

### **Carryover And Forfeiture Of Unused Funds**

If you do not use the entire amount in your HCFSAs for Eligible Medical Expenses Incurred during the Plan Year, the unused balance (up to a maximum of \$500) can be carried over to the following Plan Year and used to reimburse Eligible Medical Expenses Incurred during that Plan Year. Federal tax regulations require that amounts remaining in your HCFSAs at the end of each Plan Year, and not used for Eligible Medical Expenses Incurred during the Plan Year will be

forfeited by you. As required by law, forfeited amounts, if any, will be used by Vantiva only to defray its administrative expenses under the Flex Plan.

As described in more detail below, you cannot participate in an HSA while you have a HCFSAs. If you have a HCFSAs in the current Plan Year and you elect to enroll in the PPO Plus HSA Plan for the following Plan Year, you cannot carry over a HCFSAs balance into the following Plan Year.

## **Extension Of Benefits**

### ***IF YOU ARE DISABLED***

If you become Totally Disabled during the Plan Year, you may continue to request reimbursement for Eligible Medical Expense Incurred prior to the date of your disability and up to your annual deferral election. If you want to receive reimbursement for Eligible Medical Expenses Incurred after you become Totally Disabled, you must elect to continue making contributions to your account through COBRA.

At the time of your Total Disability, you will be eligible for continuation of benefits under COBRA, as described in the COBRA section of this Summary. If elected, contributions made to your HCFSAs through COBRA will be made on an after-tax basis.

### ***IF YOU ARE ON AN APPROVED ABSENCE***

If you are on an Approved Absence, including an FMLA leave or extended Medical Leave (e.g. medical leave beyond FMLA), and are receiving compensation, your compensation deferral will continue and you will continue to participate in the Flex Plan as though you were an active Employee.

If you are on an Approved Absence other than FMLA leave and not receiving compensation, you are entitled to request reimbursement for Eligible Medical Expenses Incurred prior to the day you became an Inactive Participant, up to your annual deferral election. If you want to receive reimbursement for Eligible Medical Expenses Incurred after you go on leave, you must elect to continue making contributions to your account through COBRA. During an Approved Absence due to military or other uniformed service covered by USERRA, if you wish to continue coverage, please contact the Human Resources Department at your work location for more information.

If you are on an Approved Absence and not receiving compensation, you will be eligible for continuation of benefits under COBRA, as described in the COBRA section of this Summary. If elected, contributions made to your HCFSAs through COBRA will be made on an after-tax basis.

### ***IF YOU ARE ON FAMILY AND MEDICAL LEAVE***

If you become an Inactive Participant by taking an unpaid leave of absence that qualifies under the Family and Medical Leave Act of 1993 ("FMLA"), you have the same rights as those taking a non-FMLA Approved Absence. In addition to those rights, however, you may:

- Pre-pay the anticipated contributions for your FMLA leave on a pre-tax basis prior to your leave;
- Continue to make your contributions on an after-tax basis during your FMLA leave; or
- Discontinue contributions during your FMLA leave and elect to resume coverage on return from your unpaid FMLA leave even though you ceased required contributions.

### ***IF YOU DIE***

In the event of your death, your spouse, dependents or estate are entitled to request reimbursement for Eligible Medical Expenses Incurred prior to your death and up to your annual deferral election. Reimbursement of Eligible Medical Expenses Incurred prior to the date of your death will be paid to your estate.

If your spouse or dependent want to receive reimbursement for Eligible Medical Expenses Incurred after your death, your spouse or dependents must elect to continue making contributions to a HCFSAs through COBRA. If COBRA continuation coverage is elected, contributions made to a HCFSAs through COBRA will be made on an after-tax basis.

### **When Coverage Ends**

Coverage under the HCFSAs ends for you when:

- Your employment terminates,
- You retire or you die,
- Your employment status changes and you are no longer eligible for coverage,
- You transfer to an employer not covered by the HCFSAs,
- You fail to make any required contribution toward the cost of coverage,
- You become covered by a collective bargaining agreement that does not provide for participation in the HCFSAs, or
- The HCFSAs is discontinued by Vantiva.

If your participation ends, you (or your dependents, in the event of your death) are entitled to request reimbursement for Eligible Medical Expenses Incurred prior to your end date and up to your annual deferral election.

Refer to the *COBRA* section of this Summary to determine whether or not you are eligible for COBRA continuation if one of these events occurs.

If you are eligible for and elect COBRA continuation coverage under the HCFSA and make the required contributions, you are entitled to request reimbursement for Eligible Medical Expenses Incurred through the end of the calendar year during which your participation ends.

In the event of your death, reimbursement of Eligible Medical Expenses will be paid to your estate.

Example:

Joe elects to defer \$2,000 to his HCFSA for the 2024 Plan Year. Joe terminates his employment effective June 30, 2024.

If Joe does not elect COBRA continuation coverage, Joe may request reimbursement for Eligible Medical Expenses Incurred through June 30, 2024 up to the \$2,000 annual election under his HCFSA. Joe will not be required to make any additional contributions to his HCFSA.

If Joe does elect COBRA continuation coverage, Joe will continue to contribute to his HCFSA with after-tax dollars following his termination of employment. Joe may request reimbursement for Eligible Medical Expenses Incurred through December 31, 2024 (or if earlier, the end of his COBRA continuation period) up to the \$2,000 annual election under his HCFSA.

**The HCFSA and The PPO Plus HSA Plan**

If you plan to enroll in the PPO Plus HSA Plan and establish a Health Savings Account (HSA), then you must cease all participation with the Medical Reimbursement portion of the Flex Plan. You cannot participate in an HSA while you have a HCFSA. Further, if you are enrolled in the HCFSA during 2024, and intend to transition to an HSA in 2024, you cannot retain a balance at the end of 2024. If you elect to enroll in the PPO Plus HSA Plan for 2024 and you fail to use the funds in your HCFSA for eligible expenses incurred before the end of 2024, you will forfeit any funds remaining in your HCFSA balance after all claims are processed for 2024 through the end of the run-out period (90 days after the plan year ends).

**Dependent Care Account**

Under the Dependent Care Account provision of the Flex Plan, Participants can defer a portion of their compensation on a pre-tax basis to the Dependent Care Account and request reimbursement from the Account for eligible Dependent Care Expenses Incurred during the Plan Year.

**Account Deferral Election**

The minimum deferral election permitted is \$100 annually and the maximum deferral is \$5,000 annually. If both you and your spouse are employed by a Participating Employer, your combined maximum deferral is \$5,000 annually. If you elect to participate in the Dependent Care Account, your annual election will be divided by the number of pay periods in the Plan Year. This amount will be deducted from each paycheck and contributed to your Dependent Care Account each pay period.

The Plan Administrator may cancel or revise the elections of key employees under the Dependent Care Account if necessary, to satisfy the Code's nondiscrimination requirements. You will be notified if such a change affects you.

***You should plan your enrollment very carefully and sign up only for the amount of money you will spend for eligible Dependent Care Expenses. Never over-estimate this amount because you will forfeit any unused amount at the end of the Plan Year. Any forfeited funds under this Flex Plan are used to defray the cost of administration of the Flex Plan.*** Please note that funds designated for the Dependent Care Account cannot be used to reimburse Eligible Medical Expenses and funds designated for the HCFSAs cannot be used to reimburse Dependent Care Expenses.

### **Dependent Care Expenses**

Reimbursement from your Dependent Care Account may be requested for Dependent Care Expenses that satisfy Code Section 129.

Dependent Care Expenses must be Incurred for a qualified dependent, which is limited to:

- Children under 13 years of age,
- Children 13 or over who are physically or mentally unable to care for themselves, or
- A spouse or elderly parent residing in your home who is physically or mentally unable to care for himself or herself.

Generally, expenses that qualify for reimbursement include day care services necessary to allow you to work, look for work or attend school as a full-time student. This includes:

- Day care facility fees (excluding transportation, lunches, educational services);
- Before-school and after-school care;
- Local day camp;
- In-home baby-sitting fees (income must be claimed by your care provider); and
- Nursery school and preschool.

This list is not all inclusive.

Services can be provided by (1) an individual or (2) a dependent care center that provides care for more than six individuals (other than those residing at the facility), receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether or not the facility is operated for a profit), and is operated in compliance with the state laws and regulations. If an individual provides care for dependents in your home, expenses will not

qualify if paid to your child under the age of 19 or any dependent for whom you or your spouse can claim a personal exemption for income tax purposes.

The total of your reimbursed Dependent Care Expenses for the Plan Year may not exceed your and your spouse's total Earned Income (W-2 pay) for that year.

### **Ineligible Expenses**

The following expenses are excluded from the definition of Dependent Care Expenses:

- Expenses for overnight camps,
- Expenses for education or tuition,
- Placement fees for finding a day care provider, and
- Sports lessons, field trips, clothing, or transportation.

### **How To Apply For Reimbursement**

Each pay period, your Dependent Care Account will be credited with a portion of your annual deferral election. Your Dependent Care Account will then be reduced by any reimbursement amount paid for eligible Dependent Care Expenses only up to the amount of contributions already credited to your Dependent Care Account. You may request reimbursement of Dependent Care Expenses that are Incurred during the Plan Year by submitting the appropriate Claim Form along with a bill or itemized receipt from your provider containing the following information:

- Name of the provider,
- Dates of service, and
- Description of services (i.e. day care, before-school program, etc.).

Claim Forms are available at [claims@naviabenefits.com](mailto:claims@naviabenefits.com). Completed Claim Forms can be mailed or faxed to the Claims Administrator using the address or fax number found on the claim form. You can also submit your claims electronically at [claims@naviabenefits.com](mailto:claims@naviabenefits.com). If you have questions about submitting a claim for reimbursement, call the Claims Administrator or (800) 669-35.

You can log on to [www.naviabenefits.com](http://www.naviabenefits.com) at any time to view account information or request a statement of your Dependent Care Account. Claims will be processed two times per week. You may elect to have your reimbursements directly deposited to your checking or savings account.

### **Run-Out Period**

Your claim for reimbursement must be for services Incurred within the Plan Year. All claims should be submitted as they are Incurred; however, claims must be submitted not later than 90 days after the end of the Plan Year for charges Incurred during the Plan Year. Claims for

services Incurred during the Plan Year may be submitted for reimbursement through March 31 of the following year. *Claims received more than 90 days after the end of the Plan Year will not be reimbursed.* Note: You do not have to be a participant in the current year to file a claim under this provision for qualifying expenses Incurred in the previous year.

### **Benefit Claims and Appeal Procedure**

If a claim is denied, in whole or in part, the Claims Administrator will furnish a written or electronic notice of the denial.

### **Forfeiture Of Unused Funds**

Federal tax regulations require that amounts remaining in your Dependent Care Account at the end of each Plan Year and not used for Dependent Care Expenses Incurred during the Plan Year shall be forfeited by you. As required by law, forfeited amounts, if any, will be used by Vantiva only to defray its administrative expenses under the Flex Plan.

### **Extension Of Benefits**

#### ***IF YOU ARE DISABLED***

If you become Totally Disabled during the Plan Year, you may continue to request reimbursement for Dependent Care Expenses Incurred prior to the end of the Plan Year and up to the amount credited to your Dependent Care Account as of the date your Total Disability begins. To be eligible for reimbursement, any Dependent Care Expenses Incurred after the date you become Totally Disabled must be for expenses that allow your spouse to search for employment or remain gainfully employed.

#### ***IF YOU ARE ON AN APPROVED ABSENCE***

If you are on an Approved Absence, including FMLA leave and Extended Medical Leave, and are receiving compensation, your compensation deferral will continue, and you will be entitled to participate in the Flex Plan as though you were an active Employee.

If you are on an Approved Absence and not receiving compensation, you are entitled to request reimbursement for Dependent Care Expenses Incurred prior to the end of the Plan Year up to the amount credited to your Dependent Care Account.

In either case, to be eligible for reimbursement, any Dependent Care Expenses Incurred after the start of your Approved Absence must be for expenses that allow you or your spouse to search for employment or remain gainfully employed.

### **When Coverage Ends**

Coverage under the Dependent Care Account ends for you when:

- Your employment terminates,
- You retire or die,

- Your employment status changes and you are no longer eligible for coverage,
- You transfer to an employer not covered by the Dependent Care Account,
- You fail to make any required contribution toward the cost of coverage,
- You become covered by a collective bargaining agreement that does not provide for participation in the Dependent Care Account, or
- The Dependent Care Account is discontinued by Vantiva.

If your participation ends, you (or your estate, in the event of your death) are entitled to request reimbursement for Dependent Care Expenses Incurred prior to the end of the calendar year during which your participation ends and up to the amount actually credited to your account.

Example:

Joe elects to defer \$2,000 to his Dependent Care Account for the 2024 Plan Year. Joe terminates his employment effective June 30, 2024.

Joe's Dependent Care Account had been credited with \$1,000 as of the date of termination. No additional contributions can be made to Joe's Dependent Care Account. Joe may request reimbursement for eligible Dependent Care Expenses Incurred through December 31, 2024 up to the \$1,000 credited to his Dependent Care Account as of his termination date.

## **HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTIONS**

An HSA-Eligible Individual who participates in the Flex Plan and establishes a Health Savings Account (HSA) with the trustee or custodian designated by Vantiva can elect to defer a portion of his or her compensation on a pre-tax basis to the HSA. In addition, Vantiva will contribute an Employer HSA Contribution to the HSA of each participating HSA-Eligible Individual who establishes an HSA on a timely basis.

A "HSA-Eligible Individual" means an individual who is eligible to contribute to an HSA under Code Section 223, who enrolls in the High Deductible Health Plan offered by Vantiva and does not have a HCFSAs for the particular Plan Year.

Non-Represented Full-time and Wholly Eligible Part-Time Employees who are HSA-Eligible Individuals are eligible to make pre-tax HSA deferrals and receive Employer HSA Contributions after completing 30 days of Continuous Service.

### **Pre-Tax HSA Deferrals**

If you meet the eligibility requirements above, you may elect to defer a portion of your compensation on a pre-tax basis to your HSA. You can elect to make pre-tax HSA deferrals at

the time of hire or during the annual Open Enrollment process each fall. Elections made during Open Enrollment will be effective the following January 1. Your election will carry over from year to year.

Your election can be changed prospectively at any time. The change in the amount of the deferral resulting from the new election will become effective not later than the first day of the next calendar month after the election is submitted to the Vantiva Benefits Solution Center by calling (800) 284-7876.

Your maximum pre-tax HSA deferral for each Plan Year is set by the Code and depends on the coverage tier you elect under the High Deductible Health Plan. The statutory annual contribution maximum amount is reduced by any Employer HSA Contributions made on your behalf.

### **Employer HSA Contributions**

If you elect coverage under the High Deductible Health Plan offered by Vantiva and establish an HSA with the trustee/custodian designated by Vantiva by the end of the first payroll period in January, Vantiva will contribute a certain amount for the first payroll period in January if you are an HSA-Eligible Individual as of January 1 of the calendar year; and a smaller amount for each subsequent payroll period in the calendar year during which you are an HSA-Eligible Individual. Such amounts will differ based on whether you elected **employee-only coverage** or **employee + spouse or employee + family coverage** under the High Deductible Health Plan offered by Vantiva.

If you are an HSA-Eligible Individual on January 1, but you have not established an HSA with the trustee/custodian designated by Vantiva at the start of the Plan Year, the applicable Employer HSA Contribution will be paid in full if you establish an HSA with the trustee/custodian designated by Vantiva prior to the last payroll processing date for the Plan Year.

No Employer HSA Contribution will be made for any payroll period beginning after the date you are laid-off or terminate employment.

### **Wellness HSA Incentive Contribution**

Employees who participate in the PPO Plus HSA Plan also have an opportunity to earn an additional Employer HSA Contribution for the employee and their covered spouse/domestic partner. If you and/or your covered spouse/domestic partner complete a health assessment through the Vantiva Wellness & Lifestyle Rewards Program Provider within the specified time limits, Vantiva will make an additional contribution to your HSA. The health assessment can be accessed by logging in to [www.myHealthCheck360.com](http://www.myHealthCheck360.com) (Company Code: TECHN). The total dollars that you can earn will be communicated in the New Hire Benefits Guide and Open Enrollment Benefits Guide. Employees must complete the health assessment within 90 days from the date they become eligible to participate in the Plan, and no later than September 30, in order to qualify for the wellness incentive contribution.

**IMPORTANT: Failure to Establish an HSA**

If you have not established an HSA with the trustee/custodian designated by Vantiva prior to the last payroll processing date for the Plan Year:

- (A) any portion of your compensation for the Plan Year that was previously withheld on a pre-tax basis for contribution to an HSA will be paid to you no later than December 31 of the Plan Year, and
- (B) you will forfeit any Employer HSA Contributions for the Plan Year.

**If You Are on an Approved Leave of Absence**

If you are on an Approved Absence, including an FMLA leave or extended Medical Leave (e.g. medical leave beyond FMLA), and are receiving compensation, your compensation deferral will continue and you will continue to participate in the Flex Plan as though you were an active Employee.

If you are on an Approved Absence and not receiving compensation, you are not eligible to make contributions on a pre-tax basis. However, if you continue to participate in the High Deductible Health Plan and pay your monthly premiums, you can make contributions to your account on a post-tax basis, entitled to request reimbursement for Eligible Medical Expenses and you will be eligible to receive Employer HSA Contributions.

**WHEN HSA CONTRIBUTIONS END**

Your pre-tax HSA deferrals and Employer HSA Contributions will end when:

- Your employment terminates,
- You retire or die,
- Your employment status changes and you are no longer eligible for HSA Contributions through the Flex Plan;
- You transfer to an employer whose employees are not eligible for HSA Contributions through the Flex Plan; or
- You become covered by a collective bargaining agreement that does not provide for you to make or receive HSA Contributions through the Flex Plan.

## **VII. VANTIVA WELLNESS & LIFESTYLE REWARDS PROGRAM**

Vantiva USA Shared Services Inc. is committed to helping you find the information and support needed to help make healthy, productive and life-enhancing choices. Our Vantiva wellness & lifestyle rewards program provides tools and support to help you have a healthy lifestyle. For more information, go to [www.myVantivaBenefits.com](http://www.myVantivaBenefits.com) and select “Wellness.”

### **Wellness Medical Premium Discount**

Employees who choose to participate in the Wellness & Lifestyle Rewards Program may be eligible to receive an annual medical premium discount for completing a series of health & financial activities. The medical premium discount will be effective the following year. Employees are not required to participate in the wellness & lifestyle rewards program.

### **Wellness HSA Incentive Contribution**

Employees who participate in the PPO Plus HSA Plan also have an opportunity to earn an additional Employer HSA Contribution for the employee and their covered spouse/domestic partner. If you and/or your covered spouse/domestic partner complete a health assessment through the Wellness & Lifestyle Program Provider within the specified time limits, Vantiva USA Shared Services Inc. will make an additional contribution to your HSA.

## VIII. CONTINUATION COVERAGE: COBRA CONTINUATION OF COVERAGE

The following contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan's Medical, Prescription Drug, Dental, Vision, HCFSA, and EAP Plans. COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **The following generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This is only a summary of your COBRA continuation coverage rights. You will receive a notice of COBRA continuation coverage.

### GENERAL RULES

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

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

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Vantiva, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.** When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: BenefitPlan Manager, 100 Valley Road Suite 202, Mt. Arlington, NJ 07856. You can also contact BenefitPlan Manager by calling (973) 393-8558.**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. If you are a Covered Employee, you may elect COBRA continuation coverage on behalf of your spouse or Children. If you elect COBRA continuation coverage, your COBRA continuation coverage will begin on the date of the qualifying event or, if later, on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

## **DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and the disability lasts at least until the end of the 18-month period of continuation coverage, then if you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. **You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to: BenefitPlan Manager, 100 Valley Road Suite 202, Mt. Arlington, NJ 07856. You can also contact You can also contact BenefitPlan Manager by calling (973) 393-8558.**

### Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated, but only if the subsequent event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60**

**days of the second qualifying event. This notice must be sent to: BenefitPlan Manager, 100 Valley Road Suite 202, Mt. Arlington, NJ 07856. You can also contact You can also contact BenefitPlan Manager by calling (973) 393-8558.**

## **THE HCFSA**

COBRA coverage under the HCFSA under the Vantiva Flexible Benefits Plan will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for the HCFSA COBRA coverage that will be charged for the remainder of the plan year.

COBRA coverage under the HCFSA will consist of the coverage amount in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, including any grace period. Unlike continuation for other health benefits, COBRA coverage under the HCFSA will terminate at the end of the plan year, including any grace period. The period of COBRA coverage under the Medical Expense Reimbursement Account cannot be extended under any circumstances.

Unless otherwise elected, all qualified beneficiaries who were covered under a participant's HCFSA will be covered together for HCFSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate HCFSA annual limit and a separate premium. If you are interested in this alternative, please contact Navia Benefits Solution Center by calling (425) 451-7002 for more information. Qualified beneficiaries may not enroll in the Medical Expense Reimbursement Account at open enrollment.

## **TRADE ADJUSTMENT ACT ELIGIBLE INDIVIDUAL**

If you do not initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under the Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount you have to pay out of pocket.

## **CONTINUATION COVERAGE: USERRA CONTINUATION OF COVERAGE**

Under USERRA, you may have a right to continuation of benefits under the Plan's Medical, Prescription Drug, Dental, Vision, HCFSA, and EAP Plans, subject to the conditions described below.

Under USERRA, if you (or your Dependents) are covered under the Plan, and you are on an Approved Absence by reason of military leave, you (and your Dependents, if applicable) may have the right to continue health coverage under the Plan. In order to be eligible for coverage during the period when you are on military leave, you must give reasonable notice to the Plan Administrator of your military leave. Upon providing notice, you will be entitled to COBRA-like rights with respect to your health benefits. You will be able to elect to continue coverage under the Plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for you to apply for or return to work with your employer. During military leave you are required to pay the Plan Administrator for the entire cost of such coverage, including any elected Dependents' coverage. However, if your absence is less than 31 days, you will continue to pay the portion of Premiums you would pay if you were an active employee, without a COBRA-type 2% administrative surcharge.

Also, when you return to work, if you meet the requirements specified below, the Plan Administrator will waive any exclusions and waiting periods, even if you did not elect to continue coverage. These requirements are (i) you gave reasonable notice to the Plan Administrator of military leave, (ii) your military leave did not exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and you received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) you apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that you were gone). You may also have to provide documentation to the Plan Administrator upon reemployment to confirm eligibility. This protection applies to you upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of your reinstatement of coverage.

## **IX. OTHER IMPORTANT INFORMATION**

### **COORDINATION OF BENEFITS**

If you or any other Covered Person is covered under another group health care plan, benefits under the Plan's Medical, Prescription Drug, Dental, and Vision Plans are coordinated with any benefits payable under the other plan so that duplicate benefits are not paid. It is your obligation to supply all of the requested information to the applicable Claims Administrator or Insurance Company. Failure to do so may delay the settlement of your claim or cause overpayment.

According to "coordination of benefits" rules, you send your claim to the primary plan first. After the primary plan has paid benefits, you send your claim, along with the primary plan's explanation of benefits, to the secondary plan.

If this Plan is secondary, it may pay benefits after the other plan has paid — but only if there are allowable expenses that exceed the primary plan's payment. Payment works as follows:

- Vantiva's Claims Administrator or Insurance Company determines the amount this Plan would have paid if it were primary.
- If there is a difference between the amount actually paid by the primary plan and the amount that this Plan would have paid as primary plan, Vantiva will pay the difference.

For more information on how coordination of benefits works and whether this Plan is primary or secondary to your other group coverage, please refer to the applicable summary prepared by the applicable Claims Administrator.

### **SUBROGATION AND RIGHT TO REIMBURSEMENT**

If this Plan pays benefits when a Covered Person incurs expenses because of injuries or illnesses that a third party such as another person or organization may be liable for, the Covered Person has a right to a Recovery.

Payments that are or may become the responsibility of another person or organization are called "Reimbursable Payments." Reimbursable Payments include past and future Covered Expenses, and Vantiva's attorney fees, expenses and costs, if any, to recover Reimbursable Payments.

The applicable Claims Administrator has the authority to interpret and apply the Plan provisions in this section and all other plan provisions and to determine the amount of the Plan's subrogation lien or right of reimbursement. For purposes of this Subrogation and Right to Reimbursement Section only, all references to "Claims Administrator" also refer to Insurance

Company if the benefit at issue is a fully insured benefit (e.g., under the Vision Plan or the fully-insured Medical Plan).

By enrolling in this Plan and applying for benefits, the Covered Person agrees to the following terms and conditions:

### **Subrogation**

- The Plan has the right to recover Reimbursable Payments from any person or organization, including an insurer or other group health plan, that is or may be responsible for compensating the Covered Person for his or her injuries or illnesses. This right to subrogation includes the right for the Plan to take legal action against any person or organization to recover Reimbursable Payments on behalf of the Covered Person, even if the Covered Person chooses not to pursue the claim. The Plan also has the right to intervene in any action or other proceeding to protect the Plan's rights. The Plan's rights to recover Reimbursable Payments from insurers includes Recovery against:
  - No-fault insurance where no person or entity may be responsible,
  - Underinsured or uninsured motorist insurance,
  - Workers' compensation insurance, or
  - Other first-party or third-party insurance coverage
- The Plan must be reimbursed first and in full for all Reimbursable Payments (regardless of whether the Covered Person is fully compensated) before any part of any Recovery is paid to the Covered Person's claims, attorney fees, other expenses or costs.
- The Covered Person and his or her legal representative must do whatever is necessary to assist the Plan and Claims Administrator to exercise their rights.
- If the total assets from a Recovery are not enough to fully reimburse the Plan's claim for Reimbursable Payments and any claim the Covered Person can make in the future, the Plan's claim must be paid before the Covered Person's claim, attorney fees, other expenses or costs.
- The Plan is not responsible for the Covered Person's attorney fees, expenses or other costs that are Incurred in pursuing a Recovery unless the Plan gives prior written consent. The Covered Person agrees that the "common fund" doctrine must not apply to any part of the Recovery the Covered Person's attorney obtains, regardless of whether the funds recovered are used to repay Reimbursable Payments.

## Reimbursement

If you obtain a Recovery and the Plan has not been repaid the Reimbursable Payments in full, the Plan has the right to be repaid from the Recovery in the amount of the Reimbursable Payments. In addition, the following apply:

- The Covered Person must reimburse the Plan before others are reimbursed and in full up to the Reimbursable Payments, even if the Covered Person is not fully paid for the losses and injuries. This reimbursement must be made regardless of any settlement agreement or court order mandates about how payments are allocated. And, the reimbursement must be made before any part of the Recovery is paid to the Covered Person's claims, attorney fees, other expenses, or costs.

The Covered Person's duty to reimburse the Plan applies to any money received from insurers, including under no-fault insurance, underinsured or uninsured motorist insurance, workers' compensation insurance, or other first-party or third-party insurance coverage, or group health plan.

- The Covered Person and his or her attorney must hold the proceeds of the Recovery to be paid to the Plan in trust for the Plan. This includes proceeds to be paid immediately upon the Covered Person's actual or constructive receipt of the Recovery. The Covered Person agrees that the Plan has a secured proprietary interest in any Recovery that the Covered Person receives or may be entitled to receive. The Covered Person acknowledges that the Plan is entitled to a constructive trust interest in the proceeds of any Recovery. The Covered Person consents to the imposition of this trust, the funding of this constructive trust using any Recovery proceeds, and the payment of funds from the trust directly to the Plan or the applicable Claims Administrator or Insurance Company.

Having accepted benefits from the Plan, the Covered Person agrees to serve as a constructive trustee over the funds. If the Covered Person does not hold the funds in trust to ensure payment to the Plan, it will be considered a breach of the Covered Person's fiduciary duty to the Plan.

- If the Covered Person does not repay the Plan, the Plan and Claims Administrator is entitled to deduct any of the unpaid portion of the Reimbursable Payments or the amount of your Recovery, whichever is less, from any future Plan benefit, if:
  - The amount the Plan paid on behalf of the Covered Person is not repaid or otherwise recovered by the Claims Administrator, or
  - The Covered Person does not cooperate
- If the Covered Person does not disclose the amount of the Recovery to the Plan or the Claims Administrator, the Plan and Claims Administrator may deduct the amount owed

to the Plan from any future benefit the Covered Person is entitled to receive from the Plan.

- The Plan and Claims Administrator may recover the unpaid portion of Reimbursable Payments or the amount of your Recovery, whichever is less, from the Providers the Plan has paid. In this situation, the Covered Person may be obliged to pay the Provider the full billed amount. The Plan would not be required to pay the Provider.

If the Covered Person receives any Recovery and does not abide by the terms of this agreement, in addition to any remedies the Plan may have, the Plan and Claims Administrator have a right of equitable offset against the Covered Person's future claims.

- The Covered Person agrees that the Plan may take legal action against the Covered Person, another person or an organization to recover Reimbursable Payments. Any legal action the Plan takes will not affect the Covered Person's right to pursue other forms of Recovery, unless the Covered Person and his or her legal representative give their approval.

#### **Your Duties**

- The Covered Person must promptly notify the Claims Administrator of how, when and where an Accident or incident occurred when the Accident or incident caused injuries or Illnesses to the Covered Person. The Covered Person also must provide the Claims Administrator with all information regarding any person or organization involved.
- If the Claims Administrator believes that the Plan may have a subrogation lien, the Covered Person must complete a subrogation questionnaire, sign an acknowledgement of the Plan's subrogation rights, and sign an agreement to provide ongoing information. These three things must be completed **before** the Plan pays or continues to pay any Covered Expenses. When the Plan receives these materials, the Plan may begin or continue advancing Covered Expenses as long as the payment in no way blocks the Plan's right to Recovery.
- The Covered Person must send the Claims Administrator copies of all police reports, notices or other papers related to the Accident or incident that caused the injuries or Illnesses.
- The Covered Person must cooperate with the Plan and Claims Administrator in the investigation, settlement and protection of the Plan's rights.
- The Covered Person must not do anything to obstruct the rights of the Plan.
- The Covered Person must promptly notify the Claims Administrator if he or she retains an attorney or if a lawsuit is filed on the Covered Person's behalf. The Covered Person also must keep the Claims Administrator informed of all developments related to a

Recovery. The Covered Person, by accepting benefits, must instruct his or her attorney to not assess any fees against the Plan in the event of Recovery without having received the Plan's prior written consent.

- The Covered Person must not release any person or organization without prior written approval from the Claims Administrator.
- The Covered Person must have the Plan named as co-payee on any settlement check making up a Recovery.
- The Covered Person must inform his or her attorney of the Plan's subrogation lien and right to reimbursement. The Covered Person also must inform his or her attorney not to make distributions from any Recovery that will cause the Plan to receive less than the full amount due unless the Plan gives prior written approval of the distributions. The Covered Person must instruct the attorney to reimburse the Plan from any amounts the attorney holds or may hold in the attorney's trust account.
- The Covered Person must refrain from characterizing any Recovery in a way that will avoid repayment of the Plan's subrogation lien or right to reimbursement.
- If the Plan advances benefits for the payment of Covered Medical Expenses, the Plan pays secondary to all PIP, Med-Pay or No-Fault insurance coverage. The Plan does not have to pay claims until PIP, Med-Pay or No-Fault coverage limits are exhausted. If the Plan pays claims that should have been paid by PIP, Med-Pay or No-Fault coverage, then the Plan has the right to receive reimbursement from the PIP, Med-Pay or No-Fault insurance carriers.

## **RIGHT OF RECOVERY**

Vantiva and the Claims Administrator (or Insurance Company, if applicable) have the right to recover, on the behalf of the Plan, any benefits that are overpaid, and reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

The Plan has established policies to determine which recoveries to pursue, and when to incur expenses and settle or compromise Recovery amounts. The Plan may not provide you with notice of overpayments made by the Plan or the Covered Person if the Recovery method makes providing the notice administratively impractical.

## **RIGHT TO AMEND OR TERMINATE**

Vantiva may amend, terminate, suspend, withdraw, or modify the Plan in whole or in part at any time, subject to the provisions of the applicable insurance contract and policy.

## **KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

**In order to protect your family's rights, you must keep the Plan Administrator informed of any changes in the addresses of family members.** You should also keep a copy, for your records, of all notices you send to the Plan Administrator.

## **X. CLAIMS AND APPEALS PROCEDURE**

### **Seeking Review of Decisions You Disagree With**

If you apply for a benefit and your claim is denied in whole or in part, each component plan has a claims review procedure that you must follow in order to seek review of your claim.

Following the claims procedure is very important because it may affect your legal rights under the plan.

The claims procedure is intended to provide a fair review of whether the terms of the Plan have been followed in your case. The claims procedure is not intended as a way to air suggestions or complaints about the benefits offered by Vantiva, and such matters will not be considered under the claims procedure.

### **Benefit Claims and Appeal Procedure**

For full details regarding the benefit claims and appeal procedure for each component plan, you should consult the benefits booklet prepared by the applicable Claims Administrator (or Insurance Company, if applicable) and contact the claims and appeal agents listed in the ERISA INFORMATION section of this Summary.

The benefit claims and appeals process is fully outsourced to the applicable Claims Administrator or Insurance Company. Vantiva has no involvement whatsoever with decisions relating to claims and appeals for the benefits described in this Summary, other than appeals for the EAP.

### **Legal Action**

If you have gone through the entire claims process, you have the right to file a lawsuit challenging the denial. The claims procedures described above are required by federal law and are designed to ensure that disputes regarding the Plan are decided by the appropriate Plan fiduciaries. Therefore, courts almost always require that a claimant exhaust a plan's claims procedures before filing suit (both filing the initial claim and appealing a denied claim). If you fail to do so, the court will likely dismiss your lawsuit. Except in rare circumstances, the court will not allow you to introduce new evidence or arguments to support your claim. Thus, you should make sure that everything that you believe supports your position is submitted to the appropriate Plan fiduciaries during the claims process.

You may pursue legal action only after you have completed the Plan's claims process. For a fully-insured benefit such as the Vision Plan, the time period for bringing any lawsuit against the Insurance Company or the Plan shall be determined by the terms of the insurance policy or law. Notwithstanding the foregoing, however, if you have completed the claims process and want to bring a lawsuit against Vantiva (including Vantiva in its capacity as Plan Administrator), any Vantiva officer, employee, or director, or any Plan committee or member, you must do so within the shorter of one (1) year of the final denial of your claim or three (3) years from the date of the services giving rise to the claim. If you want to bring a lawsuit related to the Plan for any reason other than to claim a benefit, you must do so within one year of the act or

omission giving rise to the claim. Failure to file a lawsuit within these time periods will cause your rights to expire.

The Plan is governed by ERISA, and state law is generally preempted. All lawsuits arising under the Plan or relating to the Plan must be submitted in state or federal court if the lawsuit names as a defendant Vantiva (or a participating affiliate); and employee, officer, or director of Vantiva (or a participating affiliate); a Plan committee or a member thereof; or the Plan itself.

**Scope of Discretionary Authority**

The Claims Administrator (or Insurance Company, if applicable) is the Plan fiduciary for benefit claims and appeals. The appropriate Plan fiduciary has the final and discretionary authority to determine claims and appeals, and has the final and discretionary authority to interpret all terms of the Plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by the appropriate Plan fiduciary on review is final and binding, subject to your right to file a lawsuit under ERISA or other applicable law. This decision-making authority is very broad and is limited only by the duties imposed under ERISA. The determination is intended to be given deference by courts to the maximum extent allowed under ERISA.

## **XI. YOUR RIGHTS UNDER ERISA**

As a participant, 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. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a benefit under the plan. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

### **Continue Group Health Plan Coverage**

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **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 pension or welfare benefit or exercising your rights under ERISA.

### **Enforcing Your Rights**

If your claim for a pension or 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. You have the right to have the plan administrator review and consider your claim. If you fail to exhaust the plan’s claims procedures, you will lose your right to appeal and dispute any denial.

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 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. However, before you file suit, you must first complete all of the claims procedures outlined in this Summary. If you do not follow these claims procedures, you will have no right to review and no right to bring action, at law or at equity, in any court, and the denial of the claim will become final and binding.

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.

### **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.

## XII. ERISA INFORMATION

### Plan Name

Vantiva Employee Benefit Plan.

### Plan Number Assigned by Plan Sponsor

501

### Type of Plan

Welfare Plan

### Date of End of Plan Year for Purposes of Maintaining Plans' Fiscal Records

December 31

### Plan Administrator

Vantiva USA Shared Services Inc.

Benefits Department

4855 Peachtree Industrial Blvd., Suite 200, Norcross, GA 30092, USA

Telephone Number: (818) 260-4903

Employer Identification Number: 35-1724835

Service of legal process may be made upon the Plan Administrator at the address given above.

If you write to the Plan Administrator, be sure to give enough information so that your records can be located for a prompt reply. Give your name, address, employee identification number, and location where you work or worked.

### Participating Employers

Vantiva USA Shared Services Inc.

EIN: 35-1724835

4855 Peachtree Industrial Blvd., Suite 200, Norcross, GA 30092, USA

Vantiva Supply Chain Solutions, Inc.

EIN: 95-3779864

(formerly Technicolor Home Entertainment Services, Inc.)

Vantiva USA LLC

(formerly Technicolor Connected Home USA LLC)

EIN: 46-2926832

## **ROLE OF INSURANCE COMPANY/TPA PROVIDER**

Vantiva is required to disclose certain information about the role of each Insurance Company and provider in the administration and financing of the Plan. This information is provided in the table below. For benefit types that list the funding medium as general assets of Vantiva, those benefits are paid from general assets of Vantiva, rather than through an insurance policy with an insurance company. Vantiva's share of the cost is based on the total claims experience of

the plan. The administrative services provided by the third-party administrator include claims administration, processing of benefit payments, and other administrative services.

BENEFIT TYPE/PLAN	NAME OF INSURANCE COMPANY OR THIRD PARTY ADMINISTRATOR	PLAN FUNDING	NATURE OF SERVICES PROVIDED TO THE PLAN
Medical HDHP Plan	Anthem or Cigna	Funded by the General Assets of Vantiva USA Shared Services Inc.  Employee Contributions Required	Claims Administration
Medical Plan Pharmacy – PPO/HDHP	CVS/Caremark	Funded by General Assets of Vantiva USA Shared Services Inc.  Employee Contributions Required	Claims Administration
Medical Plan Health Maintenance Organizations (HMOs). Available HMOs vary by location and include: <ul style="list-style-type: none"> <li>• Kaiser Permanente Southern California</li> <li>• Kaiser Permanente Northern California</li> <li>• Kaiser Permanente Georgia</li> </ul>	Kaiser Permanente	Fully Insured  Employee Contributions Required	Insurer, Claims Administration
Global Health Plan	Blue Cross Blue Shield - GeoBlue	Fully Insured  Employee Contributions Required	Insurer, Claims Administration
Dental Plan	Delta Dental of California	Funded by the General Assets of Vantiva USA Shared Services Inc.  Employee Contributions Required	Claims Administration

<b>BENEFIT TYPE/PLAN</b>	<b>NAME OF INSURANCE COMPANY OR THIRD PARTY ADMINISTRATOR</b>	<b>PLAN FUNDING</b>	<b>NATURE OF SERVICES PROVIDED TO THE PLAN</b>
Vision Plan	The Guardian Life Insurance Company of America	Fully Insured  Employee Contributions Required	Insurer, Claims Administration
Employee Assistance Program	Magellan EAP	Funded by the General Assets of Vantiva USA Shared Services Inc.	Claims Administration
Flexible Benefit Plan includes HCFA, Dependent Care Account, and Premium Conversion	Navia Benefit Solutions	Funded by the General Assets of Vantiva USA Shared Services Inc.  Employee Contributions Required	Claims Administration

**CLAIMS CONTACT INFORMATION  
CLAIMS ADMINISTRATORS, INSURANCE COMPANIES AND PLAN  
ADMINISTRATOR**

TYPE OF CLAIM	CONTACT INFORMATION FOR CLAIMS	CONTACT INFORMATION FOR APPEALS
Collected Vantiva-sponsored Medical Plan - Anthem (outside Memphis)	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 (866) 542-4469	Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 (866) 542-4469
Vantiva-sponsored Medical Plan – CIGNA (Memphis Location)	CIGNA HealthCare PO Box 182223 Chattanooga, TN, 37422-7223 (800) 244-6224	CIGNA HealthCare PO Box 182223 Chattanooga, TN, 37422-7223 (800) 244-6224
Prescription Drugs (for Anthem and Cigna Plans)	CVS/Caremark P.O. Box 52136 Phoenix, Arizona 85072-2136	Caremark, Inc. Attn: Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084, or faxed to: 866-443-1172.
Health Maintenance Organizations (HMOs)  Available HMOs vary by location and include Kaiser Permanente Southern California Northern California Georgia	Southern California Claims Kaiser Permanente Claims Administration P.O. Box 7004 Downey, CA 90242-7004  Northern California Claims Kaiser Permanente Claims Administration P.O. Box 12923 Oakland, CA 94604-2923	Southern California Appeals Member Appeals Special Service Grievance Unit P.O. Box 7136 Pasadena, CA 91109-7136  Northern California Appeals Kaiser Foundation Health Plan P.O. Box 23280 Oakland, CA 94623-0280
	Kaiser Permanente GA Claims P O Box 370010 Denver, CO 80237-9998	Kaiser Permanente ATTN: Appeals Dept 3495 Piedmont Road Atlanta, GA 30305

Global Health Plan	GeoBlue Attn: Claims Department P.O. Box 1748 Southeastern, PA 19399-1748  Email: <a href="mailto:claims@geo-blue.com">claims@geo-blue.com</a> Fax: +1-610-482-9623	4 ever Life Insurance Company Attn: Grievance/Appeal Request 2 Mid America Plaza, Suite 200 Oakbrook Terrace, IL 60181-4712  Email: <a href="mailto:bcsassist@bcsins.com">bcsassist@bcsins.com</a>
Dental Plan	Delta Dental of California PO Box 997330 Sacramento, CA 95899-7330	Delta Dental of California Appeals PO Box 997330 Sacramento, CA 95899-7330
Vision Plan	The Guardian Life Insurance Company 10 Hudson Yards New York, NY 10001 (212) 598-8000	The Guardian Life Insurance Company 10 Hudson Yards New York, NY 10001 (212) 598-8000
Employee Assistance Program	Magellan EAP Magellan Behavioral Health, P.O. Box 2128, Maryland Heights, MO 63043 (800) 846-6111	Vantiva Administrative Committee 4855 Peachtree Industrial Blvd., Suite 200 Norcross, GA 30092
COBRA	BenefitPlan Manager (BPM) <a href="mailto:COBRA@BenefitPlanManager.com">COBRA@BenefitPlanManager.com</a>	BenefitPlan Manager (BPM) 100 Valley Road, Suite 202 Mount Arlington, NJ 07856 <a href="mailto:COBRA@BenefitPlanManager.com">COBRA@BenefitPlanManager.com</a>
FSA and Dependent Care Account	Navia Benefit Solutions PO Box 53250 Bellevue, WA 98015-3250 Claims Fax Number: (425) 451-7002	Navia Benefit Solutions PO Box 53250 Bellevue, WA 98015-3250 Claims Fax Number: (425) 451-7002

### **XIII. DEFINITIONS**

***The following terms are used in this Summary.*** The definitions given below may not include all technical details. Please see the Employee Benefit Plan or Flex Plan document, as applicable, for complete details. The definitions provided in this Summary do not modify the Employee Benefit Plan or Flex Plan or serve as an agreed interpretation of any provision of the Plans.

**Accident**

A trauma which arises suddenly under unforeseen conditions.

**Ambulatory Surgical Center**

A Provider that is licensed (if required), is equipped mainly to do Surgery, has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present, is not an office maintained by a Physician for the general practice of medicine or dentistry, and is equipped and ready to initiate Emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.

**Approved Absence**

A leave of absence authorized by a Participating Employer. Includes all military leaves and other leaves of absence covered by USERRA.

**Authorized Service**

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level.

**Benefit Period**

The period of time that, if coverage does not otherwise end, benefits for Covered Services are payable under the Plan. Unless otherwise indicated, the Benefit Period is the Plan Year.

**Birthing Center**

A Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be constituted, licensed, and operated as set forth in the laws that apply, equipped to provide low risk maternity care, adequately staffed with qualified personnel who provide care at childbirth, are practicing within the scope of their training and experience, and are licensed if required, and equipped for and ready to initiate Emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

**Board and Room**

Charges made by an institution for board and room and other Necessary services and supplies. Such charges must be regularly made at a daily or weekly rate.

**Brand Name Drug**

A drug item, which is under patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies. There are two types of Brand Name Drugs:

- Single Source Brand: those drugs that are produced by only one manufacturer and do not have a Generic equivalent available.
- Multi-Source Brand: those drugs that are produced by multiple pharmaceutical manufacturers and do have a Generic equivalent available on the market.

**Certified Registered Nurse Anesthetist**

Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by the applicable state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

**Child or Children**

See Dependent.

**Claims Administrator**

The entity or individual authorized by the Plan Administrator to act on its behalf to review and determine benefit claims and/or appeals. The applicable Claims Administrator for each Plan is listed in the ERISA INFORMATION section.

**Claim Form**

The appropriate form for submission of a claim.

**COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1986.

**Code**

The Internal Revenue Code of 1986, as amended from time to time.

**Collected Vantiva-sponsored Medical Plans**

The group of medical plan options offered by Vantiva. The following plan is included: Vantiva HDHP Plan.

**Continuous Service**

The period of time (counted in years, months and days) beginning with your most recent date of employment as an eligible Employee with a Participating Employer, or any predecessor of a Participating Employer (as determined by the

Plan Administrator), or any other corporation which is a member of the Group related to a Participating Employer.

**Copay or Copayment**

A specific dollar amount or percentage of Maximum Allowable Amounts for Covered Services as indicated in the Collected Vantiva-sponsored Medical Plan. Copayments are the responsibility of the Covered Person. A Copayment does not apply towards any Deductible. Flat dollar Copayments are the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

**Covered Employee**

An eligible Employee who is a current Participant in the plan to which this definition applies.

**Covered Expense**

For the Medical Plan and the Flex Plan Reimbursement Account, a Covered Medical Expense. For any other component plan of the Employee Benefit Plan, an expense that is covered by such component plan pursuant to the terms of such component plan.

**Covered Medical Expense (Collected Vantiva-sponsored Medical Plan)**

The Reasonable and Customary Expenses or charges for Covered Services.

**Covered Medical Expense (Flex Plan HCFSA)**

Any medical expense Incurred for the medical care (as defined in Code Section 213) of the Participant or his or her dependent, but only to the extent that such expense is not otherwise reimbursed or paid, and only to the extent that the Participant or his or her dependent is legally obligated to pay for such expense.

**Covered Person**

A Covered Employee or an Enrolled Dependent.

**Covered Services or Covered Medical Services**

Services, supplies or treatment performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under the Plan.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by the Plan.

A charge for a Covered Service is Incurred on the date the service, supply or treatment was provided to you.

**Custodial Parent**

A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to temporary visitation.

**Deductible**

The portion of the bill a Covered Person must pay before benefits become payable under the Collected Vantiva-sponsored Medical Plan, or Dental Plan. It usually is applied on a calendar year basis.

**Dental Plan**

The Vantiva Dental Plan, which is a component plan of the Employee Benefit Plan.

**Dentist**

A person duly licensed to practice dentistry by the governmental authorities having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered. The term “Dentist” also includes a licensed physician authorized by his or her medical license to perform the particular dental service he or she has rendered.

**Dependent (EAP)**

Dependents eligible for coverage under the EAP are:

- Your spouse or Domestic Partner.
- Your unmarried Dependent Children (whether or not they reside with you).
- Members of your household.

**Dependent (Medical, Dental and Vision Plans)**

Dependents eligible for coverage under the Collected Vantiva-sponsored Medical Plan, Dental Plan, and Vision Plan are:

- Your spouse.
- Your Child(ren) under 26 years of age.
- Your Child(ren) whose coverage would terminate because he/she turned age 26 will continue to be covered if such Child is incapable of self-sustaining employment for reasons of mental illness, retardation, or physical handicap at the time coverage would have ceased at age 26. Coverage will continue for so long as he/she remains incapable. You will be required to submit verification of such Child’s continuing eligibility to the Claims Administrator from time to time.

- Your Domestic Partner.
- Your Domestic Partner's Children will be considered Dependents if they meet eligibility requirements for Children of the Employee (see below) and satisfy the following requirements:
  - Children live with the Employee and the Domestic Partner in a parent-child relationship; and
  - Children qualify as the Domestic Partner's dependent(s) for tax purposes (as defined in Code Section 152) or the Domestic Partner is required to provide medical coverage pursuant to a court order.

Children include only:

- Your own children or legally adopted children;
- Stepchildren who are principally dependent on you for maintenance and support and who reside in your household;
- Children for whom legal adoption proceedings have been initiated or placed for adoption; and
- Children under age 26 for whom you have court-ordered custody that is expected to be permanent and long-term.

Children do not include:

- Foster children;
- Children for whom you have legal custody except those listed above; or
- Grandchildren unless they have been adopted by you or you have court-ordered custody that is expected to be permanent and long-term.

It is your responsibility to monitor Dependents you have enrolled in the Plan and to notify the Plan Administrator when you no longer need coverage for a Dependent or the dependent is no longer eligible for coverage (for example, the Dependent is over age 26 ).

**Dependent** (Flex Plan HCFSA)

Dependents for whom expenses may be reimbursed under the HCFSA include **only** Dependents of the Employee for federal income tax purposes, as defined in Code Section 152.

**Dependent Care Account**

The accounting record maintained under the Flex Plan for each Participant deferring compensation to such an Account for reimbursement of eligible Dependent Care Expenses.

**Dependent Care Expenses**

Expenses that satisfy the requirements of Code Section 129 and the regulations thereunder that are Incurred by a Participant for a qualifying individual as defined therein.

**Diagnostic Services**

Tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition.

**Domestic Partner**

An individual who is in a domestic partnership with an employee if the following requirements are met:

- Neither person is married to someone else or is a member of a domestic partnership with someone else that has not been terminated, dissolved or adjudged a nullity,
- The employee and partner are not related by blood in a way that would prevent them from being married to each other in the state in which they reside.
- Employee and partner are both at least the age of consent in the state in which they reside.
- Employee and partner are both mutually responsible for basic living expenses such as food, shelter and medical expenses. Employee and partner also share financial obligations.
- Employee and partner both complete the Affidavit of Domestic Partnership and provide required proof of domestic partnership.

**Domiciliary Care**

Care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of Board and Room, even if therapy is included.

**Durable Medical Equipment**

Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose as determined by the Claims Administrator in its sole discretion, generally is not useful to a person in absence of any Illness or Injury, is appropriate for use in the home, is not for use in altering air quality or temperature, and is not for exercise or training. Durable Medical Equipment

does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, communication aids, vision aids or telephone alert systems. The Claims Administrator shall have full discretion and final authority in determining whether equipment is Durable Medical Equipment.

#### **EAP**

The Vantiva Employee Assistance Program, which is a component plan of the Employee Benefit Plan.

#### **Earned Income**

Earned income as defined in Code Section 32(c)(2), but excluding any amounts paid or Incurred by Vantiva for Dependent care assistance to a Participant. If the spouse of the Participant is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, the spouse shall be deemed to have Earned Income of not less than Two Hundred Dollars (\$200) per month if the Participant has one Dependent, and Four Hundred Dollars (\$400) per month if the Participant has two or more Dependents.

#### **Election Period**

A designated period of at least 30 days preceding the first day of each Plan Year, except that in the case of an Employee who first become eligible to participate in the Collected Vantiva-sponsored Medical Plan during the Plan Year, the Election Period for such Employee shall be the period ending on the day he or she is eligible to participate in the Collected Vantiva-sponsored Medical Plan.

#### **Emergency**

An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

The Claims Administrator shall have full discretion and final authority in determining whether a medical condition is an Emergency.

#### **Emergency Care**

Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

**Emergency Room**

The portion of a facility Provider, generally a Hospital, designated to furnish Emergency Care.

**Employee**

A person in a common-law employee-employer relationship with a Participating Employer, as determined by Vantiva.

**Employee Benefit Plan**

The Vantiva Employee Benefit Plan.

**Employer HSA Contributions**

Contributions Vantiva, in its sole discretion, decides to make to the HSA of an HSA-Eligible Individual who has enrolled in a High Deductible Health Plan offered by Vantiva.

**Enrolled Dependent**

An eligible Dependent who is currently participating in a component plan of the Employee Benefit Plan, for the purposes of such component plan.

**ERISA**

The Employee Retirement Income Security Act of 1974, as amended from time to time.

**Experimental/Investigational Treatment**

Services which are considered Experimental or Investigational include services which:

- have not been approved by the Federal Food and Drug Administration or
- for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments.

Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. The Claims Administrator shall have full discretion and final authority in determining what is Experimental or Investigational Treatment.

**Flex Plan or Flexible Benefit Plan**

The Vantiva Flexible Benefit Plan, which is a component plan of the Employee Benefit Plan.

**FMLA**

Family and Medical Leave Act of 1993, as amended.

**Formulary**

A list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved due to their quality and cost effectiveness.

**Full-Time Employee**

An Employee hired by a Participating Employer for an indeterminate period of time and who is regularly scheduled to work a minimum of 30 hours per week.

**Generic Drug or Generic**

Drug which have been determined by the U.S. Food and Drug Administration to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug.

**Geographical Area**

The general locality in which a medical service, treatment or supply is actually provided, or a greater area if necessary to obtain a representative cross-section of charges for a like service, treatment or supply. In no event will a geographic area be less than the area delineated by the first three digits of the provider's zip code.

**Global Health Plan**

Vantiva-selected group health coverage for eligible Employees seconded or otherwise assigned outside the United States, which is a component plan of the Employee Benefit Plan.

**Group**

A controlled group of corporations in accordance with Section 414(b) of the Code or any other trade or business which is related to a Participating Employer as a trade or business under common control in accordance with Section 414(c) of the Code.

**HCFA or Healthcare Flexible Spending Account**

The accounting record maintained under the Flexible Benefit Plan for each Participant deferring compensation to such an account for reimbursement of Covered Medical Expenses.

**HDHP Plan or High Deductible Health Plan (PPO Plus)**

The Vantiva High Deductible Health Plan, which is a component plan of the Employee Benefit Plan.

**HIPAA**

The Health Insurance Portability and Accountability Act of 1996, as amended.

**Holiday**

A paid holiday as determined by the Participating Employer for the Employee's work location.

**Home Health Care and Home Health Care Agency**

A program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. A Home Health Care Agency is a Provider who renders such care and it must be licensed by the appropriate state agency.

**Hospice**

A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician attending the patient who establishes and reviews such plan from time to time. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

**Hospital**

An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty.

"Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

**Identification Card (ID Card)**

The latest card provided to Covered Person showing identification and group numbers, the type of coverage and the date coverage became effective.

**Illness**

A sickness or disease which is not due to an Injury, which requires treatment by a Physician or other Licensed Health Care Professional, and is Incurred by an Employee or Dependent on or after the date of coverage under the applicable plan.

**Incurred**

The date the care or service is rendered or a supply is furnished.

For purposes of the Dental Plan, a charge will also be considered Incurred:

- On the first date of preparation of the tooth or teeth involved, with respect to fixed bridgework, crowns, inlays, onlays, or gold restorations.
- On the date the impression was taken, with respect to full or partial dentures.
- On the date the tooth was opened for root canal therapy, with respect to endodontics.

**Injury**

A physical harm or damage to a Covered Person occurring on or after the date of coverage under the applicable plan and as a result of an Accident, either directly or indirectly, along with all other related conditions.

**In-Network**

A service or supply furnished by a Provider who has entered into a contractual agreement or is otherwise engaged by the Claims Administrator, or with another organization which has an agreement with the Claims Administrator.

**Inpatient**

A Covered Person who is treated as a registered bed patient in a Hospital and for whom a Board and Room charge is made.

**Insurance Company**

The applicable insurance carrier for each insured benefit is listed in the ERISA INFORMATION section.

**Layoff or Laid Off**

For an Employee covered by a collective bargaining agreement, the period of "Layoff" described in such collective bargaining agreement. Layoff does not include discharge, leave of absence, or voluntary termination of employment such as resignation or retirement.

**Licensed Health Care Professional**

A legally licensed practitioner of the healing arts who renders services within the scope of his or her license.

**Mail Service**

A Prescription Drug program to provide maintenance medications by mail for Covered Persons who take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from a licensed Pharmacy Mail Service, which has entered into a reimbursement agreement with the Claims Administrator, and sent directly to the Covered Person's home.

**Maximum Allowable Amount**

The amount that the Claims Administrator or its Subcontractor determines is the maximum amount payable for Covered Services you receive, up to but not to exceed charges actually billed. Generally, to determine the Maximum Allowable Amount for a Covered Service, the Claims Administrator or its Subcontractor uses internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for the Covered Medical Expense. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a Physician or other non-facility Provider, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for the Plan even if the Provider has a participation agreement with the Claim Administrator for another product.

For a Non-Network Provider which is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services. In the absence of a negotiated amount, the Claims Administrator shall have discretionary authority to establish, as the Claims Administrator deems appropriate, the Maximum Allowable Amount for a Non-Network Provider facility. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility's charge, or an amount determined by the Claims Administrator, after consideration of any one or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that the Claims Administrator may have made, or other factors the Claims Administrator deems appropriate. It is your obligation to pay any Copayments and Deductibles, and any amounts which exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with the Claims Administrator.

### **Medical Plan**

Collectively, the Vantiva Preferred Provider Organization, Exclusive Provider Organization, and the High Deductible Health Plans, which are each a component plan of the Employee Benefit Plan.

### **Medically Necessary or Medical Necessity**

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Claims Administrator, on behalf of Vantiva, to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Covered Person's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Covered Person and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Covered Person, the Covered Person's family or the Provider.
- Not otherwise subject to exclusion under the Collected Vantiva-sponsored Medical Plans.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

### **Medical Supplies**

Syringes, needles, oxygen, splints and other similar items which serve only a medical purpose, but not items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly. Medical Supplies include

Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office.

**Mental Health Conditions**

Mental Health Conditions are identified as mental disorders in the most current version of the International Classification of Diseases, in the chapter titled "Mental Disorders". Mental Health Conditions are manifested through symptoms that are primarily mental or nervous, regardless of any underlying physical causes. In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual. Mental Health Conditions include Substance Abuse Conditions.

**National BlueCard Network**

The national network of Anthem Providers.

**Network (or In-Network) Provider**

A Provider who has entered into a contractual agreement or is otherwise engaged by the Claims Administrator, or with another organization which has an agreement with the Claims Administrator, regarding payment for Covered Services and certain administration functions for the Network associated with the Plan.

**New FDA Approved Drug Product or Technology**

The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- a new dosage form or new formulation of an active ingredient already on the market;
- a product that duplicates another firm's previously marketed drug product (same active ingredient, formulation, or combination);
- a new use for a drug product already marketed by the same or a different firm; or
- a newly introduced Generic medication.

**No-Fault Automobile Insurance Law/No-Fault Automobile Coverage**

State law that provides for payment of medical expenses resulting from an automobile accident without determining who was at fault in the accident.

**Non-Formulary Drug**

A drug that is not on the Formulary list.

**Non-Network (or Out-of-Network) Provider**

A Provider who has not entered into a contractual agreement with or been otherwise engaged by the Claims Administrator, or is not otherwise engaged by the Claims Administrator, for the network associated with the applicable Plan. Providers who have not contracted or affiliated with the Claims Administrator's designated Subcontractor(s) for the services they perform under this Plan are also considered Non-Network Providers.

**Non-Represented Employee**

An Employee who is not represented by a collective bargaining agent or included in a collective bargaining unit recognized by a Participating Employer.

**Open Enrollment**

A designated Election Period of at least 15 days preceding the first day of each Plan Year, except that in the case of an Employee who first becomes eligible to participate during the Plan Year, the Election Period for such Employee shall be the period ending on the day he or she is eligible to participate.

**Out-of-Pocket Maximum**

The maximum amount of a Covered Person's Coinsurance payments during a given calendar year. Such amount does not include Copayments, charges in excess of the allowed amount or Coinsurance paid toward behavioral health or treatment of Substance Abuse Conditions.

**Out-of-Network**

A service or supply furnished by a Provider that is not in the applicable Network.

**Outpatient**

A Covered Person who receives services or supplies but who is not an Inpatient.

**Part-Time Employee**

An Employee hired by a Participating Employer for an indeterminate period of time and who is regularly scheduled to work less than 30 hours per week at his or her work location. See also, Partially Eligible Part-Time Employee and Wholly-Eligible Part-Time Employee.

**Partially Eligible Part-Time Employee**

A Part-Time Employee who is regularly scheduled to work less than 20 hours per week.

**Participant**

An Employee who elects to participate in coverage under a Plan for which the Employee is eligible.

**Participating Employer**

Vantiva and each subsidiary or affiliated company of Vantiva that adopts the Plan. The Participating Employers are listed in the ERISA Information Section of this Summary.

**PPACA**

The Patient Protection and Affordable Care Act, as amended.

**Pharmacy**

An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

**Pharmacy and Therapeutics Committee**

A committee formed by the Claims Administrator comprised of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. This committee develops, reviews and/or approves guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

**Physician**

A legally licensed doctor of medicine, osteopathy, or optometry, or other legally licensed practitioner of the healing arts rendering services which are covered by the Plan, required by law to be covered when rendered by such practitioner, and within the scope of his or her license. Physician does not include you or your spouse, parent, child, sister, brother, or in-law.

**Plan Administrator**

Vantiva USA Shared Services Inc.

**Plan Year**

The 12-month period commencing on January 1 and ending on December 31.

**Prescription Drugs**

Drugs that, under federal law, may not be dispensed without a prescription by a duly licensed Physician, dentist or podiatrist. Notwithstanding the foregoing, prescription drugs used for Experimental/Investigational Treatment are excluded from the definition of Prescription Drugs.

**Prescription Legend Drug**

A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered Prescription Legend Drugs.

**Prescription Order**

A written request by a Provider, as permitted by law, for a Prescription Drug or medication and each authorized refill for same.

**Prior Authorization**

The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

**Provider**

A licensed person or facility that provides services within the scope of that license and of which the Plan approves. This includes any Provider rendering services required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities:

- Ambulatory Surgical Center
- Birthing Center
- Certified Registered Nurse Anesthetist
- Home Health Care Agency
- Hospice
- Hospital
- Pharmacy
- Physician
- Skilled Nursing Facility
- Urgent Care Center

**Qualified Medical Child Support Order (QMCSO)**

A judgment, decree, or order (including approval of a settlement agreement) issued by a court or administrative agency in accordance with state domestic relations law or the Social Security Act that creates or recognizes the right of an alternate recipient, a child of a Participant, to receive benefits under a group health plan. To be “qualified,” the order must comply with the provisions of ERISA Section 609. A QMCSO may apply to the Collected Vantiva-sponsored Medical Plans, Dental Plan, Vision Plan, EAP or HCFSA.

### **Reasonable and Customary or Reasonable Charge**

The usual charge made by a Physician or other supplier of services or supplies; provided, however, such charge may not exceed the 90th percentile of charges of providers in the Geographic Area for the specific procedure. Only that part of a charge which is considered reasonable is covered by the Collected Vantiva-sponsored Medical Plans. The Reasonable Charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge the Claims Administrator determines to be appropriate based on factors such as the cost of providing the same or similar service or supply and the manner in which charges for the service or supply are made.

In determining the Reasonable Charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, the Claims Administrator may take into account factors such as the complexity, the degree of skill needed, the type of specialty of the provider, the range of services or supplies provided by the facility; and the recognized charge in other areas. In some circumstances, the Claims Administrator may have an agreement with a provider (either directly or indirectly through a third party) which sets the rate that the Claims Administrator will pay for a service or supply. In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement.

The determination of Reasonable and Customary shall be made by the Claims Administrator in its sole discretion. The Claims Administrator shall have full discretion and final authority in making the determination of Reasonable and Customary.

### **Recovery**

A Recovery is money you receive or are due to receive from another, their insurer or from any Uninsured Motorist, Underinsured Motorist, Medical-Payments, No-Fault, or Personal Injury Protection, or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Right to Reimbursement provisions of the Collected Vantiva-sponsored Medical Plans.

### **Reimbursable Payments**

Reimbursable Payments include past and future Covered Medical Expenses paid under the Collected Vantiva-sponsored Medical Plans that are or may become the responsibility of another person or organization. Reimbursable Payments also include Vantiva's attorney fees, expenses, and costs, if any, to recover Reimbursable Payments.

**Residential Treatment**

Individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

**Skilled Nursing Facility**

A Provider constituted, licensed, and operated in accordance with applicable state law, which mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury. Care is supervised by a Physician, with 24-hour per day nursing care supervised by a full-time Registered Nurse. A Skilled Nursing Facility is not a place primarily for care of the aged, custodial care or Domiciliary Care, or the treatment of alcohol or drug dependency, nor is it a facility for rest or education.

**Special Enrollment**

A 30-day (or, for eligibility based on Medicaid or CHIP coverage, 60-day) period following loss of other coverage, acquisition of a new dependent, or change in status during which coverage elections under the Collected Vantiva-sponsored Medical Plans, the Dental Plan, or the Vision Plan can be modified.

**Specialist**

A Physician whose medical practice and expertise is in a particular medical specialty area and who is not a primary care Physician.

**Stabilize**

The provision of medical treatment in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of a Covered Person's condition is not likely to result from or during any of the following:

- discharge from an Emergency department or other care setting where Emergency Care is provided;
- transfer from an Emergency department or other care setting to another facility; or
- transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

**Subcontractor**

Vantiva or the Claims Administrator may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to services related to Prescription Drugs and Mental Health Conditions, behavioral health, and Substance Abuse Conditions. Such subcontracted organizations or entities may make benefit determinations

and/or perform administrative, claims paying, or customer service duties on the behalf of Vantiva or the Claims Administrator.

**Substance Abuse Conditions**

Conditions brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

**Total Disability or Totally Disabled**

Your complete inability, because of Injury, Illness, or pregnancy, to perform any and every duty pertaining to your occupation or employment.

For the first two years after the exclusion period under the Vantiva Long Term Disability Plan, it is your inability, because of Illness, Injury, or pregnancy, to perform your regular duties. Thereafter, Total Disability means your inability to work in any occupation or employment for which you are or may become reasonably qualified.

Under the Vantiva Short-term Disability Plan for Memphis, Total Disability is your inability, because of Illness, Injury, or pregnancy, to perform your regular duties.

You must be under the care of a Physician while Totally Disabled.

**Urgent Care**

Care provided for unexpected episodes of illness or injury requiring treatment that cannot reasonably be postponed for regularly scheduled care. Urgent Care medical problems include, but are not limited to:

- Earache
- Sore throat
- Fever (not above 104 degrees).

Urgent Care is not for life threatening conditions and does not require the use of an Emergency room at a Hospital.

**Urgent Care Center**

A health care facility with a primary purpose of offering and providing immediate, short-term medical care, without appointment, for Urgent Care. An Urgent Care Center is organizationally separate from a Hospital.

**USERRA**

The Uniformed Services Employment and Reemployment Rights Act.

**Vantiva**

Vantiva USA Shared Services Inc. as now constituted or as may be constituted hereafter, or any person, firm, corporation or partnership which may succeed to its business and which adopts the Employee Benefit Plan.

**Vision Plan**

The Vantiva Vision Plan, which is a component plan of the Employee Benefit Plan.

**Wholly Eligible Part-Time Employee**

A Part-Time Employee who is regularly scheduled to work between 20 and 29 hours per week.

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